ABSTRACT

Forty-eight videotaped episodes of Peer Play Psychotherapy (PPP) using the Relationships for Growth and Learning (R*f*GL) Peer Play Psychotherapy modality for 11 at risk preschoolers (ages 3.5-5; 6 girls and 5 boys) were analyzed across the span of the therapy year. Using a global measurement called the Coding Interactive Behavior Rating Scale (CIB, Feldman, 1998) with an exploratory & dynamic systems theory approach (Hayes and Strauss, 1998) helped to provide a conceptual framework for the study of change in R*f*GL PPP studying between pre-posttest measurement periods. This study helped to contribute to the expanding research on R*f*GL by examining the children's non-linear topographies between pre-posttest measurements by zooming in to videotaped psychotherapy sessions – analyzing the treatment in its most naturalistic form: in the therapy room and during treatment. We learned from this study that therapeutic progress is not linear; the majority of therapeutic progress can identified between pre-post measurement periods; children most often display their most progress *before* ending compared to the middle and ending phases of treatment. This study may have implications for reporting previously overlooked therapeutic progress made throughout the year, which could potentially impact funding, and the prospective for donors and grants to expand and disseminate the R*f*GL PPP to help children and families in need.

Key words: R*f*GL; play-group therapy; pre-school children; efficacy; exploratory

RELATIONSHIPS FOR GROWTH & LEARNING: *ZOOMING IN*

UNPACKING THERAPEUTIC CHANGE OF GROUP TREATMENT FOR AT-RISK PRESCHOOLERS THROUGH AN EXPLORATORY & DYNAMIC SYSTEMS THEORY APPROACH

by,

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Friendships offer children an extra-familial base of security from which they may explore the effects of their behaviors on themselves, their peers, and their environments (Rubin, et al., 2005).

Friendships can play an instrumental and supposed more important role for children whose family relationships are marked by less supportiveness and satisfaction than it is for children who are lucky enough to have just the opposite (Gauze, et al., 1996).

To this degree, healthy friendships appear to represent a complete circle of security (Marvin, R., et al., 2002).

PART ONE: LITERATURE REVIEW

Introduction to peer relationships

Percolating throughout the twentieth century and a guiding topic in the social sciences, an interest in the study of children's peer relationships emerged. Leading writers of their time, George H. Mead, Sigmund Freud, Erik Erickson, and Jean Piaget, argued that social groups have a significant impression on the individual's development. Throughout the 1930's, empirical investigations of children's peer relations emerged as social scientists began to study the nature of children's peer interactions and relationships, kick-starting the first generation of peer relationship research (Renshaw, 1981), lasting until the outbreak of World War II. Then in the 1960's, interest in children's peer relations began to rekindle (Sherif et al., 1961), bursting with interest towards the latter half of the century in the 1970's and 1980's. This second generation of research on peer relations was initiated by Harlow and colleagues in 1969, when they found that young rhesus monkeys that were nurtured by their mothers, yet deprived of peer contact, were unable to develop necessary social skills, and in turn, experienced abnormal developmental trajectories. Interestingly, when the young rhesus monkeys experienced maternal deprivation, play with young peers could compensate for some of these deficits (Freud & Dann, 1951).

In 1932, Piaget suggested that children's relationships with peers could be differentiated from those with adults. Whereas adult-child relationships are considered asymmetrical, infiltrated

by obedience, child-child relationships are portrayed as egalitarian, well balanced, and proportional. Within the setting of peer connections and interactions, Piaget believed that children could use these relationships as opportunities to play out everyday scenarios, feelings, and circumstances. Throughout these relationships, children are given the chance to examine incongruous ideas and vindications, explore alternative options or points of view, and in turn, decide to accept, compromise, or reject the notions held by peers. In addition to practicing life situations as proposed by Piaget in 1932, it was suggested by George Herbert Mead in 1934 that the ability to reflect upon the self, developed progressively over the early years of life, predominantly as a function of peer play and peer interaction.

Collectively, these findings suggest that peers relations with one another play an instrumental role in the socialization of interpersonal competence. Further, skills that are developed in this manner have a lasting impact on the individual's adaptation and regulation. However, if children are not fortunate enough to have the foundation for proper expression, or lack skills that are vital for healthy relationships, they are at a disadvantage from the very beginning.

Functions of peer relationships

Healthy peer relationships provide support, enhance self-esteem and positive self-evaluation; emotional security; endearment and opportunities for intimate disclosure; tenderness and affection; validation of fears, hopes and passions; instrumental and information support; promotion of self growth and interpersonal sensitivity; and offer paradigms of later romantic, marital, and parental relationships (Newcomb & Bagwell, 1995; Sullivan, 1953). Rubin, Coplan, Chen and Buskirk (2005) bring attention to perhaps the most important function of friendships: they can offer children an extra-familial base of security from which they may explore the effects of their behaviors on themselves, their peers, and their environments. Friendships play a particularly strong

role for children whose family relationships are marked by less supportiveness and satisfaction than it is for children who have just the opposite (Gauze, Bukowski, Aquan Assee, & Sippola, 1996). To this degree, healthy friendships appear to represent a complete circle of security (Marvin, R., Cooper, G., Hoffman, K., & Powell, B., 2002).

Parker and Gottman (1989) argue that from a developmental perspective – throughout various points of a child's life - friendships serve a variety of functions. For a young child, friendships serve the purpose of maximizing levels of delight in play. They help manage and organize behavior in the face of high emotional arousal. One can imagine that when caretakers are not emotionally or physically available, friendships can help to serve an instrumental if not vital and necessary function. In middle childhood, friendships assist in obtaining the capacity and knowledge about behavioral norms, as seen in the group socialization theory from Harris (1995, 1999). In turn, these skills help children with self-presentation and successful impression management, which are both crucial during middle childhood when anxiety about peer relationships may develop. Lastly, in adolescence, friendships aid in self-exploration and the integration of rationality and emotions.

Many researchers have found that supportive and caring relationships promote student engagement and other adaptive school behaviors (Juvonen, 2006, p. 656; Brand, Felner, Shim, Seitsinger, & Dumas, 2003; Felner & Felner, 1989). Moreover, recent studies suggest that threats to belonging impede cognitive performance (Baumeister & DeWall, 2005; Baumeister, Twenge, & Nuss, 2002). Therefore, it can be assumed that healthy and positive peer relationships are positively related to higher achievement in school when compared to those children who are lacking these relationships (Juvonen, 2006). An abundance of research helps buttress this viewpoint, namely within the academic domain. For example, students' feelings of support and connections with peers is closely and positively linked with student engagement (Becker & Luthar, 2002; Brand et al.,

2003; Eccles et al., 1993; Felner & Felner, 1989; Finn, 1989, 1993; Goodenow, 1993; Midgley & Feldlaufer, 1987; Wentzel et al., 2004). Moreover, these healthy relationships are closely linked with school competence, classroom grades (Hatzichristou & Hopf, 1996; Wentzel, 1991; Wentzel & Caldwell, 1997), standardized test scores (A. Austin & Draper, 1984), IQ (Wentzel, 1991), participation in the classroom (Berndt & Keefe, 1995; Marks, 2000), positive social behavior (Wentzel, 1994, 1998), self-esteem (Barrera, Chassin, & Rogosch, 1993; S. Harter, 1994), and less instances of violence, drug use, and teenage pregnancy (Buhrmester, 1990; Resnick et al., 1997).

