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Treating At-Risk Adolescent Mothers and their Children: Family Therapy Delivered from the Theraplay® Model

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Abstract

This advanced practicum project describes a pilot project for teen mothers and their preschool children, developed from the principles of Theraplay®, a play-based, attachment-focused intervention. Specifically, the objective of this project was to explore the applicability and value of using this type of intervention among adolescent mothers in a limited service region in Sudbury, Ontario. My experience showed that using the Theraplay model was useful in improving the relationship between adolescent mothers and their children by promoting positive interactions. The findings indicate play-based interventions have value with this at-risk population.

Résumé

Ce projet de stage spécialisé consiste d'un projet pilote pour des jeunes mères et leurs enfants préscolaire, de développer des principes de « Theraplay », une intervention basé sur la thérapie par le jeu qui vise sur l'attachement. Plus précisément, l'objectif de ce projet avait pour but d'explorer l'application et l'utilité de ce type d'intervention parmi les mères adolescentes dans une région offrant des services limités. Mon expérience fait preuve que l'application du modèle « Theraplay » améliore la relation entre les mères-adolescentes et leur enfant tout en favorisant les interactions positives. Les trouvailles indiquent que les interventions basées sur « Theraplay » ont une importance afin d'intervenir auprès de telle population à risque.

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"There is nothing to writing. All you do is sit down at a typewriter and bleed."

-Ernest Hemingway-

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Introduction

A longstanding and enduring body of research in the field of child development provides evidence to the particularly damaging effects of poor attachments and dysfunctional parent-child relationships on children's outcomes. Poor developmental trajectories in children have been shown to continue as the person reaches adulthood with negative effects continuing across their lifespan (Allen & Abresch, 2018). Secure attachment relationships are built from healthy dynamics between children and their caregivers. Likewise, devastating effects can develop from dysfunctional patterns of interaction between children and their caregivers (Bretherton, 1992).

Early childhood trauma affects a multitude of areas including relationships, brain development, emotional responses, behaviour, cognition, self-concept and future orientation, and increases high-risk behaviours (Booth & Jernberg, 2010). A strong body of research has focused on the prevalence of adverse childhood experiences in adults who present with a myriad of health problems. For example, the Adverse Childhood Experiences Study (ACE) conducted a health study to determine the impact of adverse childhood events on long-term health outcomes (Felitti et al., 1998). The ACE research demonstrates that many adults, likely to be parents themselves, have had unresolved traumatic experiences that affect their overall capacity to parent. The connection of trauma spanning generations supports the focus on repairing the trauma experiences of parents, as well as the child, signaling a strong need for family therapy as opposed to child-centered approaches. Additionally, children who experience dysfunctional caregiving are at increased risk for school readiness problems. The economic and social burden within society is on the rise to treat physical and mental health problems.

Therefore, a widespread and diverse interest in attachment-focused interventions for at-risk families is understandably a legitimate focus for governmental leaders, health, education, and social service providers.

Adolescent mothers and their children should be considered an at-risk population because the adolescent period is marked by very specific developmental challenges that often contradict the tasks and roles associated with motherhood. Adolescent mothers can lack the critical knowledge and experiences to make informed choices about childrearing practices and personal life decisions and they may lack or have inadequate support systems (Emery, Paquette, & Bigras 2008; Riesch, Anderson, Pridham, Lutz, & Becker, 2010). Children of adolescent mothers often have poorer attachment relationships; adolescent mothers (in comparison to adult mothers) are more likely to have infants who display an insecure or disorganized attachment style (Lounds, Borkowski, Whitman, Maxwell, & Weed, 2005). Attachment issues could predict further problems in children, including displays of externalizing behaviours, social and academic deficits, as well as maladaptive behaviours during adolescence and adulthood (Crugnola, Ierardi, Gazzotti, & Albizzati, 2014; Moran, Pederson, & Krupka, 2005).

Theraplay® is a family-focused model that uses play to build or strengthen the relationship between children and their caregivers. Theraplay is a modality that targets attachment issues that manifest from relational and interactional dysfunction between a parent and child (Bojanowski & Ammen, 2011). Largely based on the underpinnings of attachment theory, it is theoretically assumed that the strength of the relationship between a child and their initial caregiver will form their basis for all future relationships (Bowers, 2013). Therefore, to promote better long-term socio-emotional outcomes for children it is

imperative to target and strengthen the parent-child relationship by modeling healthy interactions that target the main pillars of a secure attachment relationship.

In this report, I discuss my advanced practicum experience in the development and implementation of a pilot project that involved the delivery of family-focused therapy using Theraplay principles and techniques to a small number of adolescent mothers and their children.

The first chapter is a review of the literature on adolescent mothers, attachment theory, and Theraplay. The purpose of this literature review is to establish a theoretical framework for addressing adolescent mother-child dyadic dysfunction. I first begin by reviewing the literature that discusses common factors that affect the adolescent mother-child relationship. Further, I explore several theoretical models of human development to explain the significance of human relationships in child development. Next I discuss individual, relational, and social influences that commonly present as risk factors for adolescent mothers. Individual influences could be biologically predetermined factors as well as adverse health risks associated with adolescent motherhood, including mental health risks stemming from higher levels of parenting stress. Family influences could consist of intergenerational factors in teen motherhood and the cumulative effect of social disadvantage and adverse childhood experiences. Relational factors within the family of origin and family of procreation are also discussed. Finally, social influences are explored in the literature on socioeconomic outcomes affecting adolescent mothers. This first section concludes with a discussion of protective factors that enhance positive outcomes for adolescent mothers and their children.

Another section of the literature review focuses on the impact of attachment relationships on children's development. First an overview of attachment theory is presented. The earliest discoveries from both John Bowlby and Mary Ainsworth are presented. Additionally, the work of Mary Main and her focus on mother-child interactions is examined with a focus on the development of the attachment classification system. The final section of this literature review explores Theraplay, a play-based, family-focused treatment modality that focuses on repairing the relationship between caregivers and children through methods grounded in attachment theory. Moreover, this section evaluates a need for Theraplay treatment and examines the effectiveness of this model with different populations, including children with language/development delays, socioemotional difficulties, and behavioural problems; foster and adoptive families; and special populations including mothers residing in shelters and adolescent mothers with young babies.

Chapter Two of this report details the process of developing and implementing The A.R.T. program, a pilot project created as part of an Advanced Practicum which provided specialized attachment-based, relationship-focused family therapy driven from Theraplay principles. I begin with a description of this advanced practicum project, specifically, I discuss the purpose and the goals of this project, which include providing specialized services and clinical skills development. I provide a brief description of the Better Beginnings Better Futures organization as it was within this agency that attachment-based, relationship-focused therapy A.R.T. was delivered. I also discuss my membership with the Theraplay Institute TTI and provide an overview of the recruitment and exclusionary criteria for the program.

I also discuss the structure of the treatment process. The treatment process begins with an initial intake and assessment phase. The purpose of the intake and assessment phase is to gather all of the pertinent data about the family and to assess the problem. During this phase, the Marshak Interaction Method observation technique is used to assess the quality of the parent-child relationship. Following the assessment, a parent feedback session is provided and a mutual decision is made with the mothers to determine if this form of treatment would be useful in their situation. The treatment stage consists of up to 15 weeks of family therapy delivered bi-weekly through 30-60 minute sessions. An example of a Theraplay session is provided.

Chapter Three explores professional development and reflexivity in practice. In this chapter I discuss how I came to learn about the Theraplay modality and explore why this type of therapy resonates with both my personal and professional self. This chapter reflects on my transformational experiential learning process. I describe the influence of the supervision I received through the Theraplay Institute, and I highlight the additional training and supervision I acquired. I draw attention to the various modes and functions of supervision that supported my personal and professional development throughout this project. I expand on the concept of reflexivity within practice by reflecting on the various forms of clinical supervision I received.

In Chapter Four I discuss the application of core features and dimensions of Theraplay. In this chapter, I expand on the findings generated from the A.R.T. program and compare the results I witnessed to literature on using Theraplay. I examine the value of play-based therapies as a supportive intervention for adolescent mothers and their children. I present the seven core features of Theraplay. Examples from the program

demonstrate how these core features both improved the caregiving practices of adolescent mothers and produced more meaningful interactions between mothers and their children. I also discuss particular relationship issues between adolescent mothers and their children as evidenced from the results of the Marshak Interaction Method at the onset of treatment. This section concludes with an overview of how the four Theraplay dimensions were used to repair these particular relationship issues as well as how the Theraplay model was delivered within the classroom of one of the children in the program. This practicum report concludes by discussing implications for social work practice, arguing the need for specialized support for at-risk families, including young mothers and their children.

Chapter 1: Adolescent Maternal Adjustment and Associated Childhood Outcomes: A Review of the Literature

The purpose of this literature review is to establish a theoretical framework for adolescent mother-child dyadic dysfunction and to highlight critical intervention strategies through evaluating qualitative and quantitative research that explores adolescent maternal adjustment. Adolescent motherhood has not always been considered problematic; in fact, during the 1950's/1960's it was socially acceptable, if not normative, for women to give birth during their adolescent years (McKay, 2006; SmithBattle & Leonard, 2012). Societal norms within developed countries shifted through time, viewing young motherhood as unacceptable or encompassing life altering consequences, illustrating how societal biases/judgments shifted young motherhood into a prevalent societal problem (Chandra-Mouli, Camacho & Michaud, 2013; Duncan, 2007; Lavin & Cox, 2012; McClanahan, 2009; Pedrosa, Pires, Carvalho, Canavarro & Dattilio, 2011). Societal acceptance, or lack thereof, of young motherhood has resulted in the stigmatization and stereotyping of young mothers as incompetent (Yardley, 2008). When adolescent motherhood is approached as a social problem there is a tendency to downplay resiliency and exaggerate negative outcomes (Bunting & McAuley, 2004). McKay (2012) cautions that not all adolescent pregnancies are unwelcome nor are all adolescent mothers and children inevitably doomed.

Despite the decline in the prevalence of teen pregnancy (McKay, 2012; McKay & Barrett, 2010), it continues to be conceptualized as a multisystemic (social, political, and health) problem (Chandra-Mouli et al., 2013; Duncan, 2007; Lavin & Cox, 2012; McClanahan, 2009; McKay & Barrett, 2010). Ontario provincial pregnancy rates from

2010 indicate Ontario has the second lowest teen pregnancy rate of all Canadian provinces and territories (SDHU, 2013). Breaking the provinces into smaller regions shows that northern Ontario communities represent the second highest teen pregnancy rate while eastern or southern communities reported much lower rates of teen pregnancies, indicating increased prevalence of young motherhood in northern or rural communities (Initial Report on Public Health, 2009).

Young motherhood, and the risks associated with this phenomenon, prompted numerous publications and researchers to share influential findings from within an array of multidisciplinary fields including a) neurobiology, human development and behaviour; b) medical and mental health discourse; c) studies of families, attachment, and relationships; and d) psychology and psychopathology. The majority of research available has indicated increased risk of maladaptive problems and long-term consequences for adolescent mothers and their children (Dahinten, Shapka & Willms, 2007; Emery, Paquette & Bigras, 2008; Feldman, 2012; Meade, Kershaw & Ickovics, 2008; Nicolson, Thomson-Salo & Mitchell, 2013; Pedrosa et al., 2011; SmithBattle & Leonard, 2012). As a result of adverse childhood experiences (ACE's) (Felitti, 1998) young mothers may lack the adaptive skills for maternal adjustment placing their own children at risk for ACE's and heightened risk for psychological, emotional, and social problems.

The adolescent period is marked by very specific developmental challenges that often contradict the tasks and roles associated with motherhood, and impact the developing relationship between the mother and child (Crugnola, Ierardi, Gazzotti, & Albizzati, 2014; Rafferty, Griffin, & Lodise, 2011). Belcher, Watkins, and Ialongo (2007)

suggest that dysfunctional adolescent mother-child interactions and relationship issues are associated with lower levels of child development knowledge and higher levels of parenting stress that increase negative parenting behaviors. Adolescent mothers have very limited knowledge of child development and appropriate parenting strategies which often result in unrealistic expectations of their children (Holub et al., 2007: Rafferty et al., 2011). Young mothers lack the critical knowledge and experiences to make informed choices about childrearing practices and personal life decisions and they lack or have unsupportive support systems (Emery et al., 2008; Riesch, Anderson, Pridham, Lutz, & Becker, 2010).

Attachment-based relationship-focused interventions have been explored as a useful treatment method to enhance adolescent mother-child relationships, strengthen infant attachments, and improve children's developmental outcomes (Nicolson et al., 2013). In a study by Guajardo, Snyder, and Petersen (2009) the association between parenting practices, parenting stress, and child behavior on the developing parent-child relationship demonstrated the need to address unhealthy interactions within the adolescent mother-child relationship. The expansion of brain research, developmental perspectives, and the study of human behaviour and relationships established that clinical decision-making associated with treatment methods used to ameliorate psychosocial difficulties should be informed by neurobiological research (Hong & Mason, 2016).

Attachment-based, relationship-focused family therapy driven from Theraplay principles can be used as a catalyst for targeting early attachment concerns and relational difficulties that may be triggering problematic externalizing behaviors in children or internalizing behaviors in mothers. Simultaneously, young parents increase their

knowledge of child development, attachment, and positive parenting practices through parent training while the primary goal of direct intervention promotes a healthy parent-child relationship through modeling healthy parent-child interactions that incorporate various characteristics of a securely attached parent-child dyad (nurture, structure, challenge and engagement) (Booth & Jernberg, 2010).

Ann Jernberg created Theraplay in 1969 with the assistance of her student Phyllis Booth following an appeal for psychological services to treat families within the Head Start program in Chicago at which time a significant gap in available services existed. Jernberg and Booth (2010) summarized Theraplay as “an engaging, playful, relationship-focused treatment method that is interactive, physical, and fun. Its principles are based on attachment theory. Its model is the healthy, attuned interaction between parents and their children: the kind of interaction that leads to a secure attachment and lifelong mental health” (p. 3). Theraplay practitioners and researchers have shown that healthy parent-child relationships develop when all four dimensions of Theraplay (nurture, engagement, structure and challenge) are present, so replicating positive interactions with these four dimensions can change the nature of the relationship between a young mother and child (Munns, 2009).

Several multidisciplinary databases were utilized for this literature review including, CINAHL, EBSCOhost, PsycINFO, PubMed, Social Work Abstracts, and Social Services Abstracts from the period between 2000 and 2016. Key search terms included attachment, adolescent mothers, development, risk factors, and Theraplay. The majority of articles included in this review were quantitative studies predominantly from

the United States. This literature review is divided into three sections: factors affecting the adolescent mother-child relationship, attachment theory, and Theraplay.

Factors Affecting the Adolescent Mother-Child Relationship

The mother-child relationship is particularly influenced by the mother's capacity for maternal adjustment and her ability to meet the demands of motherhood (Holub et al., 2007). While young maternal age has long been considered an axiom for heightened disadvantage and poor maternal-child outcomes (Duncan, 2007), it has also been identified that adolescent mothers are disproportionately at-risk due to social contexts that existed long before pregnancy (SmithBattle & Leonard, 2012). This insight prompted research to highlight the erroneous representation that maternal age is the causal factor for poor outcomes (Geronimus & Korenman, 1993; Zeck, Bjelic-Radisic, Haas, & Greimel, 2007). Knowledge that young maternal age is not the causative variable for risk and disadvantage has allowed for a more comprehensive analysis of risk factors affecting outcomes for young mothers and their children.

Many predisposing factors for young motherhood exist (Al-Sahab, Heifetz, Tamim, Bohr, & Connolly, 2012; Pedrosa et al., 2011). The following section will discuss critical risk and protective factors associated with determining such a life course. First, a theoretical framework will be established by excogitating three influential human development paradigms that derive from both sides of the nature/nurture debate on human development: a) ecological model of human development; b) social learning theory; and c) through a neurobiological lens. Next, a multilevel analysis of individual, relational, and social influences of risk will be examined. Finally, this section concludes

by considering protective factors for minimizing the effect of adverse outcomes for young mothers and their children across their lifespan.

Theoretical models of explanation. Many theories or systematic explanations have been developed to explain why people behave as they do. In this section a brief overview of human development is presented, specifically exploring developmental knowledge that highlights how dysfunctional relationships between young mothers and their children are attributed to both biological characteristics (nature) and the influence of the dyadic relationship and the wider environment (nurture). Two models of human development, Uri Bronfenbrenner's ecological model of human development and Albert Bandura's social learning theory, each derived from the belief system that relational experiences alter developmental trajectories, are discussed. Finally, the remarkable expansion of neurobiological research pertaining to adolescent and early childhood neurological processes is synthesized. The influence of mother-child relationships and early childhood experiences on altering developmental trajectories solidifies the need for relationship-focused interventions to address complex risk among adolescent mothers and their children.

Human development. Development refers to an innate systematic progression throughout one's lifespan resulting from reciprocity between biological (maturation) and social (learning) processes (Shaffer, Wood, & Willoughby, 2005). Although development is continuous, the nature of changes can vary as a result of positive or negative life experiences (Hong & Mason, 2016). An important component of human development research is broadening available knowledge that demonstrates a strong link between negative life experiences and the development of psychosocial adjustment problems,

which have been shown to alter the structure and functioning of the brain (Siegel, 2012; Porges, 2011; Schore, 2005, 2001; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Bowlby, 1953). Additionally, many theories have been developed to explain various facets of human development with many theorists sharing different theoretical perspectives adapted from assumptions or predictions about changes across the lifespan (Kail, Cavanaugh, & Ateah, 2006).

> Social work approaches which are informed by a developmental perspective accept uncertainty as not only an inevitable feature of human relationships but also understand that the nature of those uncertainties will indicate the character of the various personalities involved in that relationship (Howe, 1995, p. 4)

Extending from human development research is the acknowledgment of fundamental issues of debate. One major debate in human development examines the process of change as a continuous flow of sequential steps or consisting of several abrupt shifts across various developmental pathways, i.e. the issue of continuity vs. discontinuity (Kail et al, 2006). Some developmentalists argue that growth adheres to and transitions through developmental pathways or stages in a linear transition or coherent pattern, with each stage representing a different need or achievement, noting in cases where early stage related tasks did not occur, it could result in an array of psychosocial difficulties (Porges, 2015). In contrast, discontinuity asserts that change occurs in the absence of antecedent factors and without following a linear progression, non-dependent on the completion of prior stage tasks and functions (Overton & Reese, 1981).

Developmentalists who favor perspectives of continuity postulate that contradictions between developmental stages and the stage related tasks associated with

each of them are known to exist (Kail et al 2006). For example, transitioning into the altrusic role of motherhood before successfully achieving stage related tasks during adolescence (identified predominantly by egocentric behaviours) or simultaneously completing dual tasks may result in crisis, conflicts or challenges related to being developmentally unprepared to meet the demands of motherhood (Easterbrooks, Chaudhuri, & Gestsdottir, 2005). Young mothers who have not addressed their personal needs will have increased risk of maternal adjustment (Holub et al., 2007). Adolescent mothers often use negative or unhealthy parenting practices and display maladaptive parenting behaviours (Lounds, Borkowski, Whitman, Maxwell, & Weed, 2005) undoubtedly by reason that during adolescence many cognitive processes have not reached maturity (Kail et al., 2006), so although this behaviour is developmentally normal, understanding these heightened risk factors is critical as the literature shows a correlation between parenting capacity and attachment security (Hopkins, Gouze, & Lavigne, 2013).

Rafferty et al. (2011) supported this theory, arguing that during the stage of adolescence the cognitive and developmental readiness to parent has not yet been achieved. Further, cognitive and neurophysiological development has not yet been completed during adolescence (Crugnola et al., 2014), which may contribute to higher levels of immaturity in adolescent mothers and may affect their ability to make positive parenting decisions. This role confusion or contradiction between developmental tasks in the period of adolescence and the developmental tasks associated with parenting which are often formed during the stage of adulthood are risk factors for poor developmental outcomes (Crugnola et al., 2014; Rafferty et al., 2011). Adolescent mothers are more

likely to hold unrealistic developmental expectations of their children often due to lower levels of maternal competency (Budd, Holdsworth, & HoganBruen, 2006; Holub et al., 2007). In comparison to adult mothers, adolescent mothers showed lower levels of maternal sensitivity and attunement, and present more problematic caregiving practices (Rafferty et al., 2011). Adolescent mothers tend to relate to their children in a less supportive and disengaged manner, and offer a less nurturing environment (Hitchcock, Ammen, O'Connor, & Backman, 2008; Rafferty et al., 2011), which may represent their need to focus on their own needs, an egocentric characteristic associated with adolescence, as opposed to supporting the growth and development of their child.

A myriad of risk factors have been associated with dysfunctional interactions and relational concerns between adolescent mothers and their children, such as complex associations between early motherhood and the negative externalizing behaviors of their children, and poor social and cognitive development trajectories for both the mother and child (Crugnola et al., 2014). Dysfunctional interactions between the mother and child are often cited as a major contributor to poor developmental outcomes in children. For example, Moran et al (2005) concluded that dysfunctional interactional patterns were associated with abnormal infant development. The evidence that suggests dysfunctional interaction patterns have a strong association with poorer outcomes highlights the need to explore development from a multisystem model.

Ecological model of human development. From an ecological perspective, the course of development is influenced by the reciprocal interaction(s) between a person and the multiple systems within their environment, explained in detail by developmental psychologist Uri Brofenbrenner in *Ecological Systems Theory* (Bronfenbrenner, 1994).

While most developmentalists agree that a person's environment plays a role in development to some degree, those who share the ecological or systems perspective posit that all aspects of development are interconnected and cannot be studied in isolation from a person's environment or context (Kail et al, 2006).

Stemming from Bronfenbrenner's research, a bioecological lens reveals that multisystemic risk factors (individual, relational and/or social influences) exist within the environment and influence the occurrence and subsequent consequences of teen pregnancy (Logsdon, 2008; Pedrosa et al., 2011; Van Horne, Wiemann, Berenson, Horwitz, & Volk, 2009). A study by the *Metropolitan Action Committee on Violence Against Women and Children* (2006) indicated that adolescent females risk for pregnancy may be heightened due to biological, psychological, social-emotional (cognitive) factors, which in connection with environmental conditions interfere with the normal adolescent developmental process.

Exploring the cycle of teenage motherhood from an ecological systems lens clarifies the role of individual, family, peer, and environmental factors in predicting early childbearing (Meade et al., 2008). A significant amount of research attests to the advantage of employing ecological system theory to provide a more comprehensive understanding of the various intersecting factors that influence why young women become pregnant and face higher disadvantages (Logsdon et al., 2008; Pedrosa et al., 2011; Van Horne et al., 2009). Even worse, children born to adolescent mothers face comparable levels of risk because they experience similar disadvantages or grow up within the same systems with similar or fewer resources (Harden et al., 2007; SmithBattle, 2009). Alternatively, a young mothers' early childhood experiences can

change neurological pathways, thus influencing or shaping the way she interacts with her own child(ren) a generation later (Shah, Fonagy, & Strathearn, 2010).

Social learning theory. Social learning theory is based on the premise that learning can occur simply by imitating those around us (Kail et al, 2006) thus showing intergenerational patterns develop as each generation is simply modeling learned behaviours to which they have been exposed. Social learning theory developed from disbelief that a person's subjective experiences are driven strictly from inner forces as proponents of psychodynamic theory believed (Bandura, 1971). Instead, social learning theory argues that a person's functioning and growth is determined based on continuous reciprocal interactions with external stimuli (1971). Interactional patterns set early in life, whether positive or negative, can alter a child's sense of self and may affect their relational abilities later in life, emphasizing the significance social learning has on future development (Booth & Jernberg, 2010).