Friendships are thought to contribute greatly to the development of social competence. Deficiencies in friendships and peer support may result in a critical turning point and determinant of children lacking social adaptation and experiencing maladjustment. The literature is consistent with this perspective, revealing that children with mutual friends are generally more adjusted and socially competent than are children without friends. Moreover, children with the support of friendships are more sociable and pro-social, have higher self-esteem, and are less likely to be lonely (Newcomb & Bagwell, 1995). Children with the support of peers are able to manage difficult transitions more smoothly (i.e., separations from caretakers at school), and their self-esteem increases following these transitions if they have mutual friends and support from peers (Berndt et al., 1999; Ladd, 1990). Furthermore, support from peers breaches into victimization from other children. Specifically, children's healthy and supportive friendships mediate victimization by other peers, as friends can help to provide support and advice about how to manage the problem (Hodges et al., 1999; Hodges, Malone, & Perry, 1997). For instance, Gest et al., (2001) found that children with a greater number of mutual friends were found to be more prosocial and good-humored, and are less likely to exploit or tease others, even after taking into account their group acceptance and peer network centrality.

There is an agreement that both acceptance in large groups and involvement in healthy and satisfying close relationships have great implications for adjustment (Asher, Parker, & Walker, 1996). Interaction with intimate friends during childhood and adolescence provides wholesome rudiments for healthy and satisfying relationships later on (Sullivan, 1953). The ability to be socially competent in large groups, as well as close and or intimate relationships, is theoretically and empirically related. For instance, popularity can yield more friendships, whereby acceptance into a larger group opens up opportunities and networks of potential friends, increasing the opportunity for forming devoted friendships (Bukowski, Pizzamiglio, Newcomb & Hoza, 1996). Furthermore, prosperity within a large group requires similar skills that are necessary for forming and maintaining close friendships. The ability to resolve conflicts, share positive affect, and to reciprocate enjoyment are a few of these common skills (Bukowski et al., 1996) and some of these aspects are essential elements of early parent-child bonds, thereby relating to early attachment security.

An interesting gap in research is brought to our attention by Juvonen (2006), Juvonen & Wentzel (1996) and Urdan & Maehr (1995), who question findings on whether just simply meeting students' belonging goals will always enhance achievement. In fact, research has shown that not all peer relationships are equal and that some may be detrimental. Relationships may obstruct optimal achievement levels in academic settings when they are marked by unhealthy conflicts and have gone awry (Juvonen, 2006; Clasen & Brown, 1985; Coleman, 1961; Fordham & Ogbu, 1986; McClelland, 1961; Ogbu, 1991, 1997; Steinberg et al., 1996).

When peer relationships go awry

Hindrances to peer acceptance and intimate relationships can be represented by two contrasting and extremely common traits found among children: aggression and shyness, and

attachment styles and patterns can be viewed as an antecedent to both. For instance, children with parents who display insecure/avoidant characteristics may expect hostility from peers (Troy & Sroufe, 1987). As highlighted by Rubin, LeMare & Lollis (1990), such avoidant attachment styles and patterns are likely to emerge under inauspicious circumstances, such as a child having a difficult temperament or the social isolation or financial difficulties of the primary caretakers. The aggression that arises from these relationships is expected to pierce through larger social groups as well as closer, more intimate relationships. Moreover, it can be assumed that this hostility and anger is likely transmitted directly from the parent-child relationships to the peer-peer relationships. Unfortunately, this aggression is a vicious cycle in that it often alienates peers (Asher & Coie, 1990), which then limits the child's ability to form new friendships. Aggressive children are also likely to befriend other aggressive children (Dishion, Andrews & Crosby, 1995), and Selman & Schultz (1990) point out that these friendships are marked by antisocial, superficial, and aloof characteristics.

A similar interpretation can be applied to patterns of social withdrawal. Insecure and ambivalent patterns of attachment often lead to the expectation of rejection. In order for children to avoid this feeling of rejection, children often remain passive in the context of peers (Rubin, Bukowski, & Parker, 1998). Alike with children who have aggressive tendencies, children who are more withdrawn in nature are subject to extreme alienation from peers (Hodgens & McCoy, 1989), and this estrangement limits the candidates for close friends.

Social withdrawal isn't just limited to close friendships, as it can have an impact on large social group interactions as well. For instance, children who are more socially withdrawn are observed as less talkative and competitive with their friends than are their non-withdrawn counterparts (Schneider, 1999). Therefore, there are strong reasons to believe that child-parent

attachment may have an impact on facets of children's social transactions with peers who are not close friends.

Although having multiple friends has been considered a positive characteristic in children, the quality of friendships has a great effect on peers' adjustment. Some relationships can be marked by feelings of jealousy, derogation, and maladaptive influence, and in fact, there is evidence to show that feelings of jealousy can damage children's intrapersonal adjustment and result in negative behavior (Parker, Low, Walker, & Gamm, 2005). This is not limited to just egalitarianism, but also is heavily found among romantic relationships when they are characterized by feelings of insecurity, intense conflict, exploitation, and sadness (Joyner & Udry, 2000; Richards, Crowe, Larson, & Swarr, 1998). These findings are especially important to consider when conducting research in this area, given the risk of making sweeping assumptions that solely having friends presents a protective factor associated with positive outcomes and indicators of adjustment. Thus, it is of utmost importance to help children build a foundation of relationships that help them grow and learn, enabling them to utilize quality friendships for coping and support.

Whereas healthy peer relationships and acceptance by peers are closely linked with positive outcomes in other areas of one's life, rejection by peers is related to lower levels of academic engagement (S. Harter, 1981; Juvonen, 1996; Marks, 2000; Wentzel, 1991), increased absenteeism (DeRosier, Kupersmidt, & Patterson, 1994; Kupersmidt & Coie, 1990), grade retention (Coie, Lochman, Terry, & Hyman, 1992), higher dropout rates (Epstein & Mc-Partland, 1976; Kupersmidt & Coie, 1990), more behavioral problems (DeRosier et al., 1994; Parker & Asher, 1987), and increased risk of depression (Feldman, Rubenstein, & Rubin, 1988).

In fact, some peer relationships are marked by aggressive behavior (Crick & Nelson 2002; Poulin & Boivin, 2000). Furthermore, other findings suggest that certain discussions among peers

can have negative consequences. For example, children who discuss deviance with their peers are also at an increased risk to engage in deviance themselves, and this has been replicated and supported by an abundance of studies (e.g., Brendgen, Vitaro, & Bukowski, 2000; Dishion, Andrews, & Crosby, 1995; Dishion, Spracklen, Andrews, & Patterson, 1996; Keenan, Loeber, Zhang, Stouthamer-Loeber, & Van Kammen, 1995; Poulin, Dishion, & Haas, 1999; Urberg, Degirmencioglu, & Pilgrim, 1997). Discussions of personal problems among friends that become preoccupying can increase children's risk of internalizing disorders (Rose, 2002) and a variety of studies on early childhood mental health have illuminated connections between developmentally and socially vulnerable children and poorer outcomes in social, emotional and academic domains (Farrell & Travers, 2005; Giannakopoulos et al., 2014; Kay-Lambkin, Kemp, Stafford, & Hazell, 2007; Sims et al., 2012).