The conceptualization that children form inner working models based on early childhood interactional experiences derives from attachment literature (Bowlby, 1973). Bowlby (1979) argued that infants learn social behaviours by interpreting and modeling caregivers' responses to their social cues, thus providing a model or reference to which to refer upon encountering new social or relational experiences. Further evidence of learned patterns within attachment research shows that attachment patterns formed in early childhood remain stable throughout adulthood and later influence the attachment patterns a parent will form with their own children (Mains, Kaplan, & Cassidy, 1985). Essentially, the transmission of intergenerational attachment patterns sets in motion a continuous cycle of relational dysfunction (Bretherton, 1990). Like most theories of human

development, both ecological systems theory and social learning theory indicate that neurological development is greatly affected by experiences from the social environment.

Neurobiological perspective. Neuroscience is the body of knowledge that contributes to a better understanding about the associations between early learning and development and subsequent relationships, behaviours, health, achievements and success in life (Society for Neuroscience, 2016). Advancements in neurological research continually discover contributing factors or correlations between negative experiences within the first three years of life and the development of social, emotional, behavioural, psychological and health problems throughout different life stages (Anda, 2006; Felitti, 1998; OECD, 2007; Perry & Pollard, 1998; Porges, 2015). As well, a shift in contemporary neuroscientific research has expanded the focus on 'neuro' or 'brain' plasticity to explore the degree to which changes in the brain can occur outside of the typical critical developmental periods, a theory that is gaining support for neural growth and healing (Pickersgill & Martin, 2015). This evidence is particularly critical to research in the field of child development and family studies as it provides support for the use of neurologically-informed clinical interventions to target and ameliorate early childhood maladaptive problems as a prevention strategy for further adjustment problems in adulthood (Hong & Mason, 2016).

Brain growth, particularly right hemisphere brain development begins during the second trimester in utero and exponentially continues throughout the first year of life. "Brain research places the role of affect regulation at the center of human development and highlights the parent's crucial role in creating the child's capacity to self-regulate" (Booth & Jernberg, 2010, p 67). A critical determinant of right-brain normative growth

structures lies in the ability of caregivers to demonstrate and model regulation skills (Schore, 2001). *Polyvagal Theory* uses the term 'neural exercises' to explain the functionality of interactions between a mother and her child as opportunities to experience and practice the state of co-regulation. Lack of these opportunities threatens the child's ability to co-regulate with others or to learn adaptive skills of self-regulation (Porges, 2015). The Infant Mental Health Journal (2001) suggests that right-brain development may be inextricably linked to a child's ability to develop adaptive coping strategies to handle stress and mitigate developmental adjustment issues in later childhood. In essence, a child's developmental trajectory can be derailed if they do not acquire the skill of processing and regulating sensory stimuli from their environment (Booth & Jernberg, 2010) arguing for a comprehensive examination of critical factors from within the mother's environment that may lead to this state of dysregulation.

Individual, Relational, and Social influences

A multitude of risk factors speculated to contribute to the prevalence of young motherhood stem from a variety of individual, relational, and social influences. A multi-dimensional risk model can be used to understand and predict risk factors that may threaten maternal, child, and dyadic adjustment by exploring the influences of these factors at the individual, relational, and social level. Multi-level factor analysis frameworks have been used quite often when exploring the challenges of adolescent motherhood (Chandra-Mouli et al., 2013). It is vital for service providers to recognize and understand the intersecting attributes of potential risk factors at various levels, therefore encouraging interventions that address these multivariate issues in a comprehensive nature.

Individual influences. Individual influences include biologically predetermined factors that increase the likelihood of adolescent conception and personal problems. Early female puberty has seen a spike in Western countries, and this is concerning as early puberty exacerbates the risk of teen pregnancy (Daniel & Balog, 2009). Sexual maturity and the age of initial sexual intercourse predict the incidence of teen pregnancy (Jordahl & Lohman, 2009; Pedrosa et al., 2011). A likely factor is naivety regarding safe sex practices and the risk of pregnancy. In a study by McKay (2012) that explored teen pregnancy trends in Canada, unplanned adolescent pregnancies were significantly associated with the inconsistent use of contraceptives or an absence of contraceptive use altogether as a result of inaccurate views associated with risk for pregnancy, poor planning concerning odds of becoming sexually active, and insufficient financial resources to obtain contraception.

Complications during pregnancy and childbirth are prominent for adolescent mothers. There is considerable evidence in the literature to characterize these young mothers as vulnerable due to considerable prenatal and postnatal risks (Al-Sahab et al, 2012). In addition, young maternal age has been associated with subnormal child development outcomes (Rafferty et al., 2011). Young mothers experience more obstetric risk during pregnancy and childbearing, with higher rates of low birth weight babies and infant mortality (Brown, Brady, & Letherby, 2011; Lavin & Cox, 2012). World Health Organization guidelines regarding teenage childbearing advise that infant mortality is a grave concern, stating that stillbirths or infant deaths are more than 50% more likely with a child born to a mother under the age of 20 (Chandra-Mouli et al., 2013). In addition, children born to adolescent mothers are at an increased risk for long-term chronic health

conditions (Minnick & Shandler, 2011). Adverse health risks such as chronic respiratory problems, mental retardation, and learning disabilities have been linked to children born to adolescent mothers (Al-Sahab et al., 2012). In addition to the negative health problems experienced by children born to teen mothers, adolescent pregnancy affects the physical and mental health of young women.

Adolescent girls who become pregnant may experience devastating physical and psychological health effects. Mothers who give birth during adolescence have been reported to display mild to moderate severe posttraumatic stress, including higher documented rates of postpartum depression (PPD) symptoms (Minnick & Shandler, 2011). The literature also discusses social consequences young mothers may face, including educational deficits, lack of social opportunities, and involvement with violence, risk of suicide or even homicide (Chandra-Mouli et al., 2013). Individual attributes that have been associated with higher incidence of teen pregnancy rates include low-income status, lower academic achievement or academic aspirations (Al-Sahab et al., 2012), delinquent involvement (Jordahl & Lohman, 2009), and drug and/or alcohol use (McDonell et al., 2007). It is recognized within the literature that the compilation of these risks and disadvantages for adolescent mothers are linked to higher levels of parenting stress among adolescent mothers (Budd et al, 2006).

Parenting stress can be defined as “the aversive psychological reaction to the demands of being a parent” (Chang & Fine, 2007, p 584). Socioeconomic barriers, stressful life events, and family conflict are cited as antecedent factors of parenting stress (Belcher et al, 2007; Chang & Fine, 2007). Several authors have found that adolescent mothers appear to report higher levels of parenting stress (Belcher et al, 2007; Chang &

Fine, 2007; Hitchcock, Ammen, O'Connor, & Backman, 2008; Larson, 2004; Secco & Moffatt, 2003), a condition that increases the risk of many adverse outcomes for both the mother and child (Larson, 2004), and which influences the mother-child relationship (Holub et al., 2007).

Higher levels of parenting stress have been associated with difficult child temperaments (Chang & Fine, 2007; Secco, & Moffatt, 2003), less effective parenting practices (Larson, 2004), and poor knowledge of child development (Belcher et al, 2007). These may lead to unrealistic expectations of child development (Chang & Fine, 2007), child abuse, neglect and maltreatment (Budd et al., 2006; Secco, & Moffatt, 2003), and physical and psychological health problems in mothers (Larson, 2004). Depression was noted as the strongest predictor of increased stress levels (Chang & Fine, 2007). All of these factors may not be independent of one another. They may be intertwined and commonly influence the parent-child relationship. Failing to provide interventions that target multi-level variables increases the risk of unhealthy mother-child relationships and attachment issues (Hopkins et al, 2013).

Family influences. Multigenerational or longitudinal studies offer both a retrospective and prospective analysis of personal, familial, and social risk factors that may be transmitted across generations to heighten both the incidence of early motherhood and intergenerational disadvantage (Furstenberg, Levine, & Brooks-Gunn, 1990). Research on intergenerational factors has identified patterns of adolescent motherhood (Edwards, 1992; Stanford & Scott, 2013), attachment relationships (Bretherton, 1990; Kurth, 2013), and trauma, abuse and child maltreatment (Friend, 2012; Putnam-Hornstein, Cederbaum, King, Eastman, &Trickett, 2015) that can each transmit risk across generations. The

literature suggests that a family history of young motherhood may increase the social normative lens of early pregnancy, thus perpetuating an intergenerational cycle of young motherhood (Al-Sahab et al., 2012).

Research examining young mothers has consistently shown that children of teenage mothers are more likely, compared to children of older mothers, to become parents at an early age themselves (Meade et al., 2008). Adolescent childbearing can also be sustained by risk factors such as lower educational attainment, fewer socioeconomic opportunities, increased psychosocial problems, and family and partner instability across generations (Meade et al., 2008). Social research that views young mothers from a social, political, health or moral 'problem lens' tends to associate maternal age as the cause for disadvantage (Chandra-Mouli et al., 2013; Duncan, 2007; Lavin & Cox, 2012; McClanahan, 2009). Many researchers argue that adolescent mothers generally have limited opportunities preceding their transition into adulthood (Mollborn & Morningstar, 2009) so it is more accurately an intergenerational transmission of disadvantage and fewer opportunities that offers no motivation to delay parenthood (Furstenberg et al., 1990; McKay, 2012).

The cumulative effect of social disadvantage and adverse childhood experiences increase the risk of intergenerational transmissions of dysfunctional family functioning for subsequent generations (SmithBattle & Leonard, 2012). In a study by Pears and Capaldi (2001), it was hypothesized that parent participants who reported experiencing abuse during childhood would engage in more abusive behaviours towards their own children. The findings confirmed this hypothesis indicating that a parent was twice as likely to display abusive behaviours if they experienced historical abuse. Putnam et al.

(2015) argue that adolescent motherhood is the strongest predictor of childhood maltreatment. Not surprisingly, due to higher rates of maltreatment, adolescent mothers are more likely to have their children placed in care (Hoffman, 2006). Research has also indicated that adolescent girls placed in foster care become pregnant at a much higher rate than young girls who have never experienced the foster care system (Aparicio, Pecukonis, & O'Neale, 2015; Child Trends, 2011). Since adolescent mothers are more likely to have their children placed in care, and adolescent girls in foster care are more likely to become pregnant this link demonstrates the intergeneration effects of adverse childhood experiences.

Relational factors, including the role of the family, have been found to heighten the risk for teen pregnancy. Poor family relationships and lack of support have been identified as a risk factor (Thompson et al., 2008). Additional risk factors, such as family structure instability, non-biological two parent families, lower maternal education, welfare recipients, and low income residences, were attributed to earlier sexual intercourse and adolescent pregnancy. The cycle of teen pregnancy (Smith et al., 2013), the link between children of teenage parents becoming teen parents themselves, has been discussed by Minnick & Shandler (2011) and Smith et al. (2013). Research has also indicated that the degree of father involvement, specifically the consistency of paternal care, is correlated to teen pregnancy (Jordahl & Lohman, 2009; Pedrosa et al., 2011). Adolescent girls who grow up without their father have an increased risk of early sexual activity and teen pregnancy. The risk is highest if the fathers are absent earlier in the girls' lives (Ellis et al., 2003).

A lot of research has explored the experience of abuse and dating violence in young pregnant and parenting teens. Retrospective analysis shows that teen mothers are twice as likely to experience physical or sexual abuse during their childhood (Al-Sahab et al., 2012). Violence is another factor that impacts a young women's health. Pregnant teenagers and young mothers face a heightened risk for experiencing power, control and violence in both familial and intimate relationships (Brown, Brady, & Letherby, 2011). Violence during pregnancy has been documented throughout the literature to surface or exacerbate, perhaps due to the physical, psychological or environmental (financial) changes that occur during pregnancy. The literature asserts that "[d]omestic violence has significant emotional, psychological and social effects on women and children who experience or observe it" (Brown et al, 2011, p 363).

Despite the terrible conditions within a violent relationship, adolescent women may stay in abusive relationships simply because they long or desire to be in a relationship, desperately seek social acceptance, driven by an intense fear of losing their children, or due to the fear of stigma associated with being a single teen mother (Brown, Brady, & Letherby, 2011). The literature highlights a connection between domestic violence and homelessness. In several articles that examine the homelessness of women, the results indicate domestic violence and abuse are prominent contributing factors to experiencing episodic homelessness (Dotson, 2011; Swick & Williams, 2010; Tischler et al., 2007). When a domestic relationship breaks down or becomes violent and a mother chooses to leave the relationship, most often she must assume all financial responsibilities for the children until she is willing to initiate legal action to force the father to pay remuneration. Legal action is a very intimidating process, especially if the

father is threatening to remove the child should she initiate a court battle (Averitt, 2003). Without the additional resources, women are forced into a cycle of poverty, thus predicting their children will become entangled in this cycle also (Young/Single Parent Support Network of Ottawa-Carleton et al., 2000). Recognizing that young mothers experience violence or abuse at a heightened rate, lack socioeconomic resources, and long for love and support provides a plausible explanation for remaining in unhealthy relationships. Often children are also subjected to the abuse and violence on some level and this experience is detrimental to the healthy development of young children (Holt, Buckley, & Whelan, 2008).

Social influences. It is widely reported within the literature that young women who lack social status or economic opportunities face increased risk of early childbearing and poor socioeconomic outcomes (McKay, 212). Evidence shows that teen pregnancy rates are higher among adolescent women whose family unit experience poor socioeconomic status (Bonnell, 2002; Pedrosa et al., 2011) and findings suggest that adolescent mothers are more likely to grow up in low-income, single-parented families (Al-Sahab et al., 2012). It has also been documented that social and economic deprivations have been predicative of higher teen pregnancy rates (Paton, 2002). The scarcity of socioeconomic opportunities for adolescent mothers is widely reported, and often indicative of multigenerational experiences of disadvantage (Al-Sahab et al., 2012). Education, or lack thereof, is a primary concern according to Minnick & Shandler (2011) who assert that 50% of adolescent women who become pregnant fail to complete the requirements for a high-school diploma and go on to note that employment opportunities for adolescent mothers without an educational background are scarce, and when available the income

provided by these jobs is lamentable. For example, the average income for an adolescent mother is $6500 (p 242). These results should bring no element of surprise as to why adolescent mothers are forced to depend on public assistance (Minnick & Shandler, 2011). Lavin and Cox (2012) demonstrate that 75% of teen mothers report accessing public assistance benefits within the first five years of their child's life. These rates may be higher in Canada since welfare in Canada has been viewed as more generous and less restrictive than in the United States (Bashevkin, 2002, p 18). Not surprisingly, many young mothers depend on social resources and supports and the availability of these resources and supports are known to be a protective factor for reducing negative outcomes.

Protective factors. The availability of resources and supports enhances positive outcomes and therefore is regarded as a protective factor for maternal-child adjustment (Long, 2009; Nath, Borkowski, Whitman, & Schellenbach, 1991). Social support has been shown to decrease parenting stress in adolescent mothers, thus indirectly enhancing the attachment relationship (Emery et al., 2008). The case comparison in SmithBattle and Leonard (2012) demonstrates that despite similarities in social disadvantage and adverse childhood experiences amongst two adolescent mothers, one made considerable gains and overcame adversity attributed largely to the availability of resources and supports. In a phenomenological study that explored the lived experiences of children of adolescent mothers who had experienced maltreatment, one of the two major themes for breaking the cycle was the availability of supports for the teen mothers (Aparicio, 2015). On the other hand, parental knowledge, or knowledge of infant/child development was identified as a protective factor and was associated with increased use of appropriate parenting

strategies, healthier parent-child interactions, and lower levels of parenting stress (Belcher et al, 2007). Parents with increased knowledge of child development were better able to promote positive emotional and cognitive development of their children through healthy expectations, more supportive and empathic parenting practices, and the use of a more positive parenting style (Belcher et al, 2007; Budd et al, 2006).

Styles of Parenting. There are three major styles of parenting: the permissive parent, the authoritarian parent, and the authoritative parent (Rinaldi & Howe, 2012). These are believed to influence a child's social, emotional and cognitive development (Arnott & Brown, 2013). Permissive parenting and authoritarian parenting are typically associated with poorer outcomes, with the former style being characterized as too lenient and the latter style too strict. The authoritative style of parenting is optimal and provides more favorable outcomes (Belcher et al, 2007). This style offers many influential facets of a healthy, balanced parent-child relationship including structure, challenge, nurture, and engagement. The use of a more neglectful style (permissive) or a more controlling style (authoritarian) has been associated with higher degrees of parenting stress (Guajardo, Snyder, & Petersen, 2009).

Many of the individual, relational, and social influences of risk, in addition to the developmental stage and early childhood experiences of the mother, heighten the risk of attachment issues with her child. A secure attachment is perhaps the strongest indicator of positive child outcomes, whereas attachment insecurity has been found to predict maladaptive problems throughout the life course (Flaherty & Sadler, 2011; Raikes & Thompson, 2008). The next section will explore the innate, evolutionary, static nature of attachment relationships.

Attachment Theory

Attachment relationships have been widely studied and have been shown to have a significant impact on children's developmental trajectories: popular knowledge of attachment relationships originated from the early discoveries of attachment researchers John Bowlby and Mary Ainsworth (Bowlby, Ainsworth, Boston, & Rosenbluth, 1956; Bretherton, 1991). Specifically, John Bowlby (1953) developed the earliest knowledge of attachment relationships by closely examining mother-infant interactions while Mary Main (1979; 1985) extended the theory to recognize that studying mother-infant interactions predicted attachment patterns of security vs. insecurity, also highlighting that attachment patterns seemingly remained stable throughout adulthood.

Attachment theory, the understanding that human beings will innately develop a deep emotional connection to those who provide for their basic needs, is founded on the belief that emotional development is rooted within the period of infancy and childhood (Bowlby, 1979). From an evolutionary perspective, Bowlby (1979) suggests that a human infant's attachment behaviors are motivated by the innate needs of survival. The function of infant attachment is to increase chances of survival by ensuring proximity to a primary caregiver (Bretherton, 1990). When children encounter stressful situations, attachment behaviours become activated, thus signaling the activation of the caregiver behaviours of care and protection (Howe, 1995). Within a securely attached dyad, the repetitive nature of activating attachment behaviours, followed by responsive caregiving responses signals, helps children develop security (Frederick & Goddard, 2008). It is from these observations that the conceptualization of a parent acting as a secure base emanates (Bowlby, 1988).

Bowlby (l979) also postulates that these patterns serve the purpose of helping one come to understand their implicit view of self and others, a concept Bowlby defined as an internal working model. This implicit view is primarily used to "interpret and anticipate a partner's behaviour as well as to plan and guide one's own behaviour" (Bretherton, 1990, p. 239). Establishing attachment relationships is considered a major developmental task during infancy and likewise failing to do so creates developmental risk (Moran et al, 2005). In parent-infant or parent-child relationships where there is an inability on the part of the parent to provide for these basic needs, there is an increased risk of a failure to form normal attachments, which negatively affects the child's socio-emotional developmental trajectories (Moran et al, 2005).

The ethology of attachment and the theoretical weight of attachment principles has created a foundation for understanding maladaptive developmental outcomes for children who endure insensitive or inconsistent relationships with caregivers during early childhood (Paulus, Becker, Scheub, & König, 2016; Raikes, Virmani, Thompson, & Hatton, 2013; Raikes & Thompson, 2008; Sroufe, 2005; Steele, Steele, & Croft, 2008). Altering the development of maladaptation requires a consideration of not only the precursors to the problems (poor attachment relationships) but also the broad consequences of circumventing early interventions that would repair parent-child relationships (Suess & Sroufe, 2005) in favor of cognitive therapeutic models that may be developmentally inappropriate and which fail to connect the weight of the experiential nature of human relationships on mental processes and functioning (Siegel, 2001). Bretherton (1991) defined attachment theory alternatively as a theory of interpersonal relationships. The theoretical underpinnings of attachment theory contribute critically to

understanding child development and developmental psychopathology (Hopkins et al., 2013).

Although the terms attachment disorder and attachment problems are often used interchangeably within the literature, there is a concrete distinction, whereby an attachment disorder requires diagnostic classification within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) while attachment problems broadly describe the maladaptive outcomes attributed to a variety of influences including the varying degree of parental responsiveness (Chaffin, 2006). Mary Ainsworth (1985) provided a key piece of scientific attachment research through her creation of the Strange Situation Procedure, a laboratory experiment that measured a child's response to a short episode of separation and reunion. The Strange Situation Procedure advanced attachment theory within the arena of science as a result of its scientifically measurable system of categorizing attachment relationship patterns (Mooney, 2010). In this systematic procedure, a mother and child are assessed for approximately 20 minutes during which time a series of separations and reunions are staged and recorded. The child is alone with the mother, then left with a stranger, then left alone, and then reunited with the stranger and mother (Long, 2009). Ainsworth (1985) found three types of attachment patterns around which the children would respond consistently in the same manner: Secure, Insecure-Avoidant and Insecure-Ambivalent.

The attachment classification system. Children were categorized as securely attached when in the caregiver's presence, the child felt comfortable and trusting to explore the environment. When distressed they sought proximity to their mothers for comfort and accepted their mothers' attempts to calm and console them (Lounds et al., 2005).

Caregiver sensitivity during infancy predicts a secure attachment (Moran, Forbes, Evans, Tarabulsy, & Madigan, 2008). On the other end of the continuum, a child who displays an insecure attachment will not seek comfort from their caregiver upon reunion, either avoiding the caregiver entirely (insecure-avoidant) or becoming angry with the caregiver and not accepting consoling (insecure-ambivalent) (Lounds et al., 2005). A fourth attachment pattern, a disorganized attachment, was developed to identify infants and children that could not be categorized within the three organized patterns because they displayed very disorganized attachment behaviors that showed no consistency or predictability during the episode of separation and reunion (Howe, 2005; Lounds et al., 2005). Maternal sensitivity is theoretically assumed to be a fundamental antecedent function predicting attachment security (Lounds et al., 2005; Moran et al, 2005).

Adolescent mothers (in comparison to adult mothers) are more likely to have infants who display an insecure or disorganized attachment style (Lounds et al., 2005). Such displays could further predict attachment issues throughout their childhood, as well as externalizing negative behaviors, social and academic deficits, and maladaptive behaviours during adolescence and adulthood (Crugnola et al., 2014; Moran et al, 2005). Various studies have identified developmental and contextual risk factors associated with adolescent motherhood that predict a negative influence on the quality of the adolescent mother-child interactions, which subsequently increase attachment and relationship difficulties (Nicolson et al., 2013).

Analyzing adolescent mother-child relationship issues from an attachment perspective highlights the need to focus on the manner in which adolescent mothers interact with their children (Moran et al, 2005). Adolescent mothers have a higher

incidence of maladaptive parenting behaviors that include lower levels of responsiveness to their child's signals (Moran et al., 2005). They display a less supportive and a more detached and intrusive parenting style, in addition to employing more instrumental and less affectionate parenting methods (Crugnola et al., 2014). Adolescent mothers have a tendency to force early independence due to their lack of knowledge of child development (Moran et al., 2005). Thus, interventions that stem from a behavioural approach, focusing on maladaptive parenting behaviours utilized by adolescent mothers, are most effective and can promote a positive influence on maternal interactive behaviour (Moran et al, 2005).

Interventions that address and model critical aspects of secure attachments and healthy relationships can be a highly effective preventive approach for a high-risk population of adolescent mothers. One treatment approach that incorporates critical elements of attachment theory and focuses on healthy parenting practices that has been used with a variety of at-risk populations displaying an array of presenting problems is Theraplay.

Theraplay

Theraplay is a modality that targets attachment issues that manifest from relational and interactional dysfunction between a parent and child (Bojanowski & Ammen, 2011). Largely based on the underpinnings of attachment theory, it theoretically assumes that the strength of the relationship between a child and initial caregiver will form the basis for all the child's future relationships (Bowers, 2013). Therefore, to promote better long-term socio-emotional outcomes for children, it is imperative to target and strengthen the parent-child relationship by means of modeling healthy interactions

that target the main pillars of a secure attachment relationship (nurture, structure, challenge and engagement). Particular attention is paid to maternal responsiveness and attunement, which research has identified as key indicators of secure attachments (Booth & Jernberg, 2010). “Being cared for by attuned, responsive parents is essential to healthy emotional development” (Booth & Jernberg, 2010, p. 29).