Mental illness within the preschool years

The prevalence rates of mental health problems in children ages birth through five range from 16-21% (Egger & Angold, 2006; Lavigne et al., 1996), however, it has been estimated that only 6% of preschoolers who are in need of mental health services actually receive the help they need (Kataoka et al., 2002). Despite these discrepancies, evidence suggests that early childhood mental health problems increase risk for these children for later psychopathology, if not treated or prevented effectively (Kagan & Zentner, 1996).

Untreated childhood mental illness does not come without a human and monetary cost. In 2000, the U.S. Public Health Service declared that mental illness is the leading cause for disability for all persons five years of age and older, highlighting the importance of research designed to examine the efficacy of interventions targeted for children. Additionally, untreated early childhood mental illness creates very serious obstacles for learning and school readiness (National Scientific

Council on the Developing Child, 2008). In fact, kindergarten teachers have reported that 35% of American children reach kindergarten unprepared to learn (Boyer, 1991). Research has already established that if mental health problems are not treated or prevented effectively in early childhood, they constitute significant risk factors for later psychopathology (Fergusson, Horwood, & Ridder, 2007; Kagan & Zentner, 1996; Tolan & Dodge, 2005), academic failure (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999; McLeod & Kaiser, 2004) and also for poor physical health (Shonkoff, Boyce, & McEwen, 2009). Therefore, it is essential to have an effective, economical, viable, and accessible modality to meet the mental health needs of a diverse set of preschool children.

Socioeconomically disadvantaged children are at an especially high risk of falling through the cracks, given that far too often they are undiagnosed and untreated for mental health. Studies demonstrate that it is significantly less likely that a child will receive mental health services if they come from socioeconomically poor and ethnic minority backgrounds (Holm-Hansen, 2006; Kataoka, Zheng, & Wells, 2002; Ringel & Sturm, 2001). Furthermore, when schools are faced with economic stress, the school's staff members are more likely to resort to punitive and zero-tolerance disciplinary measures that require less financial resources, over approaches that can serve to foster a positive school climate. As a result, already underserved children (Ramey 2015) suffer from harsh discipline policies, perpetuating a vicious cycle for vulnerable children, ultimately making the pathway back to a normal developmental trajectory even harder (Brooks-Gunn & Duncan, 1997; Currie, 2005).

Racial and ethnic minorities are disproportionately negatively impacted by disciplinary social/control environments compared to their White counterparts – and childhood is no exception (Rios 2009; Soung, 2011; Kupchik & Monahan 2006). Schools with large minority student

populations, specifically black students, have even higher suspension and expulsion rates. Even though black children represent only 18% of the preschool population, they make up 48% of the preschool expulsion rates. Their rate is three times higher than their White peers (The U.S. Department of Education Office for Civil Rights, 2014). It is suggested that these higher rates can be partly attributed to the lack of attention to preschoolers' social, emotional, and behavioral needs for healthy development (NCSL, 2005); a strong predictor of later academic, social, and emotional success. These rates of suspensions and expulsions highlight the glaring gap of preventative services in early childhood settings. Unsurprisingly, and as mentioned throughout, if early childhood mental health issues are not treated correctly, they can lead to an increased risk for later psychopathology (Kay-Lambkin et al., 2007).

Therapy for at-risk preschoolers

For too many children, individual treatment and parent-child psychotherapy are unavailable, inaccessible, or simply unaffordable (Osofsky & Lieberman, 2011; Tolan & Dodge, 2005). The U.S. Public Service further points to the shortage of appropriate services for children as a "major health crisis," estimating that though 1 out of 10 children suffer from emotional and behavioral problems that are acute enough to impair normal functioning, only less than half receive treatment (U.S. Public Health Service, 2000). The report asserted that "growing numbers of children are suffering needlessly" (p. 3), stressing the importance of early intervention and family involvement.

Receiving appropriate services runs in tandem with proper identification of children in need. A 2004 study reported that only between 1 and 2% of young children in the U.S. with emotional-behavioral problems are properly identified for mental illness (Conroy & Brown, 2004). Possible reasons stem from the reality that children with mild or moderate developmental challenges attend preschools for typically developing children. Often, their challenges are not severe enough to

qualify and many preschools do not make referrals for all cases in need. Additionally, their parents can be unwilling or unable to accept referrals for evaluations and/or services.

Without proper identification and early intervention, these vulnerable young children are at an increased risk of forming internalizing and externalizing mental health and behavioral problems in adolescence through adulthood and beyond (Dunn & Goodyer, 2006). The identification of preschool children who are at risk is pivotal for reducing risk factors that could lead to poor and adverse life outcomes and can help to prevent the perpetuation of intergenerational transmission of mental illness. Thus, not only establishing, but also having an in depth understanding of proven interventions that are responsive to the unique and sensitive needs of children and their families is vital – not only to lessen unnecessary suffering, but also to prevent the development of more serious impairment across the lifespan and the resulting cost to society.

Why are preschool years so important to intervene?

The rate of annual expulsion of preschool children from untreated behavioral problems is alarmingly high: 0.7% - a rate three times higher than their older peers in kindergarten through twelfth grade (Gilliam, 2005). Expectedly, this high expulsion rate significantly decreases for those children when there is easy access to an on-site mental health consultation program within the preschool milieu. Given that over one third of preschool aged children (3–5 years) attend programs in childcare centers, housed within the preschool's milieu is an optimal site for the identification of these developmentally vulnerable children. This comes alongside opportunities for prevention and early intervention (Rishel, 2012), as well as to support positive mental health outcomes for children through mental health promotion within the school setting (Baker-Henningham, 2014). It is evident that the use of empirically supported interventions leads to positive outcomes in the socioemotional, and behavioral domains for children and their families (Masten & Powell, 2003; Hemmeter,

Ostrosky, & Fox, 2006). However, in order to continue the study, it is equally as important that we understand effective interventions from a naturalistic, nonbinding perspective, and explore how and why these treatments work.

Collectively, it is clear that the preschool years are enormously delicate and vulnerable times for at-risk children. As they rapidly move through the development milestones during infancy, toddlerhood and preschool years, the ability to follow a healthy and optimal trajectory is not only vital, but depends upon early identification and successful cost-effective treatment (National Research Council and Institute of Medicine, 2000; Walker et al., 2007). In order to continue implementing these effective and readily accessible treatment models for preschool children – in addition to knowing that they work – we need to understand how they work from a less restrictive or *quantitative-only* model. Instead, we have an opportunity to explore the effects of treatment from an exploratory and qualitative lens, allowing for nuances to flourish – like that of a child's free play.

Group treatment for preschoolers

As mentioned previously, however, there is significant gap in treatment options (Osofsky & Lieberman, 2011; Tolan & Dodge, 2005) and the vast majority of mentally ill and at risk preschool children in the United States are not receiving proper care (Gilliam, 2005).

Regardless of the sweeping clinical application of group treatment with older children, the implementation of group therapy has been limited to children younger than five years of age and the research has been sparse. This point is reinforced by highlighting that Haim Ginott's Group Psychotherapy with Children: The Theory and Practice of Play Therapy, published in 1961 and republished in 1994 and Daniel Sweeney and Linda Homeyer's Handbook of Group Play Therapy, published in 1999 are some of the only texts published on the topic of group play therapy. Further,

they suggest that though group play therapy has been used throughout much of development history of play therapy, the utilization has been very limited.

To highlight the age gap on research for group therapy for preschoolers, Sweeney, Baggerly and Ray (2014) reviewed group play therapy studies published since 1940 (n=32) and found that only 11 of these studies included preschool and kindergarten-aged children. As to be expected, they found that group therapy for young children are effective, and most successful for children who have experienced domestic violence and trauma, (Jones, 2002; Smith & Landreth, Pascual-Leone, A., 2009).; Mahmoudi, et al., 2006; Tyndall-Lind, Landreth, & Giordano, 2001), language skills (Danger & Landreth, 2005), depression and anxiety (Baggerly, 2004), self-control (Trostle, 1988), and social-emotional functioning (Fantuzzo et al., 1996).

In addition to more dynamic or play-based group treatments, researchers have also found that more structured and cognitively behaviorally-based group psychotherapies are effective for children with a wide range of problems (Morsette, et al., 2009; Chorpita et al., 2011). Additionally, in a 2011 meta-analysis, it was found that group therapy with children ages three to eighteen was successful, including cognitive-behaviorally focused treatments, across many times of internalizing and externalizing problems (Chorpita et al., 2011).

It is clear that the current body of literature offers evidence for group format psychotherapy for children, however as demonstrated throughout this paper, these studies mostly focus on school-aged children and adolescents, leaving out the preschool aged cohort who stand to greatly benefit from preventative early intervention services. For instance, in a meta-analytic study of various types of play therapy, Bratton et al., (2005) report that the average age of children receiving these mental health services (let alone group treatment) was 6.7 years of age.

To address the mental illness gap amongst these at risk children and families, Relationships for Growth and Learning (R*f*GL) Peer Play Psychotherapy (PPP), aimed to address the mental health and developmental needs of a wide range of preschool children. R*f*GL is an onsite integrated school-based mental health consultation and services program for children ages 18 ½ months through 9 ½ years and their parents.

Relationships for Growth & Learning Peer Play Psychotherapy

The birth of R*f*GL occurred in the 1960's and began flourishing by the mid 1970's through the development of its own training program with the Jewish Board for Family and Children's Services (JBFCS) in New York City. R*f*GL aims to address the mental health and developmental needs of a wide range of preschool children. Though R*f*GL has been successfully implemented in several preschools serving economically privileged children, since the 1960's, it has been most widely applied to underserved children and families within the childcare and Head Start milieus.

The therapy has developed and diverged from other types of play therapy in unique and clever ways: 1) it involves a group play context, making it cost effective, socially, and developmentally enhancing, 2) it engages in child-caretaker dyadic work, 3) the R*f*GL therapists consult with teachers and school staff, and 4) most uniquely, it is housed within the day-care centers, where at risk children and families are already enrolled at, making the attendance much easier. While there are many clinical papers describing R*f*GL which highlight R*f*GL's efficacy (Bekar, Ö., Shahmoon-Shanok, R., Steele, M., Levy, J., deFressine, L., Giuseppone, K., & Steele, H, 2016), clinically observed strengths as well as its conceptual base, this article is the first to do an in-depth, exploratory, and qualitative analysis of the R*f*GL PPP videotaped sessions.

Coding Interactive Behavior Rating Scale

In order to analyze the R*f*GL PPP videos, a global measurement called the Coding Interactive Behavior (CIB) Rating Scale was applied (Feldman, 1998) through an exploratory & dynamic systems theory approach (Hayes and Strauss, 1998) which helped to provide a conceptual framework for the study of *change* in R*f*GL PPP, studying between pre-posttest measurement periods. The CIB coding system is a global measure that historically looks at parent, child and dyadic affective states and interactive styles. This measure is typically used with adults and children aged between 2 and 36 months, however for the purposes of this dissertation, the scale was applied to the R*f*GL PPP groups. Using pre-recorded videotaped material, the CIB is broken down into 43 codes that are rated on a 5-point Likert scale. Typically, there are 21 parent [therapist] codes, 16 child codes and 5 dyadic codes, however, for the purposes of this dissertation, the codes were applied only to children and *not to the therapist*.

Study Rationale

While it is clear that the aforementioned body of literature offers evidential support for group psychotherapy for children, these studies not only focus on school-aged children and adolescents, but they are also quantitative in nature. Searches on major databases such as PsychInfo, Proquest, and Google Scholar, yield minimal to no results for *qualitative* research on group therapy for children, let alone preschool aged children. Given the evidence that preschool years and early intervention is a crucial point for intervention, the clear deficiency of research on PPP for young children under the age of five is concerning and demands more research on the study of early intervention services for young children in order to aid in the prevention of more severe mental health problems (U.S. Public Mental Health Service, 2000).

As more and more researchers begin to conduct efficacy studies on group therapy for at risk preschoolers, and specifically R*f*GL PPP, studying the treatment in depth by evaluating the therapy not *only* from a pre-posttest measurement, but rather also throughout the process of the therapy year, is hypothesized to help clinicians and researchers gain a deeper understanding of the topography of the therapy process, agents of change, and the unique trajectories of children's progress.

The use of questionnaires provides an efficient method of obtaining large quantities of data, however it limits the depth of understanding and analysis that can be conducted. Studies that have examined the efficacy of R*f*GL PPP have been enormously helpful in collecting large amounts of data (Bekar, Ö., Shahmoon-Shanok, R., Steele, M., Levy, J., deFressine, L., Giuseppone, K., & Steele, H, 2016), however relying upon pre-posttest measures *only* may restrict our understanding of the distinctions and dynamics of the therapy which differentiate it from other types of treatments and modalities. Further, they may inadvertently obscure the dynamic and discontinuous nature of individual change patterns (Pascual-Leone, A., 2009). In reaction, it has been suggested that a dynamic systems theory be used to provide a conceptual framework for the study of change in psychotherapy (Hayes and Strauss, 1998), arguing that treatment research should "move beyond simple pre–post designs and toward more sophisticated growth curve analyses that generate trajectories of change in individual and by group" (p. 945).

By exploring and reporting upon the range, nuances and depths of the therapy, we can better inform further research, dissemination, and efficacy of the treatment modality. The aim is to *zoom in*, that is, to provide insight into what is occurring between the pre-postesting, by reporting upon the nuances and non-linear, unique trajectories that each child takes, helping to identify factors that may impact posttesting measurements.

Zooming into the treatment may also help to explain discrepancies in what therapists have seen anecdotally as therapeutic change versus what the pre-posttesting measures demonstrate. Often times, while assisting in the larger efficacy study for R*f*GL (Bekar, et al., 2016), many of the therapy group children's posttest results were not aligned with the therapeutic change observed by the group therapist. Without reporting on the therapeutic change through an exploratory & dynamic systems theory approach, the treatment results and success are at risk to be underreported and missed, impacting funding, as well as potential resources from donors and grants to expand and disseminate the R*f*GL PPP and help children and families in need.

While there are many clinical papers describing R*f*GL, which highlight both R*f*GL's clinically observed strengths as well as its conceptual base, this article is the first to do an in-depth, exploratory & dynamic systems theory analysis of the videotaped R*f*GL PPP psychotherapy sessions in its most naturalistic setting, in the therapy room, using an already validated and reliable coding scale (CIB, Feldman, 1998) between pre and post measurements.