Theraplay is a family-focused treatment method that assesses and treats parent-child relationship problems that may be creating or adding to social-emotional/behavioral problems in children or inducing or increasing parenting stress and family dysfunction. The principles of this treatment modality are grounded in attachment theory. The underpinnings of attachment research and Theraplay recognize that a strong emotional bond between the primary caregiver and the child is important for optimal development and secure attachments in children.

The Theraplay modality focuses on the naturally occurring parent-child relationship, and targets problematic interactions that may be preventing parents from being attuned and responsive to their child’s needs. Four distinct domains have been identified as the building blocks of a healthy parent-child relationship. These four domains, nurture, structure, challenge, and engagement, are all evident in daily interactions in securely attached parent-child dyads. Each domain is essential to the developing relationship, and if one domain faces inadequacies then the overall relationship may suffer and could result in social-emotional or behavioral problems in children. This type of intervention bases its methods in play, using very cost-effective everyday materials (cotton balls, feather, bubbles) where the meaning and joy comes from the mutual level of arousal, engagement and companionship.

Play is essential in promoting secure attachment relationships (Moran et al, 2005). Rafferty et al, (2011) found that maternal supportive play acted as a protective factor for developmental outcomes in infants of adolescent mothers and predicted gains in cognitive and language development by the time the child reached age three. They concluded that using play as a modality to strengthen adolescent mother-child interactions and relationships may promote more favorable developmental outcomes. Since Theraplay focuses on modeling and restructuring parent-child interactions to be more supportive and attuned, this type of intervention fits well with recommendations for attachment-based interventions to focus on the quality of interactions between the mother and child, and additionally to increase the responsiveness and sensitivity of the mother during these interactions (Moran et al, 2005). Studies of infant behaviour and development have shown that adolescent mothers tend to be less engaged in playful interactions with their children compared to adult mothers and, even when they are engaged, the interactions tend to reflect more negative than positive emotional engagement (Crugnola et al., 2014).

Changing a child's inner working model or implicit relational knowledge is an essential component in altering attachment patterns that have been previously formed (Theraplay Institute, 2006). These patterns, set early in life, tend to persistently cause difficulties throughout life because of unconscious beliefs about themselves and others (Booth & Jernberg, 2010). In essence, behaviours (often driven from emotional responses to perceived reality) become habitual and are automated by the signals from the brain that develop by means of organized patterns in the mind (Mäkelä, 2003). These schemas are formed through the repetitive and reciprocal nature of early parent-child relationships.

For example, parents who joyfully engage with their children and finds pleasures in the interactions will in turn communicate to the children that they are pleasurable. To summarize, positive pleasurable interactions during infancy and early childhood will help children construct positive self-images as well developing positive images of their parent and the world around them (Booth & Jernberg, 2010). This positive sense of self and others is the ultimate objective of the Theraplay intervention.

Evaluating a need for Theraplay treatment. Amongst the various forms of clinical treatment methods available today, it can often be difficult to discern which approach to use without a proper assessment of the client's current functioning. The assessment process is key for clinically understanding the individualized nature of each family's problems, thus allowing for the development of a specific and appropriate treatment plan to meet each client's individualized needs (Booth & Jernberg, 2010). The quality of the parent-child relationship and the appropriateness of using the Theraplay modality is measured through self-reports and interviews, projective and play techniques with observational methods (Bojanowski & Ammen, 2011).

Two standardized measures of assessment are used to understand the individualized needs of both the child and the parent. The Child Behaviour Checklist (CBCL) is used to assess the child, and the Parenting Stress Index (PSI) is used to assess the parent. A comprehensive intake or background interview reviews the reasons for the referral, the developmental history of the child, the parents' expectations and the attitudes of their child(ren). The parents' attachment perspectives and attachment patterns established in childhood are reviewed using the Adult Attachment Interview (AAI), which focuses on how these early experiences within their own families may be

influencing their current relationships with their own child(ren) (Booth & Jernberg, 2010).

While a historical perspective may provide an understanding of how current problems develop, it is most important to clinically understand the current nature of the problem and its impact on the family's current functioning. To achieve this level of understanding, the Marschak Interaction Method (MIM), a structured play-based technique for observing and assessing the relationship between a parent and child, is utilized. Consisting of a series of simple tasks, this assessment illustrates the naturally occurring relationship amongst four critical dimensions of a healthy parent-child relationship (structure, engagement, nurture, and challenge). Attachment theorists demonstrate through a series of studies over the pasty forty years that parent-child interactions significantly impact a child's well-being, development, and relational capacity (Bojanowski & Ammen, 2011). The MIM is a semistructured observational method designed to elicit certain behaviours from the parent-child dyad as they perform a series of strategically standard dimensional tasks. The MIM is often completed with both caregivers, allowing for a comparison of behavioural or relational differences the child may have with different caregivers.

The effectiveness of Theraplay with different populations. Children of all ages, from infancy to adolescence may effectively be treated using the Theraplay method (Jernberg & Booth, 2010). Theraplay has a strong theoretical framework built upon research findings from neurobiology, developmental perspectives, the necessity of play in children's socioemotional development and learning, the importance of touch, and, most importantly, attachment, bonding, and the critical relationship between a child and their

caregiver (Wettig, Franke, & Fjordbak, 2006). Theraplay has increasingly been subjected to research over the past decade and its effectiveness with many different populations is now supported by experimental evidence (Booth & Jernberg, 2010). Theraplay is used to treat maladaptive behavioural problems and psychosocial issues in children. Theraplay is also used to treat parent-child relationship dysfunction and attachment problems that often present externalizing behaviours in children. Theraplay has also been a clinical treatment for many groups including early learning elementary classrooms. Some of the research findings are discussed below.

Language/developmental delays, socioemotional difficulties, and behavioural problems. Children with language delays or developmental disorders lack specific cognitive and/or language processes needed to engage in typical communicative interactions and tend to display significant difficulties forming relationships (Lindaman & Booth, 2010). Throughout several case examples, Lindaman and Booth (2010) reported positive changes in social relationships, engagement, communication, and even language following the use of Theraplay with children diagnosed on various levels of the autism spectrum. Simeone-Russell (2011) advocates providing Theraplay treatment to children with autism spectrum disorder in the classroom setting to provide effective child-focused treatment and improve the child-teacher attachment relationship by increasing positive reciprocal interactions while simultaneously decreasing stress levels resulting from communication barriers. Ritterfield (1990) reports similar benefits in a population of preschool children who displayed language delays by comparing a Theraplay treatment group to a treatment as usual group and non-treatment group. Theraplay significantly improved expressive language and positive socioemotional scores

within the treatment group, over children receiving an alternative treatment (speech language services) as well as a control group who did not receive any treatment.

The effectiveness of Theraplay has been studied quite extensively in Europe, resulting in two research studies aimed at evaluating the use of this intervention with dually diagnosed children (diagnoses of severe behavioural problems with evidence of a communication disorder). The first project, a controlled longitudinal study, was conducted in Germany between 1998 and 2005. Randomized samples of 60 dually diagnosed children were compared to a control group of nonsymptomatic same-age, same-sex peers and statistical findings supported evidence of clinical improvements amongst the treatment group (Wettig et al, 2006). The results of this study were not generalizable to other populations due to the singular access point for participants, which limited the external validity.

A second project was implemented in 2000 that expanded the population base to include multiple therapeutic facilities in Germany and Austria. Children who were participants in this study were referred based on a dual diagnosis of behavioural problems in addition to speech and/or language difficulties. After eliminating the participants who failed to meet these research criteria, the sample consisted of 291 children with a mean age of 4 years 5 months. Participants were randomly assigned to receive treatment immediately or were placed in a control group that would not receive treatment for 16 weeks. The goal of this multi-center study was to replicate the initial study and compare the findings. This sample of children had been assigned dual or multiple diagnoses consisting of both externalizing and internalizing problems. The findings from this sample showed a clinical reduction of both externalizing and internalizing symptoms

associated with oppositional defiance behaviours and shy withdrawn behaviours. Further findings showed near elimination of the behaviours in the treatment group comparable to nonsymptomatic children, with a greater effect of positive change in children identified with more severe symptoms at the onset of treatment. The findings cautioned that neuropsychological symptoms including ADHD, ASD, or delayed development were not eliminated, albeit there were positive changes with these children as well, usually improving by one degree (i.e. severe to moderate or moderate to mild). The children within this study were followed up to two years following the end of treatment. The longitudinal data indicated the improvements pertaining to shy withdrawn children and oppositionally defiant children remained stable (Wettig et al, 2006).

In a sample of 38 students, between the ages of six and eleven, attending a special needs school, significant increases in self-esteem and decreased internalizing symptoms were reported (Sui, 2006). Sui (2006) used a mixed method approach to compare the effectiveness of using Theraplay within the school environment by randomly assigning children to either a treatment group or a waitlist control group. Improvements in pre- and post-intervention scores on the Social Responsiveness Scale indicated enhanced social abilities in the children who received treatment while qualitative interviews with the children's teachers indicated they found the treatment informative and reported they would continue applying this approach with future classrooms. Additional studies demonstrated a variety of positive improvements in children's internalizing and externalizing symptoms following Theraplay treatment, including a reduction in behaviour problems, improvement in children's socioemotional development, and a reduction in parenting stress (Mayer &Wardrop, 2006; Siu, 2009; Yoon, 2007).

Foster and adoptive families. The Theraplay modality focuses on repairing or building strong parent-child attachment relationships through healthy and consistent positive interactions. Miller, Lender, Rubin, and Lindaman (2010) argue that children residing in foster or adoptive environments lack these strong attachment relationships and positive experiences, therefore the strength of the Theraplay model is a good treatment method for this population (Booth & Jernberg, 2010). May, Mowthorpe, and Griffiths (2014) present a case illustration of the benefits of an attachment play-therapy intervention for treating relational and attachment difficulties within an adoptive family in the UK. In this study, the attachment-based play therapy intervention integrated principles of Theraplay, Filial Play Therapy and Dyadic Developmental Psychotherapy. Over a 30-month period the adoptive parents and the child engaged in play therapy sessions lasting 50 minutes, each structured to improve the attachment relationship the child had with his adoptive parents. Following the intervention period, the Beck Youth Inventory BYI was administered and compared to a BYI completed prior to treatment. The comparison data illustrated significant positive changes in the child's self-concept and a decrease in his engagement in disruptive behaviours.

Special populations. Bennett, Shiner, and Ryan (2006), upon recognizing the specific treatment needs of mothers and children living in a shelter following experiencing violence in the home, selected the Theraplay method to address the interconnected needs of both children and their mothers. The importance of treating not only the behavioural concerns in children but also the attachment related difficulties the family may encounter became evident (Bennett et al., 2006). The shelter, located in St. John's, Newfoundland, Canada, developed and implemented a 6-week group program for children and their

mothers using the Theraplay approach. Sessions typically lasted 1½ hours with two sessions each week; the first session was for children only and the second session was for children and their mothers. Fifteen children and ten mothers participated in the first wave of this program with two sibling groups in attendance. Families reported that the activities were enjoyable and appropriately focused on developmental and relationship-building perspectives. Children reported having anticipation for the group sessions and became annoyed if they could not attend. Despite the fact that evidence could not be collected on positive outcomes for behavioural adjustment because of the nature of short stays within the shelter environment, the program did evaluate the positive improvements in quality of life for families while residing in the shelter environment.

Theraplay has also been used with adolescent mothers and their children. The Attachment Teen Parenting program used Theraplay to facilitate more positive and attuned relationships between teen mothers and their babies within the 10-week program (Ammen, 2000). The dual component nature of the program focused on education and support in a group format with the primary goal of supporting securely attached teen mother-child dyads. The teen mothers within this program reported having more confidence in their parenting skills and displayed fewer physical and/or mental health problems.

Chapter 2: Process of the Practicum

This chapter describes the process of enhancing clinical skills through family-focused therapy delivered to a small cohort of adolescent mothers and their children. In this chapter, I will describe the advanced practicum project, specifically the practicum environment, my designation and qualifications, and my supervisory relationships. Next, I will describe the process of delivering treatment to at-risk teen mothers and their children. I will give a brief description of the young mothers who participated in Baby's Breath Teen Prenatal and Parenting Program. Following, I will explore the development and implementation of the A.R.T. program, a pilot project that incorporated the Theraplay model delivering attachment-based therapy to treat parent-child relationship problems.

Description of the Advanced Practicum Project

This advanced practicum project involved the development and implementation of a therapeutic program for young mothers who were at-risk for poor attachments with their children. With supervision, the Theraplay model of family therapy was delivered to a small cohort of young mothers. The purpose of this advanced practicum project was to practice and refine clinical skills by delivering attachment-relationship therapy to young mothers and their children. The goal of this project was to improve family structure and stability using a strengths-based family-centered approach. Theraplay is a family-centered treatment approach that derives from theories of attachment, human development, and play therapy.

In addition to achieving my goal of enhancing my skills as a Theraplay practitioner, I also developed my strengths-based clinical skills and enhanced my

knowledge of attachment and human development. Doing so advanced my understanding that young mothers are capable and loving caregivers who may simply require more modeling of healthy parent-child interactions (using a behavioral modification model) since they most likely missed this type of modeling in their family of origin. The inherent strengths and resilience found in the young mothers who participated in my advanced practicum project was evident despite the fact that society has constructed adolescent motherhood as a cause for concern by labeling the phenomenon as a social/health problem requiring further research and interventions to prevent the prevalence of adolescent childbearing.

Agreement with the Organization

In June of 2014, I met with Carole Dodge, Executive Director of Better Beginnings Better Futures, and discussed the opportunity of completing my advanced practicum placement within the agency. Suzanne Lacelle, Laurentian University practicum coordinator, confirmed this advanced practicum placement with Better Beginnings Better Futures and Laurentian University, culminating with signed a practicum contract that also included mandatory workplace agreement forms.

At the time this agreement was created, I was employed by Better Beginnings Better Futures working within the Baby’s Breath program. This program offered prenatal and parenting education as well as support to young families living in Greater Sudbury, Ontario. An agreement was reached that I would develop a pilot project to deliver attachment-relationship therapy using Theraplay techniques with a small group of high-risk teenage mother- child dyads.

For the duration of the project, I was provided a temporary office that was locked at all times to maintain the confidentiality of the client files. The organization agreed to supply city transit vouchers that I provided to clients who required transportation to attend sessions. I was provided access to the office equipment (i.e., photocopier, fax machine) and other office supplies. I agreed to purchase any specific materials related to my practicum training (i.e., specific Theraplay materials). Carole Dodge designated Johanne Thompson, program manager at BBBF, as my agency supervisor throughout my practicum. I discussed confidentiality with Johanne Thompson, and, as an employee of BBBF, I had already signed a staff confidentiality agreement. I informed Johanne Thompson that all of my sessions would be video recorded as a requirement of the Theraplay Institute.

Membership with The Theraplay Institute

The Theraplay Institute has been the international guardian for the Theraplay modality and training since 1971. Operating out of Chicago, Illinois, the institute is a treatment centre for families, as well as an international training institute for mental health professionals around the world (Theraplay Institute, 2013). The Theraplay Institute also offers local and international training to parents and professionals on topics such as attachment, child development, and improving family functioning through the delivery of the Theraplay model. The Theraplay Institute offers clinical supervision for mental health practitioners who wish to incorporate the Theraplay model into their professional practice as certified practitioners. A component of the practicum process is receiving clinical supervision from a certified Theraplay supervisor who can observe and offer professional

feedback on translating skills training into practical interventions with actual clients.

Clinical Supervision

The topic of supervision will be discussed much more in depth in a later chapter, however, for the purpose of this project I received various forms of supervision including web supervision and 1-1 case presentations with Ms. Phyllis Booth, Co-creator of the Theraplay model, and independent supervision from Lorie Walton, a Theraplay member, practitioner, supervisor, and trainer coordinated by the Theraplay Institute. I reviewed clinical supervision with the MSW practicum appointment supervisor in Sudbury, Brenda Robinson.

Delivering Treatment to At-Risk Mothers

Better Beginnings Better Futures (BBBF) is a community centre strategically situated within the center of the Flour Mill/Donovan communities, both of which are high priority, economically disadvantaged neighborhoods. The BBBF model was implemented in Sudbury, Ontario as a research project in 1991. Ultimately, the project sought to prevent emotional and behavioral problems in children through the promotion of social, emotional, behavioral, physical, and educational development. It also provided parent education and support, thus strengthening parental resources and increasing the likelihood parents would be able to effectively respond to their children. Through community engagement and participation, the model strives to create and integrate various community partnerships in order to provide holistic, comprehensive programming tailored to fit the needs of the community.

Baby's Breath: Teen Prenatal and Parenting Program

Under the umbrella of Better Beginnings Better Futures, the Baby's Breath program was established in 2004 to support young families in Greater Sudbury. Statistics demonstrated that the district of Sudbury had a significantly higher teen pregnancy rate in comparison to the average rate in the province of Ontario (Sudbury & District Health Unit, 2013). Johanne Thompson, program manager with Better Beginnings Better Futures, identified a need for supportive services for young parents, and, subsequently, the Baby's Breath program was developed and implemented. This program offers teen specific prenatal and parenting group support and education, in addition to on-going individual support. There are several theoretical underpinnings that guide the development of the Baby's Breath program:

- it is driven from attachment principles;
- it organizes and delivers support during the transitional period from adolescence into parenthood by increasing the participants' knowledge of critical prenatal and parenting education;
- through modeling, the program promotes healthy parent-child interactions designed to strengthen the relationship and bond within the family.

My job description as program assistant with the Baby's Breath program was to co-facilitate weekly prenatal and parenting psychoeducational groups, provide individual counseling and support to the young mothers, and participate in numerous multi-agency conferences and coalitions to address the multiple needs of young families.

In addition to my role with the Baby's Breath program, as part of my advanced practicum, I developed and implemented the A.R.T. program, more specifically I

provided attachment-relationship therapy guided by the principles and methods of Theraplay to a small number of young mothers and their child(ren). Theraplay had never been offered as part of Better Beginnings Better Futures programming nor was this kind of therapy available in northern Ontario, with the closest Theraplay practitioner practicing in southern Ontario. Therefore, my training and developing skill set addressed a service gap in treatment interventions for northern families.

The A.R.T. Program - Attachment-Based, Relationship-Focused Therapy

In light of the research that associated poorer patterns of adolescent parenting with poor developmental outcomes for young children (Rafferty et al, 2011; Hitchcock, Ammen, O'Connor, & Backman, 2008; Dahinten, Shapka, & Willms, 2007), I sought to advance my knowledge and my clinical skills through this advanced practicum as I helped parents increase their knowledge of child growth and development and positive parenting practices, and addressed parents' attachment and relational concerns by providing corrective experiences that modeled appropriate parent-child interactions. In my advanced practicum, I developed my theoretical understanding of attachment principles (and the influence attachment has on mother-child interactions and their overall relationship), social learning theory, behavior modification, and strengths-based social work practice. I developed my understanding in the aforementioned areas through the facilitation of family focused therapy driven from Theraplay principles. The A.R.T. program provided specialized attachment-based, relationship-focused family therapy driven from Theraplay principles to young mothers and their children who met the program criteria.

Recruitment and Exclusionary Criteria

A letter of invitation was delivered to all families who had accessed prenatal or parenting services through the Baby's Breath program since 2010 (See Appendix A). This letter introduced myself, my role as a student in the Master of Social Work program at Laurentian University, and highlighted my opportunity to fulfill my advanced practicum requirements by offering attachment-based, relationship-focused family therapy for families who self-identified as being in need of family support. The mothers were invited to contact me via my confidential telephone line at Better Beginnings Better Futures to discuss if this type of therapy would be suitable for their family. I also accepted referrals from the Baby's Breath program, Sudbury Action Centre for Youth (SACY), Sudbury and District Health Unit (SDHU), and the Children's Aid Society of the Districts of Sudbury and Manitoulin. It was clearly communicated that the family referred must voluntarily wish to participate in the therapy. The following inclusionary criteria was set for my advanced practicum:

- Parents must have self-referred or confirmed voluntary participation as a result of an agency referral,
- Chronological age of the parent at the time of the child's birth was 19 years of age or younger,
- Child that received therapy was 5 years of age or younger,
- Parents recognized a concern in their child's psycho-social-emotional health and well-being or noted behavioral concerns in their child and/or parents had historical or present involvement with the Children's Aid Society of the Districts of Sudbury and Manitoulin,

- Parents and/or their child were not experiencing abuse/violence and were not in an active crisis resulting from past experiences of trauma.

My advanced practicum project consisted of providing up to 15 family therapy sessions delivered either on a weekly or semi-weekly basis to seven families who met the criteria discussed above. Ten families initially expressed interest in participating in the program, however, two families were not able to participate because it was determined they did not meet the inclusionary criteria. One family completed the initial intake and family background review but it was determined that the program was not suitable to their currents needs. The sessions were delivered at Better Beginnings Better Futures and lasted one hour. The session was separated into two components: a ½ hour of direct therapy, and a ½ hour of parent counseling that followed immediately after.

Structuring the Treatment Process

The sequence of treatment followed the typical sequence of Theraplay treatment outlined in the clinical manual *Theraplay: Helping Parents and Children Build Better Relationships Through Attachment-Based Play* written by co-developers of this model Phyllis Booth and Ann Jernberg (Booth & Jernberg, 2010). The A.R.T. program follows the typical Theraplay process when a single therapist coordinates the roles of both the lead and interpreting therapist. The treatment process consists of three distinct phases: (1) intake and assessment, (2) treatment, and (3) follow-up. Sessions include 30 minutes of Theraplay followed by 30 minutes of parent training.

Initial Intake Interview

The focus during Phase 1 was to gather all the pertinent data about the family, assess the problem, and to mutually decide with the mothers if this form of treatment

would be useful in their situation. The intake and assessment phase had four critical components: (1) a response to the invitation package and initial telephone conversation to review inclusionary criteria, (2) an introductory meeting to begin building therapeutic rapport, completion of the family background interview (See Appendix B) and adult attachment interview (AAI) (See Appendix C), review or completion of the Child Behaviour Checklist (CBCL) and Parenting Stress Index (PSI) (Par, Inc, 2012), and signatures on the necessary consent forms for treatment, release to record sessions, and release to share sessions for the purpose of supervision (see Appendix D), (3) observation of the parent-child interactions using the Marschak Interaction Method (MIM), and (4) a feedback session with parents to review strengths and treatment goals. This breakdown is conventional for Theraplay interventions (Booth & Jernberg, 2010).

Following a response to my invitation for program participation, participants were asked various questions designed to assess their eligibility status. I first introduced myself and gave the rationale for the program and explained my status as a Master of Social Work student at Laurentian University completing an advanced practicum. Parents were encouraged to ask any questions they might have of the program or my professional background. Participants were also given my supervisors' names and contact information and encouraged to consult either my supervisor on site at BBBF or my clinical supervisor, Brenda Robinson, with any questions or concerns they may have. Prior to the end of this telephone conversation, an appointment time was scheduled to complete the intake, assessment, and completion of consents.

The intake session was the initial step in treatment. At the beginning of the session, I again introduced myself and provided participants with a copy of the

introduction letter that explained my role, the program, and provided contact information for my supervisor. I shared a brief outline of my background, both as a registered social worker with foundational Theraplay training, and as a former teen mother of three. My motivation in sharing the latter was to begin building a therapeutic relationship with the parents by showing common ground by relating on a personal level and validating the hardships associated with parenting.

The next step consisted of carrying out the family background interview. A standard family background interview template was used with each participant. During this interview I inquired about the reason for referral, developmental and medical history for the child, the child's relationship to the immediate family, and explored the parent's attachment history through the Adult Attachment Interview (Kaplan & Main, 1985). Exploring maternal history and current functioning addressed risk and protective factors that might have impacted treatment progress and highlighted any unresolved maternal issues that made continuing with treatment inappropriate.

Following the interview, I provided the participants with an explanation of the assessment tools to be used in the program, specifically the Child Behaviour Checklist 1 ½ - 5 and Child Behaviour Checklist Teacher Report 1 ½ - 5 (Achenbach, 2016), which outlined various problem areas and helped parents recognize any externalizing behavioral concerns. The Child Behaviour Checklist is a screening and assessment measure that is frequently used with families and children 0-6 years of age (Children's Mental Health Ontario, 2002) and is a standardized assessment measure recommended in the Theraplay treatment manual (Booth & Jernberg, 2010). The participants were given the option to complete the form at home, or if needed, I assisted them with completing the

standardized Child Behavior Checklist in the office. On occasion, if this first session had surpassed two hours, a subsequent session was scheduled to complete the assessment tools.

The Child Behaviour Checklist Teacher Report Form was delivered to the child's school with instructions for completing the assessment. Additionally, teachers were invited to contact me via email or phone to discuss any academic or behavioural concerns, and on occasion, I attended school meetings to discuss the child's needs, and on one occasion conducted a session through group format in a child's early learning kindergarten class of 26 preschool children (I describe this opportunity below and in the final chapter). Sunshine Circles® delivers Theraplay treatment within the classroom setting to encourage positive relationships amongst peers and between the child and educational staff. In this particular case, a young boy was identified as having significant problems in school, as reported by his mother and confirmed by his classroom teacher who indicated clinically significant scores on the Child Behaviour Checklist Teacher Report Form. These behavioural concerns had persisted since school inception and even persisted despite a change in school. Mom received concerns from educational staff that attention deficit hyperactivity problems were apparent and further medical evaluation and treatment was advised. Initial conversations with educational staff and this young boy showed that despite being a likable child, education staff were frustrated with persistent behaviours that elicited poor interactions for this boy with his teachers as well as his peers. The education staff in this child's classroom expressed interest in learning new strategies for supporting this child within the school environment, and therefore, invited me into the classroom. Upon receiving approval from legal guardians, education

decision-makers, and practicum supervisors, I offered one classroom session and provided a sample short therapeutic interaction that could be incorporated into the classrooms daily plan. Further, I organized multidisciplinary exchanges with various service providers involved with the families in the program, organizing and conducting case conferences as needed.

The assessment phase was integral to the treatment process as it allowed me to determine if the presenting problem would be suitable for this type of intervention and allowed me to create an individualized and targeted treatment plan. The Child Behavior Checklist for ages 1 ½ to 5 years is a self-reporting instrument for parents that examine 99 problem items, offering a comprehensive overview of the parents' perceptions of child development and behavioral concerns (Achenbach, 2016). I repeated the administration of the CBCL when treatment concluded and compared the results to the initial assessment to determine if behavioural concerns had improved. Similarly, I administered the Parenting Stress Index Short Form (PSI-4-SF) at the beginning of, and after the completion of all sessions, to compare adolescent mothers' reported stress level. The Parenting Stress Index Short Form PSI-4-SF (Par, Inc, 2012) is a widely used measure of the relative stress in the parent-child relationship.

Finally, the introductory meeting concluded with scheduling an observation session where I used the principles of the Marschak Interaction Method (MIM) (Theraplay Institute, 2011) to observe the natural occurring mother-child interactions necessary for assessing the current relationship between the mother and child.

The Marshak Interaction Method

Following the completing of the intake interview with caregivers, the Marshak Interaction Method (MIM) is implemented. The Marschak Interaction Method (MIM) is a structured technique that observes the relationship between two individuals, such as mother and child, child and father, child and surrogate caregiver, or child and teacher. Thus, through analyzing and evaluating the four dimensions critical to normal, healthy parent-child interactions: nurture, structure, challenge, and engagement, goals are identified and developed into treatment plans based primarily on the individual needs of each family.

The Theraplay Institute provided an excellent summary of the functionality of the MIM by stating:

> The MIM evaluates the parent's capacity: to set limits and to provide an appropriately ordered environment (Structure), to engage children in interaction while being attuned to the child's state and reactions (Engagement), to meet the child's needs for attention, soothing, care (Nurture), and to support and encourage the child's efforts to achieve at a developmentally appropriate level (Challenge). At the same time it allows assessment of the child's ability to respond to the parent's efforts (Theraplay Institute, 2013).

Administration of the MIM

This structured observation looked at the parent-child interaction during various structured tasks. This observation session took approximately 30 minutes to one and half hours to administer. According to the Theraplay model, MIM sessions are often 30 to 45 minutes in length although some can be as short as 10 minutes or as long as 90 minutes

(Lindaman, Booth, & Chambers, 2000). In a standard MIM, each parent or caregiver in a child's life would be observed with the child separately from one another: for the purpose of this project only mothers were involved in treatment, therefore, only the mother child dyad was observed. Each MIM session was recorded, both audio and video, so I was able to review the dyads' interaction throughout the structured tasks, providing insight into their natural relationship.

The MIM observes the parent and child's natural reaction towards one another during various tasks that demonstrate if the dyad is interacting optimally in each domain. The activities are carefully selected to elicit behaviours that would make any problems in the areas of nurture, structure, engagement and challenge quite apparent.

A nurture task, like applying lotion or feeding, looks at the level of comfort both the parent and the child have in giving and receiving nurturing. If either the parent or the child is rejecting of nurturing behaviours, it identifies a critical impairment in the dyadic relationship, thus requiring treatment that focuses on increasing nurturing behaviours between the pair.

A structure task might ask the parent to form a small block tower and then instruct the child to copy the creation. If the dyad is unsuccessful with this task it may indicate that the child rejects following directions by his or her parent or it may indicate that the parent did not provide sufficient directions for the task. Either the former or the latter indicate a need to focus on structure during treatment, improving or instilling a natural parent-child relationship categorized by the parent leading while the child feels safe and comfortable to follow.

Engagement tasks evaluate the level of engagement between the pair, looking at attunement by the mother, her ability to modulate the child's level of optimal arousal and joy and playfulness throughout the interactions. This was measured by analyzing eye contact, facial expressions, voice synchronisms (rhythm), pacing and intensity (affect regulation), and appropriately modulated stimulation during simple playful activities such as peek-a-boo or row your boat. Children that withdrew or avoided playful interactions and/or parents who were preoccupied, disengaged or who showed limited interest in playfully interacting with their child signaled a need for treatment to focus in this area.

Challenge tasks evaluated the parents' ability to create developmentally appropriate opportunities for growth and mastery during activities. Sample activities in this dimension included parents drawing a picture and then asking their child to copy the illustration. Analyzing whether the drawing was either too simple or too difficult indicated that the parent might be unaware of their child's appropriate developmental level. This task also helped signal signs of poor confidence within the child and also spotlighted adult-like behaviours in children which would indicate a possible role reversal within the parent-child dyad. Treatment in this area focused on supporting the child to gain confidence in his or her own abilities by planning developmentally appropriate challenges and modeling positive support and encouragement throughout tasks, such as balancing on pillows and then jumping into the parent's arms or by simply having the child pick up cotton balls or other small objects with their toes.

MIM Analysis

The information gathered from the Marshak Interaction Method (MIM) sought to answer a few predominant questions about the parent-child relationship. From the MIM, I

sought to understand what it must be like for parents to live with this particular child for a 24 hour period. Alternatively, what would it be like as a child to be cared for by this particular caregiver for a 24 hour period? I looked for areas of strength in the parent-child relationship: what is already working well? Alternatively, what is not working well or what critical components for a healthy relationship might be lacking or non-existent. Ultimately, the answers to these questions show what the children need from their parents and provided insight into the particular treatment needs for each family, thus allowing for a more tailored detailed treatment plan. After my observations and analysis notes were completed on the present family relationship, I completed a treatment report and then contacted the family to schedule a feedback session.

MIM Feedback Session

During the feedback session, which took between 60-90 minutes, I selected segments of the interactions that illustrated inherent strengths in the mother-child relationship and I facilitated a discussion around the infant's thoughts and feelings during the interactions while simultaneously encouraging the mother to reflect on her parenting strengths. I discussed areas of improvement and the treatment plan. The primary goal was to increase the mother's awareness of how her maternal behaviours influenced her child's behaviour through directive feedback (Moran et al, 2005). The feedback session concluded with a discussion about her involvement and commitment to therapy, and, when in agreement and with verbal consent, the first session was scheduled.

Treatment

The treatment stage lasted up to 15 weeks with families that utilized the maximum amount of sessions at the duration of once a week. The participants were given

the option to complete the sessions weekly or bi-weekly. The sessions were one hour in duration, with one half hour dedicated to therapy, followed by one half hour of parent training. During the first few sessions I conducted the therapy with the child alone, so I could begin to build a healthy relationship by interacting in a playful, attuned, and responsive manner with the child. I established a healthy relationship with the child and then included the mother in therapy and had her mirror these healthy interactions. As soon as I felt the child was ready, I included the mother and had her participate and eventually lead the therapy. Each therapy session followed the same sequence with some variance in the activities, but the four domains of nurture, structure, challenge, and engagement were utilized throughout.

Foundational to each treatment session were several core features of the Theraplay approach. Each session includes: an entrance/greeting activity; a check-up activity; a feeding activity; and a closing activity. Each component is described in more detail below, along with a sample of the activity:

- Entrance/Greeting: The entrance greeting is intended to show the child how excited you are to see them. Similar to how a mother greets her baby in the morning, the therapist uses nonverbal (facial expressions, body movements, body orientation, nuances in voice) and verbal communication to communicate the joy and pleasure at seeing the child.
- Check-up: The check-up is intended both to be a reconnection after a separation between sessions, but more importantly check-up activities convey purposeful attunement to the unique and special qualities of the child, and also recognize changes and growth in the child.

- Feeding; The feeding ritual is an integral component in each session. Being fed by another person is the most basic form of nurturing that humans experience. Receiving food from our caregivers helps us develop trust and security. Feeding children in treatment allows that trust to build between the therapist and the child. The feeding process is also a regulating experience as it is calming and leads to healthy emotional development.
- Closing: The closing of a session has two purposes: first to part from the therapist, and second to return the children to their parents. It is important that the experience ends on a positive note and offers continuity between therapy and the child's natural world.

Each session had a predetermined plan based on the client's particular needs, and the typical sequence of a treatment session followed the Theraplay structure: entrance, check-up, goal related activities, feeding, song, and ending. The variances in the activities used in treatment were dependent on the presenting problem. For example, in a family who presented with altered roles (a child who is adult-like and an adult who employs passive parenting tactics) more activities geared to nurturing and structure were included, thus reversing their roles to a natural state, i.e., a parent who cares for and nurtures their child and sets clear and consistent boundaries for their child to keep them safe with the child accepting this caregiving, limits, and direction.

Upon reaching two-thirds of the way through treatment, after about 10 sessions, I scheduled a check-up session to provide parental feedback and to assess the current state of the presenting problem and family relationship. This check-up session examined the progression in the dyad, and with the mother's consultation a decision was made

regarding continuing treatment. When treatment was no longer required, the final phase of treatment commenced, defined as the termination phase, at which time I slowly disengaged from the family. The final session, generally on the 12th session, ended therapy with an upbeat closing party that focused on celebrating the child's strengths and achievements and emphasized the level of happy interaction and joy between the parent and child. If there was a still imminent concern, therapy was extended to the maximum 15 sessions.

Example of initial Theraplay session with a child who presents with anger/aggression

1. *Entrance*: therapist and child balance beanies on their head while walking from the waiting room into the therapy room

2. *Checkup:* measure height on a growth chart and create a special handshake, examining special marks, checked out muscles

3. Lotioning hurts: therapist notices any boo-boo's that need attending and rubs a small amount of lotion gently around the hurt area

4. Slippery Handshake: therapist rubs lotion on child's hands, then tries to hold child's hands, but can't and "slips" away exaggeratedly, giving excitement and surprise to child (Nurture)

5. Newspaper Punch/Basket Toss: therapist stretches a single sheet of newspaper tautly in front of child, directs child to wait for a signal before punching through newspaper, on command child punches, afterwards therapist bunches newspaper into a ball and hands it to child while making a net with circled arms, then providing child a signal to toss the newspaper ball through the net Structure/Challenge)

6. Cotton Ball Hockey/Keep it in the middle: therapist and child lie on tummies facing each other on opposite sides of a large pillow, therapist places cotton ball in the centre and counts 1-2-3 to signal to start, therapist and child try to blow the cotton ball to the other person's side of the pillow…activity merged into *Keeping it in the middle* where therapist and child try to blow at the same time to keep the cotton ball in the middle (Structure)

7. Balloon Tennis: therapist and child hit a balloon back and forth, trying to keep it in the air (Challenge)

8. Temporary Tattoos: therapist applies temporary tattoo on child (Nurture)

9. Toilet Paper Bust Out: therapist wraps child's legs, arms, and whole body with toilet paper. On a signal, the child breaks out of the wrapping (Structure)

10. Paint Prints: therapist rubs paint on child's hand, then presses the painted hand onto paper to make a print. After print is made, therapist gently washes, dries, and lotions child's hand (Nurture)

10. Feeding: Therapist feeds the child a small snack, while giving eye contact, physical closeness, and attunement to the child's reactions

11. Goodbye Song: Sing an upbeat song before parting and reuniting child with his mother in the waiting room

In conclusion, this chapter described this Advanced Practicum Project, which focused on enhancing clinical skills through family-focused therapy through the delivery of the Theraplay model to a small cohort of adolescent mothers and their children. I described the advanced practicum project, specifically the practicum environment, my designation and qualifications, and my supervisory relationships. I described the process

of delivering treatment to at-risk teen mothers and their children. I provided a brief description of the young mothers who participated in Baby's Breath Teen Prenatal and Parenting Program. I explored the development and implementation of the A.R.T. program, a pilot project that incorporated the Theraplay model into attachment-based, family-focused therapy to treat parent-child relationship problems. In the next chapter, I will discuss opportunities for professional development and reflexivity in practice that have further enhanced my clinical skills.

Chapter 3: Professional Development and Reflexivity in Practice

I did not realize until a few years ago that I wanted to specialize in play-based interventions. My personal and professional identity has always been strongly linked to attachment and child development. Throughout my practicum, I reflected on both my personal identity that was constructed from my own early childhood experiences, which critically impacted my own growth and development, and my professional identity where I was strongly inclined towards theories of child development favouring theories of learned behaviours rather than individual pathology. I became a mother at a young age; I had three children by early adulthood thus giving me ample opportunity to connect particular theories with direct practice through my own parenting lens. During my undergraduate practicum, I gained employment providing prenatal and parenting education and support to adolescent mothers and their young children. Education was delivered through direct practice, particularly modeling and coaching, and family-focused interventions were often taught through play.

I discovered Theraplay during a graduate level course when a colleague in my class delivered a presentation on Theraplay. I recall connecting the usefulness of this type of therapy in supporting the at-risk adolescent mothers with whom I worked. I wanted to try using Theraplay to increase their parenting capacity, and to promote their ability to be loving, supportive, nurturing parents to their young. Theraplay was appealing because early childhood mental, social, and emotional health problems are explored from an environmental perspective rather than an individual pathology lens. I identified the need to provide services that extended beyond my current job role providing education and support; therefore I sought to advance my training in play-based treatments. I began the

journey of becoming a certified Theraplay therapist through the Theraplay Institute's practicum, while establishing a new program at Better Beginnings Better Futures, the A.R.T. program (Attachment-based, Relationship-focused Therapy), which would deliver intensive play-based therapy to at-risk mothers and their children.

Prior to developing my practicum proposal, I had completed the academic requirements for a Bachelor of Social Work (BSW) degree (Honors) and I had completed all core and elective course requirements for a Masters of Social Work degree. My undergraduate studies helped me acquire a generalist social work framework and my professional experience improved my direct practice skills, but I wanted advanced training using clinical play-based treatments. I gained invaluable knowledge and experience throughout my journey undertaking both the Theraplay Institute's practicum and training, which were part of my Graduate Advanced Practicum. In this chapter, I will reflect on my transformational experiential learning process. First, I will describe the supervision practicum through the Theraplay Institute and highlight the additional training and supervision I acquired, which vastly advanced my professional development. After introducing the concept of reflexivity, I will highlight the various modes and functions of supervision that supported both my personal and professional development. Specifically, the concept and expansion of 'reflexivity' within practice will be explored through reflections stemming from many different forms of clinical supervision and my practices, which were all important components in helping me to grow and develop.

The Theraplay Institute Supervision Practicum

The Theraplay Institute has been the international guardian for Theraplay since 1971, and a 501(c)(3) not-for-profit corporation since 1995 (Theraplay Institute, 2017).

The Theraplay Institute plays many roles, most importantly, it is the central organizational office that trains, supervises, and monitors potential new therapists utilizing this specific treatment. The Theraplay Institute's supervision practicum is geared towards clinicians seeking best practices for treating at-risk children and families through an alternative directive play-based modality. Specifically, this treatment can help ameliorate problems through modeling and exposure, which traditional talk therapies do not provide. To apply for the practicum, TTI specifies that applicants must hold a master's degree or higher in a mental health field specializing in working with children and families (Theraplay Institute, 2017). Throughout the Theraplay Institute's certification practicum, I was matched with, and guided by, an Independent Certified Theraplay Supervisor, Ms. Lorie Walton.

Ms. Lorie Walton is the owner and lead therapist at Family First Play Therapy Centre in Bradford, Ontario, a centre that focuses on "helping children and their families deal with attachment, trauma, emotional, and developmental issues" (Family First Play Therapy, 2017). Throughout my practicum, I mailed a copy of 10 of my sessions from three cases to Lorie via a secured, password protected USB with a copy of the session supervision form completed for each session (See Appendix E). Ms. Walton provided a written copy of her session feedback, including a rated measure of success in each area, and we discussed her feedback allowing for a question and answer period via the telephone.

Additionally, I utilized the web conferencing supervision tool through TTI. Web supervision is a direct live stream that allows a clinician to present one of their own cases for 1-1 supervision while a group of observers provide feedback through peer support.

Observing through web supervision is permissible to any individual who completed Level One Theraplay training; Theraplay is practiced in 36 countries internationally, which provides for a more diverse learning community. As a result of this experience, my growth and discovery grew exponentially, and, as a result, my sense of self was enhanced from the fusing of my personal and professional identities. In my opinion, this process was both intimidating and invaluable. My identity transformed from a fragile novice social worker into a confident and effective clinician. As McTighe (2011) stated, the process of effective clinical supervision develops one's sense of self.

The Process of Theraplay Supervision and Certification

Prior to beginning my placement, I attended four days of intensive Level One Theraplay & Marschak Interaction Method (MIM) training delivered by Evangeline Munns at Wilfred Laurier University in Waterloo, Ontario as a prerequisite to apply to the supervision practicum through the Theraplay Institute in Evanston, Illinois. Ms. Munns is a published author, certified psychologist, and certified Theraplay therapist, supervisor, and trainer who has delivered training in many countries. This training centered on teaching foundational Theraplay principles and applied the knowledge of attachment, neurobiology, and healthy parenting relationships. This introductory training provided the experience needed for Theraplay informed practice and is a prerequisite for application into the practicum and certification program. Level One Theraplay training demonstrated the use of this treatment with various populations and provided introductory knowledge on following the Theraplay process, including conducting family background interviews, completing Marshak Interaction Method observations, formulating treatment plans, conducting parent feedback sessions, and practicing

Theraplay direct interventions with children and families. The successful completion of Level One training depended on my ability to lead a mock therapy session that followed a treatment plan I had developed. Upon the successful completion of Level One training, I applied to the Theraplay Institute's certification practicum. In the practicum, students are matched with and guided by a Certified Theraplay Supervisor. Certified Supervisors have a minimum of two years of experience as a Certified Theraplay Therapist and have completed a rigorous practicum to become a supervisor (Theraplay Institute, n.d).

Within my application, I provided a copy of my general Certificate of Registration with the profession of social work in Ontario (Ontario College of Social Workers and Social Service Workers, 2017), resume, certificate of professional liability insurance, which covers errors, omissions or negligent acts which may arise from the normal or usual duties carried out by the insured (CASW, nd), and a letter from Laurentian University confirming my successful completion of all course requirements of a Masters of Social Work Degree. Then I was assigned a practicum supervisor through TTI. During my practicum, I completed the required eight supervised and 32 unsupervised sessions to receive certification as a Foundational Practitioner.

I attended Level Two Theraplay and MIM skills training at the Theraplay Institute in Evanston, Illinois, from June 22nd to June 26th, 2015. As a personal initiative to increase my knowledge and training, while at TTI, I took part in two masterclasses including "Integrating Theraplay And Dyadic Developmental Psychotherapy" and, as previously mentioned, participated in a Theraplay Supervision Day with Ms. Phyllis Booth. Ms. Booth, MA, LMFT, RPT/S, is a certified Theraplay therapist, Supervisor and Trainer, and Clinical Director Emeritus of the Theraplay Institute in Evanston, Illinois,

USA (Theraplay Institute, 2017). With the knowledge and experience I gained during successful web supervisions, I boldly presented another one of my cases for supervision as a part of a Theraplay masterclass facilitated by the co-creator of the Theraplay model Ms. Phyllis Booth. I cannot begin to describe the honour of discussing my work with the woman who pioneered this treatment modality and receiving her professional validation. I strongly think that the supervision/ feedback provided from Ms. Booth and the training attendees affirmed that I was applying the principles of Theraplay and practicing effectively with young mothers and their children. I was able to address clinical challenges in this particular case with a group of professionals who had varying degrees of Theraplay training and experience. In the following section, I will briefly discuss the concept of reflexivity. This will be followed by a discussion of my experiences with clinical supervision. I discuss the use of critical reflection within supervision and expand on the term reflexivity; specifically how reflexivity in practice enhances professional development.

Reflexivity

Well-established and highly cited research by David Schön has discussed the notion of the reflective practitioner in length (Schön, 1983; 1987; 1995). Critical reflection is highly regarded as an essential skill for social workers in order to maintain competency of practice through continual growth and skill development (Petruik, Freeman, McGillicuddy, & Dimitropoulos, 2017). The ability to reflect on our own thoughts, actions, and feelings about the individuals with whom we work, and our own individual experiences of doing this work is the highly emphasized skill of self-awareness or critical reflection, and both concepts stem from the umbrella term of reflexivity

(Chow, Lam, Leung, Wong, & Chan, 2011). Chow et al. (2011) defined reflexivity as "the action of the mind by which it is conscious of its own operations" (p.?) According to Rennie (2004), reflexivity is described as the ability to reflect on the thoughts we may have about our thoughts and the feelings had about feelings while in the practitioner role, for the purpose of using this awareness to grow as a counselor. Reflexivity is a skill that I developed during the process of supervision.

Professional Development and Supervision

Effective supervision for novice social workers promotes ethical professional development standards as well as promotes effective practices and increases quality care for individuals accessing services (Ketner, VanCleave, & Cooper-Bolinskey, 2017; Ontario College of Social Workers and Social Service Workers, 2012). The Ontario College of Social Workers and Social Service Workers (2012) identified the need for relatively new social workers to be "creative in obtaining profession specific supervision" when such opportunities are unavailable in their agency. It can happen that the senior advisor may not hold a social work degree and may not have the necessary qualifications to provide clinical supervision of particular clinical skills, clinical judgment, and clinical values including ethical obligations (Ontario College of Social Workers and Social Service Workers, 2012). Technology can serve as an asset for new social workers, like myself, who may not have readily available supervisors who meet the professional registration standards or who carry enough relevant expertise to provide quality supervision. According to the Ontario College of Social Workers,

> Clinical practice is predicated on the assumption that honing professional capacity is a continuous learning commitment. Clinical supervision of social work practice

> should be provided by a member of the profession with extensive specialized knowledge and skills, especially when related to the provision of psychotherapy services. (Ontario Association of Social Workers, 2015)

Thankfully, I was able to utilize various modalities to attain supervisory relationships that met my learning needs at the administrative, educational/clinical, and supportive level.