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PART TWO: EMPIRICAL STUDY

Introduction

Healthy peer relationships provide support, enhance self-esteem and positive self-evaluation; emotional security; endearment and opportunities for intimate disclosure; tenderness and affection; validation of fears, hopes and passions; instrumental and information support; promotion of self growth and interpersonal sensitivity; and offer paradigms of later romantic, marital, and parental relationships (Newcomb & Bagwell, 1995; Sullivan, 1953). Rubin, Coplan, Chen and Buskirk (2005) bring attention to perhaps the most important function of friendships: they can offer children an extra-familial base of security from which they may explore the effects of their behaviors on themselves, their peers, and their environments. Friendships play a particularly strong role for children whose family relationships are marked by less supportiveness and satisfaction than it is for children who have just the opposite (Gauze, et al., 1996). To this degree, healthy friendships appear to represent a complete circle of security (Marvin, R., Cooper, G., Hoffman, K., & Powell, B., 2002).

Many researchers have found that supportive and caring relationships promote student engagement and other adaptive school behaviors (Juvonen, 2006, p. 656; Brand, Felner, Shim, Seitsinger, & Dumas, 2003; Felner & Felner, 1989). Moreover, recent studies suggest that threats to belonging impede cognitive performance (Baumeister & DeWall, 2005; Baumeister, Twenge, & Nuss, 2002). Therefore, it can be assumed that healthy and positive peer relationships are positively related to higher achievement in school when compared to those children who are lacking these relationships (Juvonen, 2006). An abundance of research helps buttress this viewpoint, namely within the academic domain. For example, students' feelings of support and connections with peers is closely and positively linked with student engagement (Becker & Luthar, 2002; Brand et al.,

2003; Eccles et al., 1993; Felner & Felner, 1989; Finn, 1989, 1993; Goodenow, 1993; Midgley & Feldlaufer, 1987; Wentzel et al., 2004). Moreover, these healthy relationships are closely linked with school competence, classroom grades (Hatzichristou & Hopf, 1996; Wentzel, 1991; Wentzel & Caldwell, 1997), standardized test scores (A. Austin & Draper, 1984), IQ (Wentzel, 1991), participation in the classroom (Berndt & Keefe, 1995; Marks, 2000), positive social behavior (Wentzel, 1994, 1998), self-esteem (Barrera, Chassin, & Rogosch, 1993; S. Harter, 1994), and less instances of violence, drug use, and teenage pregnancy (Buhrmester, 1990; Resnick et al., 1997).

Whereas healthy peer relationships and acceptance by peers are closely linked with positive outcomes in other areas of one's life, rejection by peers is related to lower levels of academic engagement (S. Harter, 1981; Juvonen, 1996; Marks, 2000; Wentzel, 1991), increased absenteeism (DeRosier, Kupersmidt, & Patterson, 1994; Kupersmidt & Coie, 1990), grade retention (Coie, Lochman, Terry, & Hyman, 1992), higher dropout rates (Epstein & Mc-Partland, 1976; Kupersmidt & Coie, 1990), more behavioral problems (DeRosier et al., 1994; Parker & Asher, 1987), and increased risk of depression (Feldman, Rubenstein, & Rubin, 1988).

Collectively, these findings suggest that peers relations with one another play an instrumental role in the socialization of interpersonal competence. Further, skills that are developed in this manner have a lasting impact on the individual's adaptation and regulation. However, if children are not fortunate enough to have the foundation for proper expression, or lack skills that are vital for healthy relationships, they are at a disadvantage from the very beginning.

The prevalence rates of mental health problems in children ages birth through five range from 16-21% (Egger & Angold, 2006; Lavigne et al., 1996), however, it has been estimated that only 6% of preschoolers who are in need of mental health services actually receive the help they need (Kataoka et al., 2002). Despite these discrepancies, evidence suggests that early childhood

mental health problems increase risk for these children for later psychopathology, if not treated or prevented effectively (Kagan & Zentner, 1996). Untreated early childhood mental illness creates very serious obstacles for learning and school readiness (National Scientific Council on the Developing Child, 2008). In fact, kindergarten teachers have reported that 35% of American children reach kindergarten unprepared to learn (Boyer, 1991). Therefore, it is essential to have an effective, economical, viable, and accessible modality to meet the mental health needs of a diverse set of preschool children.

Untreated childhood mental illness does not come without a human and monetary cost. In 2000, the U.S. Public Health Service declared that mental illness is the leading cause for disability for all persons five years of age and older, highlighting the importance of research designed to examine the efficacy of interventions targeted for children. Research has already established that if mental health problems are not treated or prevented effectively in early childhood, they constitute significant risk factors for later psychopathology (Fergusson, Horwood, & Ridder, 2007; Kagan & Zentner, 1996; Tolan & Dodge, 2005), academic failure (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999; McLeod & Kaiser, 2004) and also for poor physical health (Shonkoff, Boyce, & McEwen, 2009) and create very serious obstacles for learning and school readiness (National Scientific Council on the Developing Child, 2008). Therefore, it is essential to have an effective, economical, viable, and accessible modality to meet the mental health needs of a diverse set of preschool children.

For too many children, individual treatment and parent-child psychotherapy are unavailable, inaccessible, or simply unaffordable (Osofsky & Lieberman, 2011; Tolan & Dodge, 2005) or resisted for other reasons (i.e., commute time, defensiveness, accessibility). Thus, the vast majority

of mentally ill and/or at risk preschool children in the United States do not receive necessary care (Gilliam, 2005).

Regardless of the sweeping clinical application of group treatment with older children, the implementation of group therapy has been limited to children younger than five years of age and the research has been sparse. This point is reinforced by highlighting that Haim Ginott's Group Psychotherapy with Children: The Theory and Practice of Play Therapy, published in 1961 and republished in 1994 and Daniel Sweeney and Linda Homeyer's Handbook of Group Play Therapy, published in 1999 are some of the only texts published on the topic of group play therapy. Further, they suggest that though group play therapy has been used throughout much of development history of play therapy, the utilization has been very limited.

In addition to more dynamic or play-based group treatments, researchers have also found that more structured and cognitively behaviorally-based group psychotherapies are effective for children with a wide range of problems (Morsette, Swaney, Strolle, Schuldberg, van den Pol, & Young, 2009; Chorpita et al., 2011). Additionally, in a 2011 meta-analysis, it was found that group therapy with children ages three to eighteen was successful, including cognitive-behaviorally focused treatments, across many times of internalizing and externalizing problems (Chorpita et al., 2011).

It is clear that the current body of literature offers evidence for group format psychotherapy for children, however as demonstrated throughout this paper, these studies mostly focus on school-aged children and adolescents, leaving out the preschool aged cohort who stand to greatly benefit from preventative early intervention services. For instance, in a meta-analytic study of various types of play therapy, Bratton et al., (2005) report that the average age of children receiving these mental health services (let alone group treatment) was 6.7 years of age.

To address the mental illness gap amongst these at risk children and families, Relationships for Growth and Learning (R*f*GL) Peer Play Psychotherapy (PPP), aimed to address the mental health and developmental needs of a wide range of preschool children. R*f*GL is an onsite integrated school-based mental health consultation and services program for children ages 18 ½ months through 9 ½ years and their parents.

The birth of R*f*GL occurred in the 1960's and began flourishing by the mid 1970's through the development of its own training program with the Jewish Board for Family and Children's Services (JBFCS) in New York City. R*f*GL aims to address the mental health and developmental needs of a wide range of preschool children. Though R*f*GL has been successfully implemented in several preschools serving economically privileged children, since the 1960's, it has been most widely applied to underserved children and families within the childcare and Head Start milieus.