Multi-functionality of Supervision

There are various purposes for supervision. The Ontario Association of Social Workers (2015) describes the main functions of supervision are to attend to administrative objectives, to provide educational or clinical teaching, and to provide support. Throughout my practicum, I had access to multiple individuals who provided either supervision or consultation during my journey. As I was working at Baby's Breath, I had the daily opportunity to meet with Ms. Johanne Thompson, program manager at Better Beginnings Better Futures. Ms. Thompson developed the Baby's Breath program 10 years prior and was an integral partner in the Sudbury community advocating for young mothers. Ms. Thompson cultivated a strong supportive relationship with the young families who attended the program, and I learned about program development, funding, grant writing, nonprofit community programming, and community engagement at Baby's Breath.

Ms. Thompson also provided supportive supervision earlier in my time with the agency. When I first came to work at Baby's Breath, I was young and inexperienced. I was unaware of the manner in which to deal with workplace harassment and bullying that was directed towards me from a senior influential staff member at the agency. Experiencing harassment and bullying in the workplace heightened my levels of stress,

affected my self-assurance, and affected my job satisfaction. Ms. Thompson advised me about my rights as a worker and supported my disclosure to the Executive Director at the agency. Ms. Thompson's encouragement and support helped me to stand up for myself and other colleagues who had experienced similar forms of harassment. Although, filing a complaint was incredibly stressful, by doing so I was implementing practice standards set by the Ontario Association of Social Workers and Social Service Workers. The dialogues generated within this supervisory relationship helped improve my morale in the agency and supported my growth, learning, and confidence that allowed me to embark on my own success developing and coordinating this pilot program delivering intervention to at-risk young mothers and their children.

As a prerequisite of the Masters of Social Work Advance Practicum, Ms. Thompson was unable to provide clinical supervision, as she did not hold a Master's Degree in Social Work. Fortunately, I was afforded the opportunity to receive clinical supervision from Ms. Brenda Robinson during my Laurentian University practicum experience. Ms. Robinson held a Master's Degree in Social Work and remained a member in good standing with the Ontario College of Social Workers and Social Service Workers (OCSWSSW). Ms. Robinson's extensive 32 years of experience in Child and Welfare services, and her long-standing relationship with the Children's Aid Society of the Districts of Sudbury & Manitoulin, was an asset to my professional development.

Although I did not have direct access to meet with Ms. Robinson daily, she was consistently available through email and telephone. Face-to-face structured supervision meetings did occur twice per month. Participants in the A.R.T. program provided consent so I was able to document my clinical skills by providing Ms. Robinson the opportunity

to review my video-recorded therapeutic sessions which generated clinical conversations recognizing my therapeutic skills and ways in which to broaden my skills. Through this supervisory relationship, I had the opportunity to discuss her observations of adolescent mother-child relationships in the context of child welfare involvement. Also, issues of transference and countertransference were routinely discussed.

One example that was prominent throughout my supervisory sessions revolved around the fact that I often identified with many of the mothers because of my personal experience of teenage motherhood. I reflected on this connection during supervision and discussed in length the benefits and cautions of using self-disclosure of my own personal trials and tribulations. We discussed, within the supervisory setting, how and why I used self-disclosure within the therapeutic setting, particularly pinpointing if the disclosure benefited the client. I concluded that while self-disclosure was beneficial in deepening the relational dynamic with the young mothers, it was also important to keep in mind that their individual experience was deeply personal, and generalizing the experience of teenage motherhood through unhelpful disclosures could in fact devalue their personal journey. In another example, I discovered through dialogue with my supervisor and self-reflection that my personal experience of newly separating and my difficulties with joint parenting made me incredibly sensitive to this issue with my clients. I was deeply impacted by the effects of parental conflict on the children with whom I worked in the A.R.T. program, and I was grateful to have a supervisor who tuned into my emotional reactions and directed the dialogue towards increasing my awareness of the activation of these emotions. Awareness is critically important in terms of protecting against the negative effects of transference issues.

Perhaps the greatest, or my most deeply valued component of our supervisory relationship was the advancement of my recognition of and reflection on the importance of self-care. As I am new to the social work profession, and by virtue of my personal characteristics, I submersed myself into developing, implementing, and coordinating this pilot program. Ms. Robinson quickly became aware of my work ethic and then gently initiated conversations about self-care, boundaries, balance, and burnout. She helped me become more conscious of my tendencies to discount self-care, which I reasoned increased time and attention focused on the A.R.T. program and the families with whom I was working. Discrediting the building of personal time and spiritual wellness, especially in a highly mentally exhaustive field of practice, in actuality reduces alertness, productivity, and overall capacity (Raab, 2014).

As a novice Theraplay practitioner, consulting with specialized experts of this therapeutic modality was a critical phase of professional development, building my competency and clinical skills. In fact, the importance of matching new practitioners with experienced practitioners, and the connection this mentorship has on applying knowledge to practice, is so highly regarded that the Theraplay Institute highlights expert supervision as an integral component of the practicum experience (Theraplay Institute, n.d). Ms. Lorie Walton was highly competent and capable of providing high levels of guidance, instruction, and support due to her extensive clinical experience in Theraplay and play therapy. Over the course of this practicum, I sent the required eight sessions to Ms. Walton for clinical consultation. With her recommendation, after doing so I achieved certification as a foundational Theraplay practitioner.

Ms. Walton provided essential guidance through sharing her own clinical experiences and ensured that as a beginning therapist, I remained true to the Theraplay modality. For example, when setting up my playroom I initially gravitated towards fun and added a slide, pillows, and stuffed animals to the sitting area. After viewing my initial session, Ms. Walton encouraged me to reduce the level of stimulation in my playroom, thus providing a more structured and calming environment. I found that by decreasing the externalizing stimulation, I also saw a decrease in the level of hyperactivity of the children in the playroom. Most of the children struggled with regulation issues, as per the information provided from parents and teachers during intake, therefore a therapeutic setting that was simple and calming was key.

In addition to exposure to and guidance from all designated supervisors who had nearly 100 combined years of professional experience, I had many opportunities to engage in peer supervision and support. Peer support groups offer a solution for private practitioners who are without a supervisor because of the isolating factor of private work. As Akhurst and Kelly (2006) attest, sometimes group supervision may be a clinician's only mode of supervision when dyadic supervision is unavailable. I was invited to meet with a small group of private practitioners who each maintained private practices within the Greater Sudbury community and collectively created a peer support group. This collective group included practitioners who had moved into private work after retiring from agencies after decades of practice as well as practitioners who were working in both community and private practices. This informal peer support group had been meeting collectively once a month to offer case consultation to one another through a collaborative learning process. Since the group did not meet during the summer, I only

had the opportunity to attend once during my advanced practicum, though I was able to offer some insight from the lens of attachment work and my experience working with individuals who have unresolved attachment histories.

Similarly, another form of peer supervision I utilized was through a live peer supervision group sponsored by the Theraplay Institute. With regard to peer supervision groups, Ackhurst and Kelly (2006) argue that exposure to a variety of different cases, approaches, and experiences from a range of perspectives allows for greater growth. In addition to presenting my own cases, I observed other Theraplay practitioners from across the world, thus I was exposed to a variety of cases and levels of Theraplay skills. I found that having the opportunity to observe other therapists initially was useful because I was able to analyze how to present a session and visualize how a live supervision session played out in terms of receiving feedback. I previously avoided supervision because the thought of it gave me anxiety and I felt insecurity as a newly practicing therapist and had unsubstantiated fears that my skills would be criticized by more experienced therapists. By participating in the live web supervision as an observer, my self-awareness and confidence improved, as I was able to compare my work with colleagues, offer well-received feedback, and establish a more realistic mindset regarding the role of the assigned supervisor and other observers during the supervision session. I came to realize that the amount of support and constructive feedback offered through live web supervision would be invaluable to my own clinical growth.

By the end of my practicum, I had presented two of my own cases and walked viewers through my sessions. I strongly believe supervisor and peer feedback affirmed a level of professional capacity and confidence in my professional development that

incrementally developed throughout my practicum, particularly with the guidance and support of the many aforementioned supervisory relationships. As previously noted, I experienced multiple modalities of supervision and consultation each serving a vital function in my personal and professional progression.

Gaining Reflexivity in Practice Through Supervision

Understanding the models and practicing skills whilst reading literature and staying abreast of evidence-informed theories is simply not enough; enhancing my own awareness through attuning and reflecting on each experience built proficiency in my social work practice. Reflexivity simply means reflecting on your clinical or practice experience in a manner that gives insight into your strengths and limitations, or better said, recognizing areas that may need improvement. Supervision is the mechanism by which this guided critical reflection and exploration occurs (D`Cruz, Gillingham, and Melendez, 2007).

Practicing reflexivity during my practicum was both an immediate solution-focused method of clinical judgment, as well as a deeper, more self-reflective and meaningful practice. My clinical judgment stemmed from conscious critical thinking about the evidence supporting my judgments, particularly paying attention to past experiences, values and personal beliefs. Reflexivity was crucial throughout the many phases of my therapeutic work, but particularly during the analysis of observations and parent feedback sessions. Many times, I had to be attuned to my emotional responses that were triggered during observations of some interactions between the young mothers and their children. For example, in several dyads the mother expressed a great deal of frustration regarding the child engaging in noncompliant or oppositional behaviours, and

often labeled their child with Attention Deficit Hyperactivity Disorder or Oppositional Defiant Disorder, thus suggesting that the problem lie solely in the child. Moreover, the children I worked with were between two to five years old, and certainly, while young children have been diagnosed with neurobiological disorders it should not be the first line of inquiry. I found that many of the children deemed non-compliant or oppositional actually had unmet needs that caused *resistance*. Resistance, in Theraplay terminology, broadens the lens to viewing opposition in terms of the parent-child dyadic interactions, rather than evaluating only the child's behavior. (Eyles, Boada, &Munns 2009). I had to monitor my emotional reactions and engage in empathic understanding to avoid responding in a critical or disapproving manner towards the mother, which would have negatively impacted our therapeutic alliance and treatment progress.

Conclusion

In this chapter, I have discussed the multiple modes of supervision I received throughout my practicum, describing the role each played within my development of reflexivity in practice. Reflexivity is crucial in professional development, for me, it became the framework or lens for viewing my professional self and it improved my confidence in my practice skills. In the final chapter, I will discuss how the results from the A.R.T. program were comparable to the findings throughout the literature on Theraplay and play therapy with children. I will conclude by illustrating some of the challenges I encountered throughout the development, implementation, and coordination of the A.R.T. program with suggestions for future practice.

Chapter 4: The Application of Core Features and Dimensions of Theraplay

To fulfill partial requirements for my Master of Social Work at Laurentian University, the A.R.T. program was implemented as a pilot to deliver attachment-based, relationship-focused family therapy driven from the Theraplay intervention model to at-risk adolescent mother-child dyads. The chronological age of the mothers at the time of their child's birth was 19 years of age or younger. The child brought for therapy was five years of age or younger. The ten dyads selected were self-referred to the program out of concern for socio-emotional, behavioural, or relational problems. Families participating in this program were considered at-risk due to involvement with the Children's Aid Society within two years of the program start date. Two of the 10 families who began the program did not enter the treatment phase and therefore will not be included in this discussion. This program focused on the relationship between mother and child (no fathers took part due to their lack of involvement in their children's programming).

The core features of the Theraplay model targeted attachment issues that manifested from relational and interactional dysfunction between a parent and child (Bojanowski & Ammen, 2011). The results found within The A.R.T. program aligned with a vast amount of literature that supports Theraplay interventions as an effective treatment choice for a variety of behavioral, emotional and relationship problems in children (Bennett, Shiner & Ryan, 2006; Munns, 2009; Siu, A. Y., 2009; Wettig, Coleman, & Geider, 2011; Wettig et al, 2006). Even with just a few sessions, there was a reduction in the problems that initially led to the referral. Particularly with younger children, play based therapy offered a safe environment to allow greater effects of treatment; play is more natural and comfortable for children (Winburn et al, 2017).

Findings also demonstrated that using the Theraplay modality with adolescent mothers and their children benefited not only the children, but also the mothers, who because of their own attachment histories struggled to provide attuned, playful interactions that were sensitive and responsive to the child's needs. The focus in the playroom was repairing the relationship rather than focusing on the individual parent or child problems.

In this chapter, I expand on the findings generated from the A.R.T. program and compare the results to literature on using Theraplay. I found Theraplay techniques worked well with adolescent mothers and their children to treat a wide variety of problems, which will be illustrated further within this chapter. I have divided this chapter into four sections. Section one will examine the value of play-based therapies, like Theraplay, as a preventative and corrective intervention for adolescent mothers and their children. I will present the seven core features of the Theraplay model and demonstrate how these features simultaneously met the unique needs of both the adolescent mothers and children in this program. Particularly, I show how the seven core features were instrumental in improving the caregiving practices of adolescent mothers, which produced more meaningful interactions between mothers and their children. Section two will explore particular relationship issues between adolescent mothers and their children, as evidenced from the results of the Marshak Interaction Method at onset of treatment. Following, I will show how the four dimensions of Theraplay were used to repair these relationship issues.

The Core Features of Theraplay

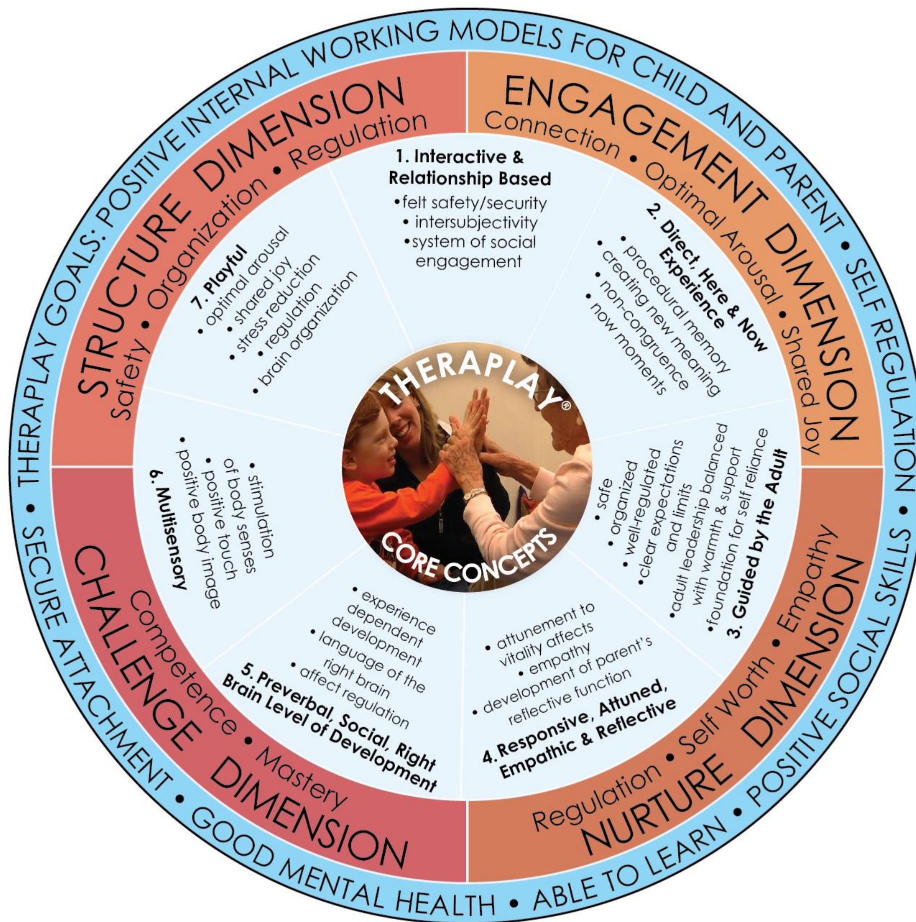
The engaging, playful, and intensive nature of Theraplay sessions produced powerful corrective experiences in a relatively short period of time. The relationship

between the mother and child was the focus during each session, instead of focusing on the individual child or parenting problems. Despite focusing solely on improving the relationship there was a reduction in the behavior problems that led to the referral for treatment. These improvements extended into other environments as well. For school aged children there were significant improvements in the child's functioning at school. Some common signs of improvements included teachers' comments such as: "improved mood," "increased attention, compliance, and cooperation," "less withdrawn," "improved relationships with peers and staff" and "improvement in managing emotions."

I found that as the problems in children decreased so did the overall parenting stress of the mothers. The Parenting Stress Index Short Form was used to measure the level of stress in the parent-child relationship. The PSI covers three domains that are believed to encompass the experiences of stress in parenting. Comparing the results of the PSI provided interesting findings. On the subscale for parental distress (related to stress from their role as a parent) only two mothers reported distress. In comparison, all of the mothers indicated they strongly agreed with items from the difficult child subscale, which assessed parents' perceived ability of how well they managed their children's behaviour. The third subscale, the parent-child dysfunctional interaction scale, assessed parents' levels of satisfaction with their relationship with their children and responses varied quite significantly in terms of whether mothers strongly disagreed or strongly agreed. These findings indicated that the mothers' level of stress was connected to the perception that their child was difficult or hard to manage.

The full range of positive outcomes in correcting both externalizing behaviours in children and improving the caregiving capacity of adolescent mothers is best understood

by examining the core concepts of Theraplay. The seven core concepts of Theraplay shown in the inner ring of the diagram below provide the theoretical framework for understanding the positive outcomes for children and families.



(Booth & Jernberg, 2010)

1. Theraplay is Interactive and Relationship Based

This core feature of the Theraplay model is the foundation for the treatment of families. The Theraplay model targets relational and interactional dysfunction between a parent and their child that could predict attachment issues (Bojanowski & Ammen, 2011). Theraplay originated as an early intervention and prevention program for parents and

children whose relationship was affected by the presence of risk factors or the stressors of everyday life. The goal in Theraplay sessions is to bring the child and parent together so they can interact with one another in a new way. Essentially, the quality of the relationship between a mother and her child is improved by facilitating a connection that is playful, attuned, and responsive.

Connecting in such a direct, interactive way was initially a struggle for the mothers. Many of the mothers in this program expressed difficulty connecting and relating to their child for many reasons. Many mothers reported that their child's behaviour was difficult to manage and was often upsetting. Interactions that typically occurred were disciplinary in nature. Often there were other siblings at home, or in two cases the mother was pregnant during treatment, leading to competing bids for mom's attention. Five of the seven mothers also worked or attended school, so for a large portion of the day the child attended daycare or school. By the time everyone arrived home there was limited time to eat dinner, complete night-time routines, and prepare for the day to come. Many mothers reported that they often used this time to unwind themselves and allowed TV or tablet time to get a break. Interestingly, during this unstructured time increased problem behaviours were reported. Due to the demands of everyday stress very few opportunities for positive interactions were occurring. The interactions that were occurring were conveying some negative messages to the child (eg. "I don't want to listen to you" or "I love TV more than you").

The interactive relationship is categorized as the back-to-back interactions between a child and her caregiver. During interactions between a child and her caregiver, sensitive caregiver responses are critical for building secure relationships. Maternal

sensitivity is considered a predictor of the mothers' ability to respond appropriately to her child's stress cues. Research has shown that adolescent mothers demonstrate lower levels of maternal sensitivity in their interactions.

For the duration of every 30-45 minute session, each mother-child dyad came together, face-to-face in the playroom, participating in a series of playful interactions designed to build physical and emotional closeness. Rhythm and synchrony were incorporated into the songs and movements and became the communication between the pair. Effectively, children learned to mirror their mothers, demonstrating synchronization among the pair. Ultimately, mothers began to recognize changes in their children's emotional states throughout the activities, leading to their ability to shift the interaction accordingly. Her responses became more sensitive and attuned to her child's needs for comfort, nurture, and support.

In the playroom, the mother and child reconnected with one another by experiencing joy and excitement in their interactions. Without any competing interests, the mother was able to provide attention to her child. One activity that was important for building these deep connections was the 'check-up' activity each session. The children enjoyed having their mother notice their special qualities and sharing in their growth. The second part of this activity had the mother attend to any hurts by applying lotion in a nurturing way. This attention conveyed to the child that his mother cared and would take care of him. The experience was truly reparative for their relationship.

2. Theraplay is a Direct, Here-and-Now Experience

This core feature of Theraplay is to physically connect the parent and child together in session to interact with one another and practice a new way of connecting that

is characterized by being together in the moment and enjoying each other's company. This interactive experience shapes the child's brain. The focus is on what is happening in session rather than recent problems or past experiences. The children with whom I worked responded joyfully to having their mothers' undivided attention. This deeper connection provided the experience to allow for the synchronization between the pair to occur. It was evident when a mother was disconnected during session as it would throw off the synchrony during the interaction. The Theraplay language defines these direct experiences as "now moments" or "moments of meeting" which are crucial for reformatting implicit knowledge of relationships, a sort of internal reorganization of knowledge that expands the experiences from which the individual can draw. From these new experiences, the goal is for the child to see themselves in a more positive way and for parents to have a changed view of their child and of their own competence as parents.

Children often came to sessions filled with negative views of themselves and the relationships in their lives. For example, many children were referred for services because of anger and aggression at home and school. Experiencing these problems created disconnection in their social relationships. They had come to see themselves as not worthy of positive social connections. During Theraplay sessions, interactions with the child are fun and engaging and convey a message to the child that the adult enjoys their relationship. The experience in Theraplay is noncongruent with the earlier messages the child has received and this causes the child to challenge what he has come to expect, allowing him to form new implicit views of himself and others around him.

3. Theraplay is guided by the Adult

Integral to attachment theory is the understanding that a healthy relationship requires the presence of a caring adult who can make the baby feel she is in the hands of someone who will keep her safe (Bowlby, 1988). This core feature guides Theraplay and is critical for ensuring parents are able to provide a safe, organized, and regulated experience. Children can often miscue or send a message to their caregiver that they want to be in control themselves, and parents can miss cues given by the child. When cues are missed, children come to learn they cannot trust their parent to be there for them, so they prematurely begin to care for themselves. This lack of safety causes children to become over independent is a sign of pseudo-mature or pseudoautonomous defenses (Mordock, 1997).

Many children who appear younger or older than their actual age often have unfulfilled younger needs (Munns, 2014). Adolescent mothers often push their children to experience developmental milestones at a quicker rate, perhaps they view it as an indication or a reflection that they did a good job parenting their child. Throughout the program, most of the mothers excitedly or proudly shared that their children met certain developmental milestones early, when in fact it was beyond their normal developmental abilities at that age. For example, many mothers stated their child could hold their own bottle at an early age in infancy. What I often observed was mothers often propping their children's bottle up to achieve this result which caused those children to miss out on that deeply nurturing activity of feeding that is integral to the stage of infancy. The literature supports the connection between unfilled younger needs and children who become pseudomature (Munns, 2014).

It was clear in observing the dyads that mothers in this study had difficulty providing the appropriate level of guidance. During tasks that elicited an element of structure, there was a mismatch in normal dynamics- either the parent immediately looked to the child to lead the experience or the parent attempted to provide guidance and the child had difficulty accepting the parent's lead. This type of mismatch can create big problems in the parent-child relationship. Role reversal is a significant parent-child relationship concern that is identified and treated using Theraplay. Essentially, role reversal occurs when a change in the normative family hierarchy causes the child to be in control of their own environment rather than the parent making decisions regarding the necessary care to support the child's growth and development. Typically, when a child is in control of their environment, they are observed leading the interactions. This role reversal is a learned defense in which the child experienced a caregiver who was unavailable to convey a safe and predictable environment. Role reversal can be quite common with young mothers who may not have had safe and predictable environments themselves.

The MIM is a good tool for predicting role reversals. The parents are given a series of tasks written on cue cards. They are told that the entire session lasts about 30 minutes, but they control the pace at which they move through each activity. The interactions between the mother-child dyads who display role reversal are characterized by the parents looking to the child for direction of how to proceed through the tasks. Through changing these earlier patterns, Theraplay works to repair role reversals by ensuring that the adult is in the lead, guiding the child throughout their experiences in the playroom. The adult guides every aspect of the session from choosing the activities that

form the agenda through modulating the activities throughout the session. The message that is conveyed to the child is that the adult will remain in charge in order to keep them safe. Specific examples of identifying and treating role reversals will be discussed later in this chapter.