The therapy has developed and diverged from other types of play therapy in unique and clever ways: it involves a group play context, making it cost effective, socially and developmentally enhancing; it engages in child-caretaker dyadic work; the R*f*GL therapists consult with teachers and school staff, and most uniquely it is housed within the day-care centers, where at risk families are already enrolled at, which meets communities where they are, thus making attendance and accessibility much easier for them. While there are many clinical papers describing R*f*GL which highlight the therapies clinically observed strengths as well as its conceptual base (Bekar, Ö., Shahmoon-Shanok, R., Steele, M., Levy, J., deFressine, L., Giuseppone, K., & Steele, H, 2016), this article is the first to do an in-depth, exploratory & dynamic systems theory analysis of the videotaped psychotherapy sessions.

Study Rationale

While it is clear that the aforementioned body of literature offers evidential support for group psychotherapy for children, these studies not only focus on school-aged children and adolescents, but they are also quantitative in nature. Searches on major databases such as PsychInfo, Proquest, and Google Scholar, yield minimal to no results for *qualitative* research on group therapy for children, let alone preschool aged children. Given the evidence that preschool years and early intervention is a crucial point for intervention, the clear deficiency of research on PPP for young children under the age of five is concerning and demands more research on the study of early intervention services for young children in order to aid in the prevention of more severe mental health problems (U.S. Public Mental Health Service, 2000).

As more and more researchers begin to conduct efficacy studies on group therapy for at risk preschoolers, and specifically R*f*GL PPP, studying the treatment in depth by evaluating the therapy not *only* from a pre-posttest measurement, but rather also throughout the process of the therapy year, is hypothesized to help clinicians and researchers gain a deeper understanding of the topography of the therapy process, agents of change, and the unique trajectories of children's progress.

The use of questionnaires provides an efficient method of obtaining large quantities of data, however it limits the depth of understanding and analysis that can be conducted. Studies that have examined the efficacy of R*f*GL PPP have been enormously helpful in collecting large amounts of data (Bekar et al., 2016), however relying upon pre-posttest measures *only* may restrict our understanding of the distinctions and dynamics of the therapy which differentiate it from other types of treatments and modalities. Further, they may inadvertently obscure the dynamic and discontinuous nature of individual change patterns (Pascual-Leone, A., 2009). In reaction, it has

been suggested that a dynamic systems theory be used to provide a conceptual framework for the study of change in psychotherapy (Hayes and Strauss, 1998), arguing that treatment research should "move beyond simple pre–post designs and toward more sophisticated growth curve analyses that generate trajectories of change in individual and by group" (p. 945).

By exploring and reporting upon the range, nuances and depths of the therapy, we can better inform further research, dissemination, and efficacy of the treatment modality. The aim is to *zoom in*, that is, to provide insight into what is occurring between the pre-posttesting, by reporting upon the nuances and non-linear, unique trajectories that each child takes, helping to identify factors that may impact posttesting measurements. It is hypothesized that firstly, treatment progress will *not* be linear, and secondly, most progress would be found at the Before Termination phase, whereas the least would be at the Middle and Ending phases.

Zooming into the treatment may also help unpack and explain discrepancies in what therapists have seen anecdotally as therapeutic change versus what the pre-posttesting measures demonstrate. Often times, while assisting in the larger efficacy study for R*f*GL (Bekar, Ö., Shahmoon-Shanok, R., Steele, M., Levy, J., deFressine, L., Giuseppone, K., & Steele, H, 2016), many of the therapy group children's posttest results were not aligned with the therapeutic change observed by the group therapist. Without reporting on the therapeutic change from through an exploratory & dynamic systems theory approach, the treatment results and success are at risk to be underreported and missed, impacting funding, as well as potential resources from donors and grants to expand and disseminate the R*f*GL PPP and help children and families in need.

While there are many clinical papers describing R*f*GL, which highlight both R*f*GL's clinically observed strengths as well as its conceptual base, this article is the first to do an in-depth, exploratory & dynamic systems theory analysis of the videotaped R*f*GL PPP psychotherapy

sessions in its most naturalistic setting, in the therapy room, using an already validated and reliable coding scale (CIB, Feldman, 1998) between pre and post measurements.

Materials and methods

Forty-eight videotaped episodes of Peer Play Psychotherapy (PPP) using the Relationships for Growth and Learning (R*f*GL) therapy modality for eleven at risk preschoolers were analyzed across the span of one school term (October-June). The participants within this study ranged from ages 3.5 to 5 years old, (six girls and five boys). During the initial phase of treatment the groups started off with eleven total children. However due to unpredictable clinical occurrences (to be mentioned in the results section), one child was prematurely removed from his R*f*GL PPP group by his mother. All parents of the children who participated in this study were outreached to within their daycare setting.

Therapy sessions were chosen at random across the span of the therapy year by the coding team, edited to five-minute segments, and chosen by the coding team for an episode with a beginning, middle and end. After, the video clips were categorized into phases of treatment: Early (n = 13); Middle (n =13); Before Ending (n = 13), and Ending (n = 9) phases. All videos were coded blindly regarding the time of treatment phase. The R*f*GL CIB coding team included three members: Jessica Tappan, LCSW, a psychotherapist with a specialty in early childhood psychopathology; Lauren deFressine, M.A, a clinical doctoral student from the Center for Attachment Research at The New School for Social Research; and Jaclyn M. Levy, M.A., a clinical doctoral student from the Center for Attachment Research at The New School for Social Research and the author of this dissertation and psychotherapist of the R*f*GL PPP videos.

Coding Interactive Behavior Rating Scale

In order to analyze the R*f*GL PPP videos, a global measurement called the Coding Interactive Behavior (CIB) Rating Scale (Feldman, 1998) with a 'dynamic systems theory' approach was applied (Hayes and Strauss, 1998) in order to provide a conceptual framework for the study of *change* in R*f*GL PPP. The CIB coding system is a global measure that historically looks at parent, child and dyadic affective states and interactive styles. This measure is typically used with adults and children aged between 2 and 36 months, however for the purposes of this dissertation, the scale was applied to the R*f*GL PPP groups. Using pre-recorded videotaped material, the CIB is broken down into 43 codes that are rated on 5-point Likert scales. Typically, there are 21 parent [therapist] codes, 16 child codes and 5 dyadic codes, however, for the purposes of this dissertation, the codes were applied only to children and *not to therapist*.

The coders of this study were all statistically reliable and achieved high agreement, (Chronbach's $\alpha = .93$). This paper reports on the scores of the CIB coding scheme across ten months of R*f*GL PPP. Pseudonyms have been used throughout this paper in order to protect the confidentiality of participants. All identifying information has also been removed. Written informed consent to participate in the study was obtained from all participants' parents who gave their written consent for their children to take part. The study was granted ethical approval from the The New School Institutional Review Board.

Sample characteristics

The preschoolers of this study attended early childhood daycare and were all identified as necessitating treatment based upon clinician's conduction of unstructured clinical in-class observations. These clinical observations have been called the "gold standard in the field" (Egger et al., 2015), and are typically conducted over the span of 2-3 weeks in the beginning of the school

year. Further, they involve teachers' and parents' unstructured reports and observations. Subsequently, the parents of the identified children were then outreached to and offered the opportunity to partake in the twice-weekly R*f*GL PPP for their children with collateral and/or dyadic sessions to adjunct the therapy, all housed within the early childhood daycare milieu. Even if the parents declined their own treatment (which many have done), their children were still able to participate in the R*f*GL PPP groups. This not only allows children to benefit from treatment regardless of their parents willingness, but also allows for even the most reluctant parents to become acclimated to therapy. Once consented, historical intake information was then gathered, however oftentimes, parents were often reluctant and avoided either showing up to intake appointments and/or withhold much of the historical information regarding traumas and past psychiatric histories within their families. Compliant with the agency clinic protocol, children are diagnosed just before they begin treatment. This diagnosis is as thoroughly discussed as possible with a seasoned reflective supervisor, as the clinician begins to integrate the historical data provided with the classroom observations and the teacher and parents reports. The following section will describe each child who participated in this study.

GROUP 1

Destiny & Cathy

Background: Destiny (ID 213) is a 4-year-old White and Puerto Rican girl who is domiciled with her maternal grandmother, Cathy (65 years old), in a shelter two blocks from the daycare center. At time of birth, though Destiny tested positive for Cannabis in her bloodstream, she met all of her developmental milestones. At two weeks old, Destiny was thrown out into a dumpster by her biological mother, Gabby, who was 15 years old at the time of Destiny's birth. When Cathy

heard from a neighbor that Gabby "got rid of her baby," she immediately came to Destiny's rescue. Soon after, Cathy filed for full custody, and ever since has been Destiny's primary caretaker.

Presenting issue & progression of treatment: The school's R*f*GL psychotherapist outreached to Destiny and Crystal, as Destiny exhibited behaviors and symptoms found in children with Reactive Attachment Disorder and early childhood trauma (Zeanah et al., 2004). For instance, Destiny was observed overgeneralizing attachment figures and would indiscriminately hug and kiss adults before she had the chance to trust them. As the class "caretaker," Destiny would share all of her toys and leave herself with none. She was highly attuned to adults' mental states, often appearing concerned about her teacher's emotions and moods versus losing herself in the rhythm of play. When she repetitively lined up toys and dolls all in an organized row during play, it became clear that her need for control was vital. Not only was Destiny exhibiting great difficulty sleeping during naptime, causing extreme disruption in her classroom, but also, she was unable to sleep in her own bed in a studio bedroom at a women's shelter. As such, Cathy eagerly consented to R*f*GL 2x weekly treatment for Destiny and her own weekly psychotherapy with the same therapist to adjunct Destiny's care.

In beginning of treatment, Destiny was the caretaker of the group, acting as a co-therapist: a mediator, timekeeper, and mother. The major aim of the therapy was to offer Destiny a space where she could allow the therapist and group to take care of her – a place where she did not have to care for everyone and everything for her own survival (Chee, L. P., Goh, E., & Kuczynski, L., 2014).

As treatment progressed towards the Middle phase, Destiny began acting out. This was initially interpreted as her starting to feel safe in the group and allowing the therapist to take care of her by implementing appropriate boundaries and limits. However, her behaviors, such as increased

startle response, extreme liability and fear, continued to worsen to a disproportionate degree, and thus additional intervention, both individually and collaterally, was required.

After investigation and intensive therapy, Destiny revealed her teacher held her down and hit her during naptime a few weeks prior, (simultaneous to when her behaviors started to worsen) when she did not fall asleep right away. The school and clinical team immediately investigated this claim, which was confirmed by a witness teacher who did not speak up. Both teachers (perpetrator and witness) were then promptly removed from the school. As a result, the therapist provided trauma-focused interventions, helping Destiny to not generalize her traumatic experience to *all* teachers and caretakers, especially given her early history of extreme neglect.

Though numerous and consistent interventions were provided, Destiny remained fearful and on high alert while around caretakers throughout the remainder of treatment. It is hypothesized that her therapeutic progress was heavily and negatively impacted. At the very end of treatment, she had an extremely difficult time putting words to her emotions and affect, and acted out in many ways while saying goodbye (similar to other children). Despite this trauma, she was still able to form attachments to her group members, engage in collaborative and symbolic play, and form a bond with the therapist.

Brandon & Wanda

Background: Brandon (ID 211) is a 3.5 year-old Dominican-American boy who is domiciled with his biological mother, Wanda (24 years old) and older sister, Victoria (9 years old), in Section 8 housing two blocks from the preschool. In the beginning of treatment, Wanda was unemployed, however over the course of therapy was able to obtain stable employment. Though Wanda reported that Brandon met all of his developmental milestones and denied any family past psychiatric history, over the course of treatment, not only was it apparent that Brandon was

nonverbal, but Wanda disclosed multiple traumas related to physical and emotional abuse from Brandon's father, which Brandon was a direct witness to.

Presenting issue & progression of treatment: The school's R*f*GL psychotherapist outreached to Brandon and Wanda, as Brandon exhibited behaviors and symptoms found in children with Autism Spectrum Disorder and an Unspecified Communication Disorder. For instance, Brandon did not communicate verbally with other children and teachers, made minimal eye contact with severely blunted affect, and made repetitive guttural sounds when approached by teachers and adults. Brandon played alone in the classroom, repetitively lining up trains one by one, never connecting one to the next. During transitions, Brandon was disruptive within the classroom as he would jump on chairs and run around in circles despite the teacher's continuous limit setting. Despite his extremely disconnected presentation there was vibrancy in his eyes, leading the R*f*GL team to hypothesize that there was more to Brandon's presentation and etiology than solely a pure Autism as well as a language impairment. When Wanda was notified about Brandon's need for therapy she was defensive and paranoid, saying this was just "what White people do to children." However, after the therapist provided alliance-focused and motivational interviewing therapy interventions, Wanda agreed to treatment with a time-limited agreement, expiring within 3 months, if "treatment did not work." As such, Wanda ultimately consented to R*f*GL 2x weekly treatment for Brandon in addition to her own weekly psychotherapy with the same therapist to adjunct Brandon's care.

As mentioned, in the beginning of treatment, Brandon was identified as possibly falling onto the Autism Spectrum, was nonverbal and appeared disconnected. He would not play with other children in the Early phase of treatment, and often spent entire sessions rolling trains back and forth in solitude.

As Brandon entered into the Middle phase of treatment, he displayed only the beginnings of progress, however there was hope for disconfirming his initial diagnosis. For instance, he joined other children in play, improved in speech (despite not receiving any related speech services), and was better related.

After making this progress however, similarly to Destiny, he quickly began to act out, albeit, exhibiting much lower levels of externalized and oppositional behaviors. For instance, he would throw toys at the therapist or another child, (though this was typically in reaction to other children stealing his toys), dump boxes of toys on the therapy room floor, and refuse to clean up at the end of sessions.

Before Termination, Brandon's progress skyrocketed. He became extremely well related, catching up to his peers verbally, sharing toys, and joining in on collaborative, elaborative, and creative play. Simultaneously, Brandon's mother, Wanda, received stable employment, which helped to alleviate financial stressors within the family.

Similar to Destiny, Brandon had a very hard time ending and expressing his emotions during the last session, acting out in tandem with Destiny. Despite this, he was extremely focused on social interactions, attachments, and the sentimental value of goodbye letters – all pointing to his appreciation for meaningful relationships.