4. Theraplay is Responsive, Attuned, Empathic, and Reflective

This core concept of Theraplay is derived directly from research into the kind of parenting that leads to a secure attachment between a parent and child. Attachment security is dependent on the availability of a caregiver who is consistently sensitive and responsive to her child's changing needs. The mothers in this study seemed confused as to the meaning of attachment. One mother discussed her child's clinginess as a sign of a strong attachment, while others often confused their bond to their child as an indicator of attachment. In fact, the observational data gathered from the MIM showed signs of attachment problems in all of the dyads.

The role of parent sessions and feedback were to support mothers in their development of reflective functioning. The function of reflection is essential for mothers to be attuned to their own emotional states and experiences. Establishing an attuned, supportive relationship with the mothers during these individual sessions created a safe environment and communicated that their needs were also important. During parent sessions, I helped them understand their own attachment experiences, and explained how these experiences impact how they relate to their own children. Supporting this new lens of viewing her child helped one mother respond more empathetically to her child's struggles at school. Instead of immediately responding to the child's suggested misbehaviours during the day, the mother instead initiated some Theraplay activities with

her son when he arrived home. This attention conveyed to the child that his mother was happy to see him and wanted to enjoy his company. This mother indicated a significant decrease in behaviours at home. Through guided reflections, mom was able to empathize with her child who felt disconnected and anxious at school. Throughout this process, mom adapted an advocating role to deal with her son's anxiety rather than being the disciplinarian of negative behaviours.

Video feedback was instrumental in helping the mothers to visualize how their interactions might be affecting their child's behaviours (Beebe, 2003). Consistent with the Theraplay manual, segments of sessions were played for parents and feedback was provided in the moment, allowing them to take a step outside to view the interaction from a different lens. These feedback sessions are extremely important because with guidance the parents are able to gain a more positive understanding of their children's responses. For one three year old girl and her mother, reviewing sessions was an important component to the dyad's overall progress. The mother was able to identify, by watching video of their interactions that her daughter engaged in negative attention-seeking behaviours after the daughter's attempt to get her mother to interact with her failed. The mother was able to see when she was subconsciously dismissive that the child engaged in negative behaviours because it led to her mother responding to her. Although mom's reaction was not positive, it was still attention and this negative interchange became their typical pattern of interaction. A child prefers negative attention to no attention at all. By recognizing this pattern of behavior during the feedback session, mom was more receptive at home to her child's bids for her attention and she was quicker to respond. In

only four sessions, this child’s engagement in negative behaviours decreased significantly.

Children attribute meanings to the interactions they have with others. From these interactions they attach meaning to their environment (whether it feels safe or dangerous), to their caregivers (whether they are attuned and responsive to their needs or not), and to themselves (whether they feel happy, curious, confident or scared). A child’s inner working model references their latent view of themselves that is formed by subconsciously analyzing the many interactions they experience throughout their lives. What occurs is the formation of neural pathways that lay the structure for how the children will analyze future interactions and relationships. Children develop coping strategies in response to previous experiences that have negatively impacted them, so in the future they can protect themselves from suffering the negative experiences again (Munns, 2009).

One key aspect of the Theraplay modality is the focus on changing the child’s inner working model. Theraplay cultivates a more positive inner working model by allowing the child to experience truly joyful interactions with a caregiver. Theraplay provides new experiences needed to change the child’s view of themselves and also at times provides the caregiver with opportunities to see the child through a different lens. These new experiences in Theraplay provide a discrepancy from what the child has come to expect in relationships, experiences that were once negative become positive, challenging the brain to create new experiences. Creating new positive experiences leads to the changing a child's inner working model of themselves and the world around them. Improving a child’s inner working model increases self-esteem in children and decreases

behavioral and social problems. Essentially, children react differently as they see themselves differently.

5. Theraplay is geared to the Preverbal, Social-Emotional, Right-Brain Level of Development

This core feature of Theraplay supports the theoretical base for brain development in children. Research on children's brain development demonstrates that early experiences (both positive and negative) alter the brain in critical ways. The first five years of a child's life is a period where the brain grows rapidly and is highly malleable. Neural connections are developing and forming the structure the child will use later in life and this structure largely depends on the caregiver relationship.

In theory, Theraplay is formed around this idea of promoting positive brain growth by enhancing positive experiences for the child through the parent-child relationship. The right-brain is first to develop and is activated during infancy and early childhood. During this stage of brain development a child responds to nonverbal social and emotional cues from their environment. Theraplay relies on non-verbal, face-to-face emotional communication to produce adaptive growth and development. Theraplay interactions deliver the language of the right brain: eye contact, touch, movement, and rhythm, all attuned to appropriate levels of pacing and intensity that help convey a message to the child that someone is attuned to their unique needs. This level of attunement creates new patterns in the brain and it is particularly important in supporting coregulation of affect. Children who have parents who can coregulate for them develop the critical skill of self-regulation.

Children who are dysregulated or frightened may communicate this unbalance through externalizing behaviours such as aggression, defiance, or withdrawal. Many children are referred for treatment to address problems with emotional reactivity (tantrums), anger, defiance or noncompliance, or aggression. Essentially, these children are struggling to manage intense feelings and need a trusting adult to coregulate their experience for them. For example, in one case a five-year-old girl, when she experienced boredom, would become dysregulated and often reacted in an aggressive way. A key point of therapy was helping her mother learn to identify her inner emotional states that were contributing to externalizing behaviours.

6. Theraplay is Multi-Sensory

This core feature of Theraplay is to provide stimuli to all the senses in a way that replicates the range of sensory experiences a young child would experience in a healthy relationship. Active physical interaction is planned to stimulate vestibular and proprioceptive responses, while calming touch and soothing sensory experiences create "cared for" feelings. The range of sensory experiences is incorporated into the various activities used in Theraplay for the purpose of encouraging optimal levels of arousal.

The role touch plays in health development is understood and supported in the Theraplay method. Hands-on behavior was a common presenting problem for referral during this study. Some kids struggled with hitting peers at school, while others hit parents or siblings when they were emotionally dysregulated. I found that while many of the children used negative forms of touch, very few actually demonstrated positive forms of initiated touch with their mother. The observational data from the nurturing tasks on the MIM showed that many of the dyads had difficulty with activities that were meant to

draw physical closeness. In one activity, the task is for the mother to apply lotion to the child. I noticed that some mothers verbalized this activity as weird particularly when the child was male (although they all admitted to using lotion on their child during infancy). During the lotion your child task, one five-year-old boy presented as anxious-avoidant, which mirrored his mother's perceived level of discomfort. At the onset of treatment, in this same dyad there were very few spontaneous acts of affectionate touch. Nurturing activities were intentionally used more often to increase their level of comfort with physical closeness. One of the most significant self-reported changes for this child was the increase in affection and decrease in aggressive behaviors at home and at school.

7. Theraplay is Playful

Children create meaning in their lives through play. In play, when children come together, they start to learn what to expect from others around them and begin to form relationships. Play in early relationships supports children's emotional regulation and social development. A parent becomes the first partner in play for the child. When children do not have playful experiences with their own parents, they miss the important building blocks of how to be social and connect with others. Children who enter school without these skills struggle in this environment that demands social readiness to succeed.

One common theme revealed through the A.R.T. program was that most children, irrespective of age at the time of therapy, struggled with imaginative play. The results of the Marschak Interaction Method (MIM) observational assessment completed with each child at the onset of the program exposed a lack of imaginative play, not only with the child but also with the mother. The first activity in the MIM instructed the mother to lead

imaginative play using two basic squeaky toys. It was evident that some mothers were uncomfortable with this task, and looked to the children for directions on how to play with the squeaky animals, which in turn seemingly created anxiety for the child and this discomfort created resistance during the activity. Most of the children did not want to do the activity or were engaged very minimally and for a short period. Interestingly, this task of playing with squeaky animals helped make both the mothers' and childs' anxiety noticeable. When the child showed resistance his/her mother quickly ended the activity, likely to avoid her own discomfort. In fact, during the parent feedback session the mothers admittedly stated they found the activity uncomfortable because they were unsure of what to do. Also, the results of the Adult Attachment Inventory correspondingly identified that the mothers did not engage in imaginative play with their own parents, therefore showing how a lack of social modeling carries over generations. When the MIM was repeated at the end of treatment the child demonstrated more comfort with the imaginative play activity and the parent was engaged and led light dyadic play with the same squeaky animals, and this demonstrated that the mother and her child learned to play imaginatively.

In conclusion, the seven core features of Theraplay were instrumental in correcting critical relational problems that were impacting various aspects of the dyad. The Theraplay model promoted positive, playful interactions that were engaging and full of joy. This new way of interaction with each other improved the richness of their relationship, increased the synchrony between the pair, and improved the mother's ability to be attuned and sensitive to her child. Theraplay offered a reorganization of how each member viewed the relationship and each other.

In the following section I will discuss the findings as they relate to observations of the mother-child relationship during interactions that fall within the four dimensions of Theraplay: structure, engagement, nurture, and challenge. These dimensions were of focus due to their representation of the characteristics that securely attached dyads possess. These ranges of interactions that occur between a healthy parent-child have been studied and categorized and placed into the four main dimensions of Theraplay (shown on the middle ring of the earlier diagram). An analysis of each dyads' relationship was accomplished through the administration of the Marshak Interaction Method (MIM), a play-based observation that identifies if there are areas of concern in each dimension of interaction.

During this structured observation, a series of simple tasks were written on cue cards with all materials required for completion placed beside in large envelopes with corresponding numbers. The mothers were instructed to read the task out loud and then proceed through the tasks at her pace. One task requested that the mother leave the room for one minute without her child, a task that was designed to replicate similarities to the Strange Situation. Following observation and analysis, a feedback session with each mother allowed for a reflective review of selected video clips that highlighted the goals established on the treatment plan. Some key findings of what was learned from the interaction patterns of these dyads during the MIM will be discussed.

The dimension of structure is assessed using the MIM by examining how the interaction is organized: who makes decisions, who leads the interactions, what is the overall hierarchy of the relationship, and which roles does each party occupy. First, for the most part, the mothers in this study had difficulty taking charge, setting appropriate

limits, following through with expectations, and regulating and organizing the interaction. Typically, the children made attempts to control the interaction by refusing to complete some tasks or through resistance unless the activity was modified to their liking. One child as young as two insisted on changing the order of the activities, which her mother allowed. In another example, one mother seemed apprehensive to expect her daughter to follow through with her demands and was easily persuaded when the child changed the course of the interaction. This mother appeared unresponsive, perhaps defeated by the level of defiance and control her daughter exhibited. In the activity play-with-squeaky-toys, one mother asked her son several questions about how to play with squeaky animals. Similarly, during the teach-your-child-something activity, this same child was expected to lead the activity: “What can I teach you that you don’t already know?” Half of the mothers struggled to think of something new to teach their child, which alluded to concerns regarding role dynamics. In fact, various patterns of role reversal were evident. In many examples, the parent and child roles were reversed: the child was in control and her mother followed her lead.

Another common unhelpful role dynamic was the mother in a teacher role: pedantic, rigid, and focused only on the task at hand. One mother, who was able to identify this relationship dynamic after reviewing the MIM, realized that she engaged in teacher/student interactions a lot with her two year old, noting that a lot of expectations/demands were unrealistic for the child’s age. This child presented very independent for her age and would become upset if she was not in control. During structure activities, children displayed anxiousness and became fidgety or oppositional when their mothers looked to them for direction. I noticed that the children would seek

out structure at times by checking in, looking towards the parent for either support or clarification, but these cues were often missed. During build-a-block-structure, one five-year-old boy continually looked to his mother during his attempt to build a structure just like hers and made several attempts to seek feedback saying, “Right?” but his mother did not respond.

The dimension of engagement was assessed using the MIM by observing the mother’s ability to engage her child throughout the interaction. The level of disengagement varied with each dyad although missed cues were observed in each pair. I noticed during some interactions that there was a lot of physical space between the pair and their bodies were somewhat turned away from one another. In one example, a mother had her six-month-old baby facing outward for the majority of the interaction, limiting her ability to attune to and connect with her daughter. I found it was difficult for the mothers to remain attuned to their children’s states and reactions, and this problem often led to disengagement during the tasks. Commonly, a child would provide non-verbal cues of engagement during activities that were often missed. For example, during playing-with-hats one mother stopped the activity to move on to another in the middle of a shared moment of optimal arousal with good eye contact and playful dialogue. The child showed her displeasure at ending the activity through disappointment though this communication was missed by her mother. Similarly, during the squeaky-toy activity, one mother took the toy away after a very short time despite the fact the child was still engaged in play. The child showed displeasure by throwing herself back and although the mother returned the toy back, her daughter did not reengage in the activity. There appeared to be a

mismatch of arousal states or the pair seemed out of synchronicity with their levels of engagement.

Also, at times I observed inconsistency between verbal and non-verbal responses. For example, one child exclaimed she was excited during an activity, but nonetheless showed no signs of non-verbal expression to match this verbal statement. In some dyads, I noticed the mother at times used vocal and facial expressions in an attempt to engage, though later in the interaction maintained a flat affect and displayed minimal eye contact. Such inconsistency may be confusing for young children who depend on visual cues. For the most part, verbal language, reasoning and persuasion, or statements of guilt were used as a method of enticing engagement. During block building, one five-year-old excitedly looked towards her mother and stated that she liked playing with her, and in response, without eye contact, the mother simply repeated the same without nonverbal expression or change in affect.

In activities that explored the pairs' comfort in dyadic play there was a lot of hesitation and uncertainty in both the mother and child. In one example, during the squeaky-animal task, the mother tried to engage her son by having her fish ask his fish a lot of questions to which he did not respond. She tried again to engage by having her fish hit his fish and said his fish had bumped into hers. This child was unresponsive to his mother's attempts to engage him and it appeared as though this type of play was not normal for the pair. Another mother-daughter engaged with the squeaky animals through a teacher-student dialogue ("What animal is this? What colour is it") and during the MIM feedback this mother reflected on the fact that she was unsure of how to lead the play with her child. In one dyad of mother and her six-month-old baby, the mother appeared

more comfortable engaging with the child using objects (toys) than she did interacting and connecting using eye contact, touch, and rhythm (songs and dance).

The dimension of nurture was assessed using the MIM by observing the mothers' ability to provide comfort, calming, and care. I found a general lack of comfort to the children's emotional cues (sad, bored, hungry, scared). I observed at times the mother would misinterpret the child's cues which often resulted in a negative reaction. For example, a child said, "Ow," while his mother was combing his hair, to which she responded by snapping, "I'm not hurting you," which resulted in the child not wanting to continue the activity. In this example, the mother projected her feelings onto the child, rather than accepting and attending to his needs. I also found that misleading cues were shown to the child. For example, on one occasion, a young girl bumped her head while being silly and while her mother attempted to comfort her, she also laughed at her at the same time.

I found the children were often not receptive of receiving nurturing behaviours from their mothers. In one dyad, the child happily initiated nurturing behaviours towards her mother (lotioning, combing, feeding) but was not receptive when her mother attempted to reciprocate these nurturing behaviours. During the feeding task, some children fed their mothers first, showing a significant reversal in caretaking behaviours. Similarly, some mothers avoided nurturing tasks. For example, during the lotioning task that directed the parent to lotion the child, one mother simply asked if her two-year-old daughter wanted some hand cream and placed a small dot of cream on the child's palms and then directed her to rub it all over her hands. The child said, "Mommy," and then the mother rolled up her daughter's sleeve to allow the child to lotion herself. A common

thread during the observations was concerns regarding physical closeness. One five-year-old boy and his mother showed very minimal displays of physical touch and displayed anxious-avoidant behaviour during the nurturing tasks. Earlier assessment data for this pair suggested the boy was not affectionate, but parents believed his avoidance was normal, as the mother indicated the boy had a tough exterior like his father. I commonly noted that physical affection was not given.

The separation task showed differing concerns. In one example, the parent did not prepare the child for separation, so when the child realized her mother was leaving, she became upset, saying she wanted to go with her. In this mother's effort to finish the task, she did not provide empathy or attune to her child's need for comfort in the moment. In another pair, the two-and-a-half-year-old girl became clingy or emotionally reactive when her mother tried to leave, resulting in the mother not completing the task. This mother initially said she would be right back and the child said, "Okay," but after the mother asked her for a kiss, and the child said, "Bye," she immediately stood up unhappy about her mother leaving. Several times the mother tried to grab her coffee from the desk and hurry out the door, leaving her daughter upset, but eventually the mother carried her back into the room while she was crying and simply carried on with the next task. One mother attempted to distract her one-and-a-half-year-old daughter by throwing a ball in the opposite direction across the room and leaving quickly when her attention followed the ball. Although the child appeared confused, she found her bottle and was able to self-sooth and became interested in a toy. When her mother returned, she did not notice until her mother took the toy she was playing with away, causing her to become upset. I found that the two five-year-old boys did not seem to care that their mother was leaving the

room, though it was evident that the unstructured time left them dysregulated. The five-year-old girl, however, questioned why her mother was leaving the room, and when she did not get a satisfactory answer, the girl insisted on going with her mother. One mother read the instruction for the task to herself and then got up and told her daughter to wait in the room, saying she would be back in one minute. The child asked where she was going, but the mother calmly repeated her directions again to wait in the room for one minute and then she left the room. The child then went to the door, opened it, and her mother in a very warm, firm voice told her to go back in the room for one minute. The child went back in the room and explored the envelopes and other materials.

The dimension of challenge was assessed using the MIM by observing the parents' ability to use appropriate levels of challenge that would create a sense of competence and pleasure in success. This dimension appeared to be the most comfortable for the pairs as they remained engaged in tasks of challenge significantly longer than tasks from any other dimension. I noticed more verbal and nonverbal encouragement (bravo, awesome, high fives, smiling). I found that the mothers initially had unrealistic developmental expectations of their children. The majority of challenge tasks were often beyond what would be developmentally appropriate. In one example, during the teach-something-new task, a mother tried to teach where rain comes from using language that the child herself would not use. In another example, during building-blocks, one mother started the activity over when her child's first tower was not exactly the same (there was a slight space between blocks) inducing a bit of frustration and apprehension. When the mother built her second tower, it was more intricate, making it even harder for her child to be successful. It was apparent that his anxiety and lack of confidence stemmed from

high expectations set by his mother. The boy showed visible signs he was frustrated throughout the task. When he was not successful at replicating the tower, he sank in his chair with defeat. Choosing overly difficult challenges decreased the child's chance of successfully completing the activity, and failure is linked to lower self-esteem later in life.

I also found that the activities chosen during the MIM challenge tasks became more competitive rather than cooperative. Many mothers adopted a teacher role, focusing on showing how smart the child was. Even tasks from other dimensions became about teaching the child. For example, during tell-your-child-a-story-about-when-they-were-a-baby, one child was uninterested in the story and instead was pointing at things around the room; the mother would interrupt her narrative to teach her child about what she was pointing to and was correcting her when the child said the wrong thing. During the feeding task, this same mother was teaching her about what she was eating (asking questions, sorting, repeating words) while the child sat at the table eating. I observed mothers were proud when their child successfully completed a task or demonstrated levels of intelligence. Theraplay helps to refocus challenge tasks so that parents understand that providing on-going support and guidance and sometimes even physical assistance is important when children work towards completing a new task or acquiring a new skill.

Above I have discussed the core concepts of the Theraplay model established from the qualities found within healthy parent-child interactions. Following, I discuss particular relationship issues between adolescent mothers and their children, as evidenced from the results of the Marshak Interaction Method at onset of treatment. I will also

discuss how the four dimensions of Theraplay were used to repair these relationship issues.

Incorporating the Dimensions in Treatment

The four Theraplay dimensions, structure, engagement, nurture, and challenge, were each useful in targeting problems in interaction patterns, problems which may have negative impacts on the parent-child relationship and ultimately contribute to a child's negative behaviours. The activities alternated between high-levels of activity to low-level activity in order to help the child practice regulation. Low-level activities were used at the beginning and end of the session to prepare the child for transition. Each session always started with a check-up where a lot of attention was placed directly on the child, highlighting their special qualities. For example, with one child I noticed and commented to him, "You have a small brown sparkle in your green eyes… they sparkle like a star." In earlier sessions, some children showed they were not used to this direct form of attention through avoiding eye contact or creating some type of distraction from themselves, but as the focus remained on them in a special playful way, they began to accept it more and showed they enjoyed the attention, especially from their mothers.

The activities in the structure dimension were useful to regulate and model for the mothers how interactions should be appropriately stimulating, organized, and directed by the adult. It was found that the mothers struggled to provide direction, which increased levels of dysregulation. Some of the children were so easily excited that they often demonstrated behaviours of hyperactivity or impulsivity at home contributing to the dyads attachment or relationship problems. In session, I noticed these children were extremely sensitive to sensory stimuli and would often become overly excited and have

difficulty calming down. Being aware of these regulatory difficulties, I would maintain physical closeness with these children by having them sit in my lap facing their mother or by ensuring we held their hand during activities. Some activities like row-your-boat were used to practice modulation by varying states of calm and quiet, changing to a quicker speed, increasing the energy, and swiftly calming back to a slower, calmer mood again. Through Theraplay, playful activities were always led by the adult to convey to the child that their mother could keep them safe. Especially for the children who struggled with regulation, predictable activities were included in each session, and by repeating experiences, the child was able to get better at regulating by anticipating what activity was coming next. For the four and five-year olds, activities like mommy-says and red-light-green-light were used to have the pair more comfortable with mothers giving the commands. Observations and parent reports confirmed that children who presented as easily dysregulated were able to control their impulses better. One mother stated after four sessions, "When he starts to get hyper at home, he will come and want to be near me. I think he knows he needs help to calm down." This feedback was encouraging to hear as this child was one who initially avoided physical contact and affection with his mother. In another example, a mother noted that her overly independent two-year-old daughter began responding to redirection better as opposed to simply saying, "No," and initiating a battle for control. When the mother asked the child to put on her coat, and the daughter refused, she changed her response and said, "Okay then, let's go." When the child got into the car, she asked for her jacket, so her mother said, "You want your jacket, okay, we will put your jacket on when we get there." The child responded well to this and

no tantrum occurred, which shocked her mother. We reflected on how the child was communicating her comfort in having limits and boundaries.

During earlier sessions, resistance to activities, particularly from the structure dimension was common. Resistance was handled with a paradoxical approach. In one example, a child showed resistance during bubble-pop because she wanted to be in control and hold the bubble wand to blow. Rather than give in to the child's attempt to control the activity, I switched and had the mother blow a bubble and encouraged the child to pop the bubble. In another example, a five-year-old boy displayed resistance during bubble-pop by trying to change how he would pop it, "I want to pop them instead," which was handled by accepting this child's need for control, but also maintaining that the adult is in charge, "Oh how did you know I wanted you to pop them after you poke them…get your poking finger ready…here it comes…poking finger ready.. Despite resistance I maintained the same playful nature throughout the session. Despite the fact that activities from the challenge domain often exceeded realistic developmental expectations, activities of challenge were initially the most comfortable dimension for both the mothers and children in this study. There was very little resistance with play, when challenge was incorporated. Consequently, challenge activities were often included as a means of enticing engagement and decreasing resistance during activities that tended to engage with areas of need from other domains. Particularly when introducing activities intended to build structure to reorganize the dyad, so that the adult was in charge, challenge was added to lessen resistance. This addition was accomplished by choosing activities such as newspaper-punch or basket-toss and adding in the element of structure by having the adult lead the activity through signals.

The major goal from the engagement dimension was increasing the overall use of engagement through creating moments of meeting and elements of surprise. Using the cotton ball blow game, we (parent, child, and therapist) would sit in a circle and blow a cotton ball to one another, at times changing the intensity of the blows. This activity increased the moments of meeting between the mother and child. For example, every time the parent or child would go to blow to one another, they would move in closer and look up to one another and smile. I encouraged and facilitated increased attention to the child's non-verbal signals. One of the more engaging ways to transition the parent into the later part of the session was playing hide-and-seek. This activity was preplanned during the parent session and the mother was watching the session live from a different room, so she knew when to enter. The mother was encouraged to playfully look for the child in several obvious places before finding the child behind the pillows. When the mother found the child, they were encouraged to show delight and physical affection. I always hid with the child to help regulate the experience for them. During the session, I positioned the child in certain ways during the activities so the child would look towards her mother, increasing the opportunities for moments of meeting. In one example, a child was sitting in a chair eating a fruit-by-the-foot snack when his mother said surprisingly, "Can you suck it up like a piece of spaghetti?" The child tried and both mother and child laughed together and shared good eye contact during this activity.

Throughout the activity, when the child displayed non-verbal emotional cues, I focused on helping the mother become more attuned by recognizing and identifying what the cue was and predicting what the child was trying to communicate through the cue. In one example, a two-year-old girl was having a lot of fun playing ring-around-the-rosy,

and when the song ended she would immediately look to her mother. I said to the child, "You're having a lot of fun," and then said to the mother, "What do you think she is trying to say to you when she looks at you after the song has finished?" The mother laughed and said, "She wants me to do it again." I used this interchange as a teaching moment and said, "Oh, she is communicating to you that she is having fun playing with you and is not ready for the activity to be finished yet, so if she is still in the moment of having fun and we expect her to stop at this moment, how will she respond?" The mother replied, "She would throw a tantrum at home if I didn't do what she wanted." To help this mother see the emotional response differently, I said, "Although it may seem like a controlling behaviour, it's also possible that in this moment, she is having fun with you and doesn't understand why it has to end. Maybe she just wants a few more moments of mommy time, What do you think she needs from you right now?" The mother looked at her daughter and said, "You love ring-around-the-rosy with mommy, one more time okay…and then we will play something else." The pair had good eye contact and the mother was able to meet the child's level of engagement. In one dyad of a mother and her five-year-old son, who initially presented in the MIM as disconnected, by the 12th session the mother provided consistent levels of attunement demonstrated through eye contact, connecting through songs, and providing warmth and sensitivity through her non-verbal facial cues. Although initially this pair showed a lot of physical distance between them, towards the end of the program both would initiate more physical contact by scooting closer to one another and spontaneous acts of affection through hugs and kisses. I noticed that this mother also kept her hand near or on her son's leg as a calming response.

Most of the children displayed some difficulty accepting nurturing from their parents, therefore, a major goal in each session was to include nurturing activities such as soothing and comforting behaviours when the child was upset and increasing caretaking behaviours through feeding activities. During every session the child would receive attention and comfort for any scratches, bumps or bruises they had through lotioning-care. As the sessions continued, the children would start to point out little marks because they enjoyed having their mothers attend to their hurts. During sessions we worked on the mother recognizing when her child might have got hurt, even if it was unlikely that the child got hurt, so the mother could convey she was paying attention and would comfort the child. Activities using cotton balls and feathers (cotton-ball-soother or cotton-ball-feather-guess) were selected to allow the mother to provide nurturing touch, but still in a playful form, especially for the children who displayed pseudomature or overly independent behaviours. One girl, five-years-old, was initially very resistant to any form of soft, nurturing touch from her mother. Instead, activities like face painting and powder palm (using baby powder on the hand so the lines on the palm of the hand stand out) were used initially to provide less direct forms of physical touch. Another activity that the children enjoyed and which helped build tolerance of nurturing activities was blanket swing. Gradually, children who were more reserved became more accepting of their mother's nurturing attempts. One overly resistant five-year-old cradled into her mother's lap while they played remember-when (recalling a positive memory from the past) and during lullaby, and even allowed her mother to feed her while she sat on her lap. I found that even the mother-son pairs showed significant improvements in their acceptance of nurturing. One mother had her five-year-old son sit in her lap while they looked through a

mirror while she led the check-up. She said, "Come sit in my lap…I want to look at your big, beautiful eyes…What colour are they today?" while she nuzzled in closer to him. While she pointed out all his special marks, she would give him little squeezes as he smiled widely and emitted sounds of excitement.

During the MIM, observation activities from the challenge dimension were seemingly the most comfortable for the pairs, however, it was apparent that the children struggled with self-confidence. The goal in introducing activities of challenge was to help the child change this negative view that was constructed so that he could feel confident and enjoy his successes. Often the children would resist an activity by saying they could not do it. One five-year-old girl would start to act like a baby during tasks of challenge that were simple and easy enough for her to accomplish. Introducing simple activities that provided immediate experiences of success were useful to help the child feel more confident. For example, many of the older children enjoyed newspaper-punch and were pleased when their hands pushed through the paper. One girl who seemed afraid and resistant of this activity initially required the extra support of my hand gliding over hers through the paper, but once she saw the result, she wanted to try it over and over in the session and often asked about it in other sessions. This particular clip was important to show her mother, who had been viewing the session from another room. We discussed how sometimes her daughter's resistance may be her way of seeking her mother's support as a confidence boost. Small elements of challenge were interwoven into activities with which the children were familiar. For example, in cotton-ball-blow (which was a big hit with the children) I would move my hand slightly back to add an element of challenge. The intent of adding challenge was to do so in a way that the children would

still find success and feel good about themselves. One of the main goals of the use of challenge activities was to introduce more cooperative games where the mother and child shared in their excitement of working together. Some examples of these types of games included balloon-balance, where the mother and child would keep the balloon between their bodies, and keep-balloon-in-the-air, where the mother and child would work together to see how many times they could hit the balloon back and forth in the air. A positive outcome was that there was an increase in support and encouragement throughout these cooperative activities, which was demonstrated through verbal comments such as, “You’ve got it,” “We are an awesome team,” and “You’re great at this activity!” It was nice to see the dyad having fun playing together and celebrating even small successes.

In this chapter, I discussed the seven core features of Theraplay and have demonstrated how these core principles of Theraplay model simultaneously met the needs of the mothers and their children in this project. Then I explored particular relationship issues I observed between adolescent mothers and their children during the Marshak Interaction Method and demonstrated how the four dimensions of Theraplay were used to repair these relationship issues. In the final chapter, I will discuss my experience with implementing Theraplay principles into the Early Learning Kindergarten (ELK) classroom of one of the children in this program. Although I did not indicate the use of Theraplay in the classroom as a goal in my practicum proposal, an invitation from one of the participant’s teachers allowed me to experience the benefits Theraplay can have for groups of children. I will also discuss the challenges I encountered throughout

the various phases of development, implementation, and coordination of the A.R.T. program.

Chapter 5: Benefits and Challenges Implementing Theraplay

In the following chapter, I will discuss my experience implementing Theraplay principles into the Early Learning Kindergarten (ELK) classroom. The chapter will conclude with a brief discussion of the challenges I encountered throughout the various phases of development, implementation, and coordination of the A.R.T. program.

Group Theraplay in the School Environment

Implementing Theraplay in the classroom environment was not initially a practicum goal of mine. However, I was invited into the classroom of one of the program participants and had completed group Theraplay training through the Theraplay Institute, so I took advantage of this opportunity.

Theraplay has successfully been adapted from an individual-focused treatment modality into a viable group format called Sunshine Circles (Siu, 2014). Sunshine Circles uses the social-relationship principles foundational to Theraplay, but is specific to the classroom environment (Tucker & Schieffer, 2017). Sunshine Circles was developed by the Theraplay Institute for the purpose of incorporating the therapeutic nature of relationship-focused play within a whole classroom environment. The goal of therapy within the classroom targets widespread behavioural and socio-emotional problems among children entering early learning programs. Children entering early learning programs have not yet mastered emotion regulation or social skills for various reasons, including poor executive functioning skills due to underdeveloped brain regions or even perhaps lack of co-regulation or modelling by caregivers. Incorporating therapy into early learning classrooms allows children to transition more easily into school and acts as a preventative measure for further mental health services.

“Group Theraplay can be implemented with multiple children in a classroom setting with a mental health professional (e.g., school counsellor, social worker, etc.) and teacher present” (Simeone-Russell, 2011). Teaching or modeling the Theraplay modality for teachers provides them with an effective way to respond to children’s social and emotional needs within the classroom environment. Recent literature that discusses teachers’ prominent areas of stress include feeling ill prepared to deal with the socio-emotional needs of young children (Tucker, Schieffer, Willis, Hull, & Murphy, 2017). Similarly, I found that many teachers of the children in the A.R.T. program openly shared their inability to manage the emotional and behavioural needs that manifested in many of the children in their classrooms. Another area of concern was the health of teacher-student relationships. Including relationship-focused teaching methods in the classroom not only improved the teacher’s relationship amongst the children but also improved the relationship between the teacher and the child. Completing the group Theraplay one day training provided me with the basic instruction of incorporating the Theraplay modality in a group format. Teachers were very receptive to learning this modality and assisted throughout the 30-minute block where I led Group Theraplay with a classroom of approximately 25 kindergarten children.

I found that the child receiving individual treatment displayed a sense of confidence and mastery having had some exposure to the activities and structure ahead of time. All children showed signs of joy during the activities and were adequately engaged. The children quickly grasped the core rules of Theraplay in the classroom: no hurts, stick together, and have fun. Behavioural problems were responded to in a positive way that guided or shifted the focus from the behaviour to the playful, fun and engaging activities.

Because of the limited nature of my involvement in the classroom, I was unable to focus significantly on the children who were overtly shy within the group. With more sessions, I could have helped the shy children become more involved in the activities slowly and at a comfortable pace. Teacher feedback immediately after the session, and in discussions about the young child initially referred to the A.R.T. program aligned with the literature in terms of showing the value of incorporating Theraplay into the classroom (Siu, 2014). Effectively, the A.R.T. program participant was more outgoing and socially accepted by his peers during and after the session. The children showed improvements in impulse control and pausing the need for immediate gratification. The children showed positive social support for one another and banded together during the session, something that the teachers had discussed was a concern in the classroom. Staff noted a significant improvement in this child's relationship with his teachers and education assistant, and this improvement continued throughout the rest of the school year. I found that many teachers identified that they felt ill equipped to handle the behavioural and mental health needs of children entering kindergarten. Often, they cited difficulty with building relationships with the child. Often their view of the child was quite negative due to overwhelming feelings of stress, and this intervention altered their interactions with the child.

Theraplay techniques have been used to remedy a wide variety of maladaptive problems in children. One key aspect of the Theraplay modality is the focus on changing the child's inner working model. A child's inner working model references their latent view of themselves that is formed by subconsciously analyzing the many interactions they experience throughout their lives. The formation of neural pathways lays the

structure for how the children will analyze future interactions and relationships. Theraplay cultivates a more positive inner working model by allowing the child to experience truly joyful interactions with a caregiver. Theraplay provides new experiences needed to change the child's view of themselves and also at times provides the caregiver with opportunities to see the child through a different lens.

In one example, Peter, aged five years old, was often referred for services to deal with inattention, aggression, and emotional reactivity in the school environment. Peter's mom would get daily notes from the school advising of Peter's many issues at school that day. Reading such negative notes so often made Peter's mother upset, so she would often lecture Peter once he arrived home. Peter seemed to always be in trouble and, because everyone around him expected Peter to behave this way, he continued to do so. After some time in the program and several instances of showing Peter the more positive attributes he held, Peter began to see these qualities in himself and was excited to share them with his mother. The change that occurred in the home environment shifted to the school environment as well. Peter was excited to share these positive qualities at school as well, and his teachers shifted their own view of Peter. One small change in one relationship altered Peter's interactions with all of the other relationships he had in his life.

Implementation Issues and Challenges

While treatment is critical and has the potential to provide substantial benefits for both adolescent mothers and their children, unfortunately, this population is difficult to serve. Often times the primary needs have not yet been met, which make it difficult to attend to other matters (Maslow, 1943). The consequences of stress caused by

impoverished living conditions alter the brain's ability to focus on matters of self-growth and exploration (Maslow, 1943). One of the issues highlighted in my work with adolescent mothers was that many of the mothers had unresolved trauma from adverse childhood events and/or were currently in active situational crisis. And, therefore, I was compelled to use clinical judgement when deciding whether it was appropriate to continue working with these mothers. Ultimately, this decision was made when there was significant concern that the mother was unable to be present and supportive for her child due to her own personal needs. This decision was made in consultation with my practicum supervisor.

In this section I will discuss the implementation issues and challenges that arose during this project. First, I will discuss the factors that I believe attributed to program participation. Specifically, I will discuss special considerations made to determine when a client is not ready for treatment. I will also discuss the factors that affected on-going participation. I will discuss particular logistics that were a barrier in the implementation of this project, and how the coordinator attempted to resolve these barriers. Finally, I will explore clinical challenges that I encountered through the implementation of this project.

The majority of the mothers in this project described significant sources of stress during the intake phase of this program. I considered the extent to which these environmental stressors were impacting the mother-child relationship and ascertained whether this type of intervention was suitable for the family. Paramount to my decision was whether another program or service would likely provide a better outcome. Many mothers discussed personal experiences of adverse childhood adversities. A couple of mothers spoke about their involvement in the child welfare system as children, both

speaking of the experience as traumatic, due to feelings of loss and separation from their siblings and extended families, and a sense of abandonment and disconnection from experiencing inadequate caregiving. Similar to other findings, it appeared as though a pattern of negative relationships formed as most mothers chronicled experiences of intimate partner violence in their current and/or previous dating relationships. Often the mothers were aware of abusive behaviours and expressed wanting to shield their children from witnessing unhealthy relationships.

Whilst the Theraplay model is family-focused, and certainly an intervention that benefits not only the child but the parent as well, it is imperative that the parent's individual needs will not interfere with their capacity to use the four dimensions in Theraplay - structure, engagement, nurture, and challenge. Many adolescent mothers are still children themselves, who have not yet been able to process or resolve traumatic childhood experiences. Undoubtedly, these unresolved experiences impact their capacity for caregiving, subsequently affecting their relationships with their children and their children's development. There are instances, when, in fact, it may be the parent in the dyad who is predominantly requiring treatment.

Typically, in the Theraplay model, if a parent presents with some unmet needs, perhaps related to trauma or negative childhood experiences, the therapist would spend time working with the parent alone prior to bringing the child into treatment. Theraplay, with its healing properties can help a parent progress so they are able to then provide the essential dimensions of a healthy parent-child relationship. The therapist would provide individual Theraplay sessions to the parent and also use feedback sessions to work

through gaining reflective awareness. The therapist would decide with the parent when the child should be introduced into sessions.

During this practicum, I did provide parent feedback sessions, however, I did not have scheduled time to work with a parent alone first if required. While that would have been ideal on a number of occasions, it was not possible, and therefore, instances occurred when it was in the client's best interest to refer to another service that could better meet their own individual needs. For example, one 15-year-old mother self-referred to the program out of concern for her ability to bond with her newborn son. During the intake phase, this young mother explained she was experiencing stress related to a traumatic experience that was currently in the process of legal proceedings. This young mother was demonstrating physiological symptoms of traumatic stress and had limited supports around her to support her through this stressful process. In this example, this mother's immediate needs for personal counselling and victim support took precedence.

Another common theme that imposed particular challenges was the issue of triangulation between parents. It was not uncommon for these young parents to talk negatively about the other parent in front of the child or even to the child. Although the damage of doing so was discussed with the mothers, fathers did not participate and therefore the same caution could not be discussed with them. It was evident that the effects on the children of speaking ill of the other parent were not viewed seriously. One potential reason could be that adolescents in this developmental stage are egocentric and primarily think about their own needs, whereas adult mothers are more likely to have more developed cognitive abilities and enhanced skills to be considerate of another

person's needs or feelings also. If parents' personal challenges hinder the process of the growth of their child, Theraplay would not be the first treatment choice. Such parents should receive their own therapy or treatment for their personal challenges before engaging them in Theraplay with their children (Booth & Jernberg, 2010).

The success of treatment and attendance was also greatly affected by the level of readiness. I found that many of the mothers were struggling to obtain basic needs and this stress affected their readiness for treatment. Maslow (1943, 1954) stated that people are motivated to achieve physical needs first, which take precedence over higher level growth needs. Maslow differentiated between deficiency needs and growth needs. Deficiency needs result from an inability to secure basic needs to sustain life, whereas growth needs signal a desire to grow as a person. Demographically speaking, all of the young mothers who participated were considered low-income, many relied on social assistance, many lived in social housing, many had strained relationships with their child's father, and many had subsequent pregnancies or another child. Three of the ten mothers were continuing their education while two had part-time employment. Undoubtedly, the overwhelming pressures of these demographic factors affected their level of readiness for treatment. Several young mothers decided to end treatment before the program end date and commonly stated it was too difficult to commit to the program at this time.

Additionally, many logistical barriers were identified during this project. All but one participant in this study relied on public transportation to attend sessions. Many of the mothers could not afford the cost of bus tickets for both themselves and their children. Luckily, this project was supported by Better Beginnings Better Futures and received

complementary bus tickets to provide to participants. Childcare was also an issue for the adolescent participants for siblings of the child in treatment. The majority of participants were single mothers who did not have consistent external support from friends or family, thus many did not have reliable babysitters to access. The cost of an early childhood educator was absorbed by the project coordinator to allow for the mothers to participate. A registered early childhood educator supervised the other child(ren) while the session occurred in another playroom in the agency. Reducing the logistical barriers was critical to ensuring consistent participation and session attendance.

The challenges discussed above related to participant challenges; however, I also experienced challenges with implementation as a service provider in a smaller northern community. Typically, when Theraplay services are provided to families, two therapists assume work with either the child while the second therapist acts in the role of the interpreting therapist working with the parents simultaneously. I found it challenging mitigating the issues of handling the roles of two therapists when working alone. The role of the interpreting therapist who works with the parent is typically to watch the session with the parent to help them understand what is happening in session and to reflect on their child and provide feedback and training in the moment. Working alone required some modifications. Instead of one session weekly, I had to provide two sessions per week. During the second session, the focus was on the parent to help them understand and practice the activities that would be used in session. This second session is also where video feedback was instrumental. I brought segments of the sessions to play back for the parents to review and reflect on. This method of delivery was a bigger time

constraint as it required two hours per week per family. I often met the parent in their home for the parent session to avoid barriers of transportation and childcare.

Conclusion

This chapter will discuss implications for social work practice that will argue the need for specialized support for at-risk families, including young mothers and their children. The Adverse Childhood Experiences (ACE's) Study highlights the connection between exposure to childhood trauma and poor life course trajectories. Findings from this study highlight the need for specialized services that incorporate elements of attachment, development, trauma-informed care, and brain research in order to strengthen family relationships. Safe supportive relationships are shown to be a protective factor for resilience in these mothers and their children; services must be government or public funded. I will demonstrate how financially supporting early interventions can ultimately reduce societal strain caused by the cumulative effect of social disadvantage on future generations, thus reducing social costs associated with intergenerational transmission of psychosocial factors, developmental trauma, poor education, employment, and low economic status.

In this chapter, a brief description of The Adverse Childhood Experience (ACE) Study, in addition to, wider social science research on ACE's and toxic stress will be presented. Following, I will connect the role of adverse childhood experiences to the young mothers and children with whom I work. Next, an overview of the implications of the ACE studies to social work practice and resulting ACE-informed clinical recommendations will be shared. Specifically, I explore how the strengths-based power of the Theraplay model improves child outcomes while simultaneously addressing possible unmet needs of inexperienced adolescent mothers who may have had adverse

childhood experiences, essentially advocating for Theraplay as an evidenced-informed, ACE-informed early intervention and prevention model.

Adverse Childhood Experiences (ACE's) Study

Kaiser Permanente and the Centers for Disease Control and Prevention conducted a health study to determine the impact of adverse childhood events on long-term health outcomes (Felitti et al., 1998). The study, now coined *The Adverse Childhood Experiences (ACE) Study,* found a strong relationship between exposure to abuse, neglect or household dysfunction in childhood and multiple risk factors for poor health, and even death. More recent statistics examining the prevalence of ACE's in a nationally representative sample showed that nearly 50% of children had experienced one early life adversity (Clinton, 2018). Determining a person's ACE score is achieved by asking 10 standardized questions that assess for 10 types of childhood trauma: five questions relate to personal trauma while the other five questions relate to family characteristics that may also predict the development of trauma.

ACE's, Toxic Stress, and Trauma

Widespread social science research has been reporting the connection between ACE's and poor long-term outcomes for decades, but despite this knowledge, very little is being done to prevent the cyclical effects of adverse childhood experiences that affect a caregiver's parenting capacity and often lead to their own children developing ACE's. When the environment in which a child is raised is fraught with toxic stress, the child's neurological system is continuously activated and becomes stressed as well. Children's brains are incredibly sensitive to chronic stress because stress causes chemical changes in the brain. When the stress hormone cortisol is released in high levels it effects neurons in

the brain that keep the child's systems on high alert even when they are not in immediate danger. Essentially, children that experience chronic stress have systems that stay activated continuously, affecting other functions and systems. Chronic stress in the relationship between a child and their caregiver can result in trauma. This form of trauma is sometimes labeled as relational trauma or developmental trauma. This type of trauma is different as it is not caused by a single event, rather it is developed following repeated exposure to neglect, abuse, humiliation, and emotional abandonment which conveys to the child that no one is available to protect them (Booth & Jernberg, 2010).

Ministry funded specialized services for trauma are available; however, trauma assessments generally flag for a single traumatic exposure and may disregard traumatic responses associated with prolonged exposure to stress. It is important to recognize the impact of adverse childhood experiences of toxic stress caused by a myriad of differing risk factors, which may be different from one person to another. The impact of toxic stress lies in the continual activation of our threat detection system (fight or flight or freeze), which, when activated, produces increased cortisol levels that alters brain development and causes an overactive threat response system, even in absence of an actual threat. Research and education should advise relevant stakeholders, such as the Ministry of Children and Youth Services, that investing in evidenced-informed early interventions that are multi-systemic is imperative if enduring change is expected. It is counterproductive to fix the child and then send him back into the environment that led to the problem.

ACE's in Young Mothers and Their Children

When children experience adversity it can have long-term negative effects, and without a safe supportive relationship with their caregiver, their risk increases. In some cases, caregivers may be unable to provide this safe supportive relationship because they too have had adverse childhood experiences. Although the sample of young mothers in this project was small, the findings are significant on the grounds that all 10 of the mothers at onset who self-referred had an ACE score of at least one. Many, in fact, had scores higher than four. Some of the children in this project already had an ACE score of one, in some cases two, even though the children in this sample were five years of age or younger. As your ACE score increases, so does the risk of disease. The risk of social and emotional problems and disease in adulthood increases significantly for individuals with higher ACE scores, with a score of four or more indicating serious possible life outcomes (www.acestoohigh.com).

Unresolved or unacknowledged trauma in either the children brought for therapy, or perhaps in their caregivers, needs to be addressed before behaviorally focused treatment begins. It is imperative to understand the child's experiences and current risk factors with the aim of focusing on the underlying factors of the problem, which may in fact be related to a caregiver's experience of trauma that may be causing systemic family issues. It is important to understand that caregivers may not be aware that their own adverse childhood experiences may unconsciously, and inadvertently, contribute to their child developing a psychosocial or behavioural problem. The reality of the young mothers in this project was that they only understood the problem they referred for as a "problem with their child." However, with support, some of the mothers in this project

were able to reflect more deeply on their children's experiences, and of their own, and this reflection shifted their view of their child's behaviour from a problem-focused lens into an experience-focused lens. As parents responded differently, their children reacted differently. This sequential transformation occurs in the relationship when the experiences of each person in the relationship is truly seen and heard, conveying a message of safety and healing.

Implications of the ACE studies to Social Work Practice

Following the original ACE study, scientific research has steadily been on the rise to understand the impacts of adverse childhood experiences. In respect to social work practice, Larkin, Felitti, and Anda (2014) indicate that the alarming findings from "the large scale epidemiologic study of the relationship of adverse childhood experiences to adult health and social well-being throughout the lifespan…connect social work activities to national health policy [evidently through] health promotion and disease prevention"(p.#). Due to the strong connection between ACE's and the development of psychosocial/behavioral problems or developmental trauma to lifelong physical, mental, and social disadvantage, the authors highlight the importance of early intervention with communities, families, and individuals in order to mitigate risks associated with adverse childhood experiences.