Thomas & Victoria

Background: Thomas (ID 3) is a 3.5 year-old Puerto Rican boy who is domiciled with his mother, Victoria (21 years old), father, Roberto (24 years old), 5 siblings (varying ages), 2 aunts, 1 uncle, grandmother, and grandfather. The R*f*GL therapist and mother remembered one another from treating her older daughter 4 years prior as a co-therapist with a LCSW. At the time of Thomas' treatment, his mother was unemployed and reported multiple traumas, including a lifetime of her

own sexual and physical abuse (details unspecified), however would not engage in collateral psychotherapy and thus, a full developmental and familial history was not obtainable.

Presenting issue & progression of treatment: The school's R*f*GL psychotherapist outreached to Thomas and Victoria, as Thomas had extreme difficulties separating from his mother during school drop off in the mornings. For instance, Thomas suffered from unsoothable tantrums; hysterically crying, he would stare out of the window and yearn anxiously for his mother's return. Thomas would not engage in any classroom activity, leaving teachers with no choice but to call his mother back to school prematurely on a daily basis, reinforcing his tantrums, and making it even more difficult to acclimate to age appropriate separations. Thus, Victoria was extremely agreeable to consent to R*f*GL 2x weekly treatment for Thomas. Though she agreed to weekly dyadic psychotherapy with the same therapist to adjunct Thomas' care, she only showed to one out of the ten scheduled sessions.

In the beginning of treatment, Thomas was tremendously fearful. He refused to join the therapy group during pick-up and was extremely fearful of the therapist with no identifiable cause. In order to bring Brandon to the therapy room, the therapist requested that his primary teacher accompany him to the beginning sessions to help serve as a safe base and transitional person/object (Winnicott, 1986). During these sessions, Brandon cried uncontrollably for over 10 minutes, held onto the doorpost with all of his might while being carried into therapy room, and even tried to climb out of the window. His extreme distress required the therapist to return him back to the classroom for a few sessions, as well as request his teacher to join the beginning stages of the other sessions.

As Brandon entered into the Middle phase of treatment, he began to acclimate to the therapy room, form a bond with the therapist, and appear interested in play. For instance, while his peers

played, he maintained close proximity to them, watching their play with a very curious and yearning eye.

Towards the end of the Middle phase, after much progress was made with Thomas, his behaviors began to change for the worse, raising concern for the therapist. During a particular group, Thomas began to pull out baby dolls, playing out an abusive scenario occurring between "him and mommy." At one point, he hit the doll on the face with another toy and said, *"bad baby, you stupid motherfucker."* Undoubtedly, this required immediate intervention and a call was made to Child Protective Services after discussing concerns with his mother. Following the call, his mother was understandably upset; she rapidly became violent, aggressive, and agitated. Since a strong therapeutic was not formed initially, she was unable to talk with the therapist and decided to remove Thomas from treatment immediately without negation. Thus, he was unable to say goodbye to the group and his treatment was halted prematurely.

Madison, Robyn & Chris

Background: Madison (ID 209) is a 3.5 year-old half Black and half White girl who is domiciled with her biological mother, Robyn (42 years old), and her father, Chris (64 years old), as well as two siblings; one infant brother (6mos), and one older brother (18 years old) who was diagnosed on the Autism Spectrum Disorder. Robyn worked at home as a stay-at-home mother, and Chris, a combat veteran, was a manager of janitors at a nearby school. Robyn reported that Madison met all of her developmental milestones and did not have a family history of mental illness. However, over the course of treatment, Chris revealed that he was struggling with alcoholism, and Robyn reported a diagnosis of her own Borderline Personality Disorder.

Presenting issue & progression of treatment: The school's R*f*GL psychotherapist outreached to Madison, Robyn, and Chris, as Madison was extremely aggressive in the classroom.

This was evidenced as she bit other children, refused to share toys, and displayed severe impulsivity. In addition to her presentation within the classroom, her parents reported that she had significant difficulties listening to rules and directions at home. As such, Robyn and Chris eagerly and willingly consented to R*f*GL 2x weekly treatment for Madison with their own weekly collateral psychotherapy with the same therapist to adjunct Madison's care.

In the beginning of Madison's treatment, she was extremely aggressive. She would bite her peers, throw toys at others, and appear to completely disengage when boundaries were set. Throughout the Middle phase of treatment, Madison's behaviors worsened and became dangerous. For instance, a group member began playing with a toy that Madison had been using, making sure to ask her first. Madison remained unresponsive and happily continued to play with a different toy; the other child interpreted no response to mean, 'proceed.' However, this was not Madison's intent. Once Madison realized the toy she believed to have claimed was being played with, she took scissors and attempted to cut the child's ear, as the therapist swiftly intervened. While the therapist was limit-setting, it appeared as though Madison was actively ignoring her peer, raising the question of whether Madison was simply unaware of this child's request, and perhaps unable to hear her. Thus, the therapist recommended that she see an audiologist for a consultation.

Madison's hearing test revealed that she required surgery to implant tubes in her ears (a bilateral myringotomoy). After she returned from her surgery, though she still was oppositional with peers, she was able to genuinely engage in meaningful conversation and internalize rules and boundaries. As consistent limit-setting, repairs with peers, and positive social feedback were experienced throughout the Before Termination stage, Madison became much more pleasant, well related, and collaborative with her peers. Her true potential began to blossom and take shape.

Unfortunately, Madison was absent during the last sessions of treatment due to a bad flu. However, though she was not physically there, the group contacted her via video-chat from the therapists phone to include her in the group goodbye. Still, as a result of her absence, her scores were not coded on the CIB scale.

GROUP 2

Ethan and Michael

Background: Ethan (ID 5) is a 5 year-old Puerto Rican, Dominican and American boy domiciled with his maternal uncle, Michael (38 years old), and older brother, Marco (12 years old). At the young age of two, ACS removed Ethan from his mother's care (Michael's sister) due to neglect and physical abuse. At the time of ACS removal, Ethan was found to be malnourished and abused, and Ethan's mother was found abusing multiple and unspecified illicit drugs. Upon investigation, it was discovered that she was also using illicit drugs, such as heroine and alcohol while pregnant with Ethan. Ethan was immediately placed in foster care for 6 months until Michael agreed to kinship and then took full custody over Ethan. As Michael took over custody for Ethan at 3 years old, it was unclear if Ethan met his developmental milestones.

Presenting issue & progression of treatment: Ethan was originally outreached to by one of the school's R*f*GL psychotherapists when he was 3.5 years old and first began daycare. Ethan displayed behaviors typically associated with Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Impulse Control Disorder and Disruptive Mood Dysregulation Disorder. For instance, it was initially reported that upon outreach, Ethan would have persistent outbursts in the classroom, throw chairs at other children, run out of the classroom, and completely ignore limit-setting. Within the home, Ethan's uncle reported extremely aggressive and high-risk behavior, such as threatening the uncle and other family members with large kitchen knives. Additionally, Ethan would not eat

unless directly fed by his uncle, had frequent nightmares and bedwetting, and was observed having an exaggerated startle response when approached by adults. Importantly, Ethan initially started R*f*GL groups with a full time R*f*GL clinician for one year, and then was transferred to a trainee when the original therapist moved clinics. He stayed with the new trainee until he was 4.8 years old and then transferred to the next trainee (writer) at 5 years old until his graduation from the daycare into kindergarten. Initially, due to Ethan's disruptive and alarming presentation, Michael eagerly and willingly consented to R*f