In my role as a clinical social worker, I work with children under 18 years of age. In the agency where I work, there is a specialized service for children who display signs of trauma that allows for the child to be assessed by a trained trauma assessor. The agency has a small number of trained assessors who are certified in Geraldine Crisci's Trauma Assessment and Treatment Certification Program. Following assessment, if the

assessment indicates that trauma counseling is warranted, the child is provided trauma counselling, which incorporates specific treatment strategies based on the person's individual experiences. Prior to embarking on my practicums, I associated trauma to experiencing a single event (understanding the exposure to that event may differ) that left unresolved effects in the person. However, leading experts in the fields have demonstrated that developmental trauma can produce similar responses and will increase this child's risk of many physical health, mental health, and social issues throughout life. Developmental trauma is less likely to be caused by a single adverse event, but instead, evolves due to the sensitive nature of children's brain development that increases their vulnerability to experiences of repeated chaos, threat, inconsistencies, and unpredictability in their environments. Understanding trauma through this lens reinforces the evidence that many children on my caseload may in fact be experiencing developmental trauma, and, therefore, depend upon clinical interventions that respond by understanding the child's experiences, not by addressing an overt problem behaviour.

There is an obvious growing need for mental health services for children and youth across the province, and in response, several Ontario ministries collaborated to address mental health priorities that would invest in a new mental health system. The Moving on Mental Health action plan states "[o]ur goal is to deliver a coordinated, responsive system that makes sense to parents and young people, that is easy to navigate, that enables fast answers and clear pathways to care. Most important of all – the system must deliver early and appropriate help for each child and youth who needs it" (Ministry of Children and Youth Services, 2012). Specifically, the Moving on Mental Health action plan requires core mental health services that are publicly funded and required to be

available at every lead mental health agency scattered throughout Ontario communities (see Figure 1). The research derived from various disciplines and the knowledge of leading experts provide strong evidence for incorporating ACE's assessments and interventions into clinical services for children. In the study discussed earlier by Larkin, Felitti, and Anda (2014), the authors urge social workers to engage in ACE-informed clinical intervention[s]. Firstly, clinicians must increase their awareness of the impact of ACE's on both the parent and child in order to support children's health and well-being. The ACE study findings provide response strategies that align with extensive social science research showing evidence for effective family support that encourages positive parenting by means of strengthening the parent-child relationship.

ACE-informed clinical interventions can be streamlined across sectors with educators, medical practitioners, and mental health practitioners becoming more aware of indicators of adverse childhood experiences and contributing risk factors of toxic stress. The first step would be to assess for possible childhood trauma (including developmental trauma) by gaining the child's ACE score. Determining the child's ACE score is as simple as asking 10 standardized questions that assess for 10 types of childhood trauma. Pediatricians should be informed and use this ACE assessment when children are referred for specialized medical care to determine if trauma could be impacting other problems. Children who have at least one ACE may be impacted by trauma and should receive trauma-informed care.

Moreover, early learning kindergarten classroom teachers could use this ACE assessment to identify children entering school who have experienced trauma and help refer the child and their family for trauma-informed care. Children's mental health

agencies should assess for child trauma, if it has not already been identified, when children are referred initially for services in order to ensure they receive the appropriate intervention. Focusing on early identification of children at-risk of long-term disadvantage makes it possible for these children to receive specialized intervention that mediates adverse childhood experiences sooner. Early identification (the earlier the better) is necessary for change and could shift the recent pendulum of increased funding for mental health services in the long run by reducing the intergenerational transmission of mental health risk factors.

Decades of research on ACE's and the connection to cumulative risk has attracted stakeholders but the response has been primarily on screening for ACE's rather than presenting ACE-informed clinical interventions (Allen & Abresch, 2018). This section concludes by sharing the value of Theraplay as an ACE-informed clinical intervention. The Theraplay model can be adapted to deliver ACE-informed clinical interventions in a variety of formats: individual, family, groups, and even in the classroom. A collaborative community partnership with the school system may be a critical pathway for early identification and intervention. A strong relationship between a child and teacher may in fact mitigate issues that arise from absenteeism or dysfunctional family relationships that would leave the child feeling alone and unsafe. Negative views may themselves be a risk factor for poor outcomes as views of others become internalized and accepted. A strengths-based approach helps individuals recognize and build upon their resilience to deal with adversities.

Theraplay Interventions

Theraplay should be considered a valuable ACE-informed clinical intervention. Theraplay is a structured form of play therapy that builds upon the notion that children require connection and relationships, and when these connections are not present or relationships are unhealthy, risk occurs for social, developmental, behavioural, and even health problems. Comparing the theoretical framework of Theraplay with a review of the scientific literature on attachment and childhood brain development points to why this treatment model is so effective. Another reason is the focus in Theraplay on repairing the attachment relationship, which has long been considered a protective factor in developing resilience to adverse experiences across the lifespan. Similarly, Theraplay is a trauma-informed model that focuses on regulating a child's arousal state in order to rewire the child's brain towards healing. First and foremost, a child must feel safe and secure with their caregiver irrespective of the presenting treatment problem. As a leading expert in trauma, Bruce Perry discusses in his neurosequential approach, that treatment should be geared to the area of the brain that was damaged by the relational trauma, and in early childhood that would have been the right, lower brain areas (Perry & Szalavitiz, 2007).

Targeting children early through ACE scores will identify the children who would benefit from trauma-informed care that focuses on relational therapy. Children's mental health offices and child welfare agencies undeniably have many children involved in their services that would benefit from relational therapy, and, ultimately, allocating some funding for intensive family therapy could fund ongoing research to measure the efficacy of delivering Theraplay to at-risk families as an ACE-informed clinical intervention. Unfortunately, practitioners in private practice appear to have Theraplay training and

often require a fee for service. Additionally, practitioners are more available in southern Ontario. Moreover, Theraplay training has never been offered to clinicians in northern Ontario, therefore the value of this model is unknown to child workers in the north. The Theraplay Institute does offer on-site training in Canada, but since the closest trainer is further than 100 miles from Sudbury, the cost is higher. Trainees who complete Level One training can use Theraplay techniques but cannot assert they are delivering the Theraplay model until they have successfully completed TTI practicum requirements. Following completion of the practicum, a successful candidate can proceed further to become a certified Theraplay Trainer and/or Supervisor. There are currently 17 certified Theraplay therapists in Ontario, with the closest listed working in Barrie, Ontario, which is approximately 300 kms from Sudbury, Ontario. Investing in Theraplay training locally will reduce the costs and travel time that currently prevent the delivery of Theraplay in northeastern Ontario.

I will conclude this report with a final reflection on this practicum experience. I will revisit my responsibilities and reaffirm my role and will account for my learning objectives set in my project proposal. I will express why I believe I surpassed my goal of increasing clinical skill development in family-focused treatment. Specifically, I discuss the impact specialized training, my experience in the TTI practicum, and mentorship from experts in the field had on my critical professional self. This experience has been invaluable far beyond what I could have anticipated.

Final Reflections

This placement experience has not only been a professional endeavor but enabled me to reflect on my personal motives, which are deeply ingrained within my own adverse childhood experiences and the subsequent hardships I encountered. I recognize the power of supportive relationships in developing resiliency to overcome barriers and challenges. Presumably, my personal experience in part made me gravitate towards the Theraplay model because I could personally reflect on its value.

This report detailed the evolutionary process of developing and implementing a therapeutic program for young mothers who were at-risk of poor attachments with their children. This program was developed as an Advanced Practicum Project in partial fulfillment of the requirements for the degree of Master of Social Work at Laurentian University's School of Social Work. In partnership with Better Beginnings Better Futures (BBBF), this pilot project began in June 2014 and concluded in June 2015. My objective was to deliver an attachment-based relationship-focused interventional model to adolescent mothers and their children. Specifically, I envisaged a need for treatment specific services for mothers who were attending a teen parent education program through BBBF.

Throughout the duration of my practicum, I continuously advanced my theoretical knowledge, and through direct practice, formed connections between theory and practice. This experiential learning helped me achieve my practicum goal of becoming a skilled family-focused clinician. More so, I have immensely advanced my clinical knowledge and skills throughout this practicum experience, especially by partaking in the practicum through the Theraplay Institute. Through the TTI practicum I received comprehensive

training in the fields of attachment theory, brain development, trauma, and assessment and intervention derived from a model of play. I was fortunate to have been trained by many leading experts in their fields, including Daniel Hughes (Dyadic Developmental Psychotherapy), Stephen Porges (Polyvagal Theory), and Eliana Gil (Gil Institute for Trauma Recovery and Education). I have been trained by many leading authors and trainers employed by the Theraplay Institute, including Evangeline Munns, Dafna Lender, Andrea Bushala, Sarah Lindaman, Rand Coleman, and by Phyllis Booth, co-creator of the Theraplay model. In addition, I received on-going supervision from Lorie Walton who provides extensive experience to the play therapy discipline and Theraplay. Ms. Walton provided excellent mentorship and supportive guidance while I was refining my skills to align with the Theraplay model. She provided excellent suggestions for handling difficult problems with this at-risk population and with this support my self-confidence for responding to challenges grew. The vast amount of knowledge that I learned from each expert and throughout this experience is beyond what I had anticipated at the onset of this advanced practicum.

The transformative power of the Theraplay model in improving the relationship between adolescent mothers and their children was apparent in this project. There were observable differences in the interactions of mothers who attended sessions, with the greatest effect in dyads who attended between 10-15 sessions. The families who participated in less than five sessions seemed uncomfortable with the direct nature of the model, and given that this practicum timetable did not allow for individual sessions for the parent as a primer, it is hard to ascertain whether their discomfort may have resulted from their own unmet needs. Although a case management role for addressing

socioeconomic barriers was not the main focus, it became a necessary component of the program. It was evident that family, social, and environmental factors impacted the mothers' experience of parenting stress. The mothers who participated in this project did not feel the parenting role was stressful; however, increased stress increased negative parenting behaviours. The mothers experienced external stress and strain, which impacted their responsiveness at times; however, it was clear that they valued their role in their child's life and they were open and receptive to parent feedback and modeling. My experience has affirmed for me that Theraplay can be an effective way to treat a variety of child-related problems through repairing the mother-child relationship and promoting resiliency in at-risk adolescent mothers and their children.

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Appendix A

February 1st, 2015

My name is Melissa Long. I am a graduate student in the Masters of Social Work Program at Laurentian University. As part of the requirements of my degree in Social Work, I am offering attachment-based family therapy to adolescent mothers and their children. This practicum is sponsored and supported by Better Beginnings Better Futures.

I am studying the use of attachment-based family therapy as a helpful tool for addressing child-related behaviors, reducing parenting stress, and strengthening mother-child relationships. I will be using a modality of therapy that is informed by Theraplay© principles. ***Theraplay*** is a structured form of play therapy for families. The goals of Theraplay© are to enhance attachment, self-esteem, trust in others, and joyful engagement. The sessions are designed to be fun and interactive replicating the natural, healthy interaction between parents and young children. I am currently trained in level one Theraplay© and will be continuing the Theraplay© practicum and certification process. However, since I am not currently certified I cannot label the therapy I will be providing as Theraplay©.

If you decide to participate, you will meet with me for an interview at which time I will gather background information, explain the purpose of attachment-based family therapy and how it can be useful for targeting child-related concerns or enhancing the parent-child relationship. In particular, you will be asked questions about your family information, presenting problem, child's history, and we will discuss any questions you may have and decide if your family meets the criteria to participate. The meeting will take place at Better Beginnings Better Futures, and should last about an hour and a half.

Following this introductory meeting, your family will be scheduled to come in to participate in an observation session. During this session, you will be asked to follow simple interactions with your child which will allow me to observe your parent-child relationship as it naturally occurs. Following my review of your family's observation session, I will conduct an analysis and treatment report, which I will share with you at parent-feedback session. If you wish to follow through with attachment-based family therapy weekly sessions may then begin. Your family will have a maximum of 15 sessions, lasting one hour in duration with 30 minutes of therapy and 30 minutes of parent counseling. Our initial session, and any therapy sessions that follow will be video taped so that I can accurately reflect on what is discussed. Only my two supervisors, and myself will have access to the tapes. My supervision team consists of Brenda Robinson who is my practicum supervisor through Laurentian University; as well I am receiving training through *The Theraplay Institute* in Chicago where I am working towards certification as a Theraplay Therapist.

Participation is confidential. Any information provided to me will be kept in a secure location at Better Beginnings Better Futures. In the future, I might decide to share my experiences working with you and other families so that others can learn about the benefits of Theraplay. I will never

reveal any information that could identify you. You will receive complimentary bus tickets to attend and return from any therapy sessions.

Taking part in this therapy is your decision; participation is completely voluntary. Participation, non-participation or withdrawal will not affect your ability to participate in The Baby's Breath Program. You may also quit the therapy at any time or decide not to answer any question you are not comfortable answering, although it is important to note that the course of treatment may be affected if valuable family or child-related information is withheld.

I will be happy to answer any questions you have about this type of therapy and the problems it is suited to address or my role as a Masters of Social Work student. You may contact me at 705-671-1941 ext 219 and melissal@betterbeginningssudbury.ca. Should you wish to speak with my immediate supervisor for any reason you may contact my Executive Director Carole Dodge at 705-671-1941 ext 224 or via email at caroled@betterbeginningssudbury.ca.

If you are unsure if this therapy would be helpful for your family, you may phone me at the telephone number provided and we could complete a quick assessment or have a discussion about any child-related or individual difficulties you may be currently experiencing.

Thank you for your consideration. I look forward to working with you and your child.

With kind regards,

Melissa Long
450 Morin Ave
705-671-1941 ext 219
melissal@betterbeginningssudbury.ca

Appendix B

Family Background Information

Date of Interview:	CASE #
Child's Name:	DOB:
Address:	Home Phone:
Name of individuals present for the interview and their relationship to the child:	

Referral Source: - ____

Other Agency Involvements: - ____

Family Physician: ______________________________ Telephone: - ______________________________

Family Information:

Mother

Name:____DOB:- ____

Occupation: ____

Education: ____

Contact Number: ____

Father

Name: ____DOB:- ____

Occupation:____

Education: ____

Contact Number: ____

Siblings

Name	Sex	DOB/Age	School/Daycare

Name of others living in home and relationship to the child:

Presenting Problem:

Other Assessments:

Assessment	Date

Copies of Assessments Requested: Yes No

School History:

Current Grade: ______________________________ Academic Level: _____________________________________

Age Child Entered School: ______________ Language of Education: ________________________________

Describe the Child's School Experience:

Non-school Age □o
Who Provides Daytime Care: ____

Any concerns:

Child History:

Pregnancy: planned/unplanned, complications

Birth/bonding during infancy:

Other information

First tooth:	Roll over:
Sit:	Crawl:
Walk:	Talk:
Sleeping:	Feeding:
Illness	Toilet training:

Allergies:
Temperament:
Independence:

Relationships:

To mother:
To Father:
To Siblings:
To Peers:
Other:

Behavior/Discipline:

Child's response to limits:

Parenting style:
Form of disciplined used:
Social support system (family/friends/other):

Family History: Mother

Birthplace:
Siblings:
Parental relationship in childhood:
Level of affection in childhood:
Describe your childhood:
What is your family relationship like presently:

Family History: Father

Birthplace:
Siblings:
Parental relationship in childhood:
Level of affection in childhood:
Describe your childhood:
What is your family relationship like presently:

Marital/spousal relationship:

Relationship between the child's parents/new relationships:

Discussion/Consents:

Discuss Theraplay Commitment and Marshak:
Sign consent for Therapy:
Sign consent to video record sessions:
Other agency involvement- Sign consent to disclose:
Interviewers signature:
Date of interview:

Appendix C

The Attachment-Focused Questionnaire for Parents:

The below parent attachment questionnaire was adapted by Dan Huges, developer of Dyadic Development Psychotherapy®, from Siegal, D.J. & Hartzell, M. (2003) Parenting from the inside out. The questions are as follows:

1. What was it like growing up? Who was in your family?

2. How did you get along with your parents early in your childhood?
   How did your relationship evolve through your youth and into the present?

3. How did your relationship with your mother and father differ? Were similar?
   Are there ways in which you try to be like/not like each parent?

4. Did you feel rejected or threatened by your parents?
   Were there other things that happened in your life that were overwhelming or traumatic?
   Are these experiences still bothering you today? Do they still continue to influence your life?

5. How did your parents discipline you? What impact did that have on your childhood?
   How does impact your role as a parent now?

6. Do you recall your earliest separations from your parents? What was it like?
   Did you ever have prolonged separations from your parents?

7. Did anyone significant in your life die during your childhood or later?
   What was it like for you then and how does it affect you now?

8. How did your parents communicate with you when you were happy/excited?
   How did they communicate with you when you were unhappy/distressed?
   Did your father and mother respond differently during these times? How?

9. Was there anyone besides your parents who took care of you?
   What was that relationship like for you? What happened to them?

10. If you had difficult times during your childhood, were there positive relationships in or outside your home that you could depend on? How did those connections benefit you then and how might they help you now?

Appendix D

Consent for Attachment-Based, Relationship-Focused Family Therapy Based on Theraplay©

Theraplay© is a child and family treatment for enhancing attachment, self-esteem, trust in others, and joyful engagement. It is based on the natural patterns of healthy interaction between parent and child, and is personal, physical, and fun. Theraplay interactions focus on four essential qualities found in parent-child relationships: Structure, Engagement, Nurture, and Challenge. Theraplay sessions create an active and emotional connection between the child and parents, resulting in a changed view of the child as worthy and lovable and of relationships as positive and rewarding.

Touch is a normal, healthy part of all parent-child interaction and is very important for the healthy development of all children. Various kinds of touch are essential to Theraplay treatment. Theraplay touch is playful and engaging as seen in many of the surprising and delightful activities; it is nurturing in the care giving activities; it is organizing and modulating in the structuring activities; it is used to help or guide the child in the challenging activities. At all times our goal is to maintain the safety and meet the developmental needs of the child.

A child who has been inappropriately or hurtfully touched in the past needs to relearn what gentle, fun and appropriate touch feels like, and therefore learn that he is worthy of this kind of treatment. Also, children who may be extremely sensitive to touch need physical closeness and playfulness, therefore Theraplay treatment seeks ways to provide these experiences in ways that are tolerable for the child, and eventually to expand his tolerance for new sensory experiences.

If a child is angry, dysregulated or out of control in a session and has not responded to other efforts to calm her, the Theraplay therapist and parents stay with and contain the child in some way; this may involved cradling the child on the lap of an adult, an arm around the child, or close, soothing physical contact. If you are able, you the parent will contain the child with support from the therapist. As soon as the child settles, the containment stops and the adult will continue interacting with the child. Containment in Theraplay is done in reaction to the child's dysregulated behaviors; the therapist never provokes the child in order to contain the child. The model for this type of containment is that of a parent who holds an over tired, over stimulated, or frightened toddler in order to calm him. The reasons for containing a child are:

-To keep the child, the parent, and the therapist safe,
-To communicate to the child that the therapist and his parents can protect him from aggressive or self-injurious impulses,
-To let the child know that the therapist/parent can accept and assist him with strong emotions,
-To control the situation until the child is able to regain self-control.

You, the parents, will play a major role in Theraplay treatment. However, at the beginning of treatment, the Theraplay therapist will be the more active member of the team and initiate the interactions, for the following reasons:

-To provide a model for a new way of interacting for you and your child

-To get past the child's initial resistance so that your first experience with the new kind of interaction is positive

-To help you feel more sure of yourself and comfortable with touch.

If you feel uncomfortable with physical contact, we will move slowly until we develop a relationship with you and better understand your interaction with your child.

I have read the above statement and give permission for my child to participate in Theraplay-informed therapy as it is described.

____

Parent's Signature

____

Practitioner's Signature

____

Date

Appendix D

Parent Consent to Videotape

Date: ___________________________________

I give Melissa Long permission to videotape me and my child in all assessment and treatment sessions while my family is receiving therapy. Videotapes will be used to enhance treatment of the family (for example, we review portions of sessions with you to enhance positive treatment outcomes). I understand that these tapes and the content of these sessions are confidential. I understand that I may withdraw my permission to videotape with a written request. The consequence for not giving this permission is that the therapist and your family will not be able to review the sessions and therefore it may prevent your family from getting the most benefit from treatment.

Signature

Name

Child's Name

Address

City, Province, Postal Code

_________________________________ Telephone

_________________________________ Witness

Additional Permission:

As I am a student completing my academic training, I require the opportunity to discuss my clinical skills with trained and experienced supervisors, who will oversee our treatment and my learning experience. My signature below gives Melissa Long permission to use the videotapes of all interactions between my child and myself in, any and all, supervisory sessions. I understand that I may withdraw my permission to videotape with a written request.

Signature ____

Witness ____

Appendix D

Records Retention Policy

As a Theraplay© practicum student who is in the process of becoming a certified Theraplay© therapist, I will be adhering to all policies held by The Theraplay Institute.

The Theraplay Institute is required to keep your video and paper records confidential. The Theraplay Institutes adheres to the following policies for managing and retaining information about your family:

1) Written records- all written case records will be kept in a confidential file in a locked cabinet until your child turns 21 years of age. After that time, your child's records will be destroyed. You are entitled, with a written request, to receive a copy of your written records at any time.
2) Videotaped records- videotapes of any session(s) or communications between your family and the therapeutic staff will be kept either in a confidential file in a locked cabinet or in a password-secured database that has several levels of electronic barriers to retain confidentiality. Once your family's therapy is terminated, your video records will be deleted/destroyed unless you have signed specific consent to allow your video records to be used for future training purposes.

I have read and agreed to this Record Retention Policy.

Parent signature: ______________________________________

Date: ____

Appendix E

Session Supervision Form

Please include this form with each session

Name:____________________________________ Date____________
Supervisor:____
Client (initials):_________ Session #______________________________

At the beginning of each case, please send the following materials in addition to the materials required for on-going sessions:

_____Background/ intake information on child and family, last names removed for confidentiality
_____Tape of MIM session, along with the MIM analysis form
_____Consent form signed by the parent(s) giving permission to videotape and share the tapes and information about the family with the supervisor (DO NOT send to TTI)

Please make sure that all DVDs are clearly labeled.

When submitting for Level I practitioner certification, supervisors must rate the performance of the student on each area using the scale below:

Supervisor Rating Scale:
5: Exceptional-minimal suggestions
4: Good skills-above average progress
3: Average-acceptable
2: Needs improvement and additional supervisory support*
1: Significant deficit area-may require supervision beyond the standard practicum

**If student is rated less than Average (3) please provide an explanation and remedial plan*

A. Specific goals for this session:

SUPERVISOR'S RATING 1-5: ______

B.

List of activities planned:	As actually happened in the session:

C. Your assessment of your work in the following areas
(Give specific examples by activity):

SUPERVISOR'S RATING 1-5: ______

1) Your efforts to keep child optimally regulated:

2) Your pacing of activities:

3) Variety and sequence of activities (example, balance between nurture/ structure, quiet/ boisterous, faster/calmer):

4) Your overall use of Engagement (use of surprise, "moments of meeting", etc):

5) Your attention to child's nonverbal signals:

6) Your modifications for trauma history:

7) Would you work differently with this child in the future; if so how?

D. Comments on the child's behavior:

SUPERVISOR'S RATING 1-5: ______

E. Parent involvement:

SUPERVISOR'S RATING 1-5: ______

1) Your efforts to provide structure for the parent (i.e., Did the parent have a comfortable place to sit? Did parent know what was expected/how to do the activities? Did you provide enough direct coaching/guidance to parent?):

2) Your facilitation of parent-child engagement:

3) Parent's reaction to child:

F. Transference/Countertransference issues:

SUPERVISOR'S RATING 1-5: ______

G. Plan for the next session:

SUPERVISOR'S RATING 1-5: ______

H. Questions for the supervisor: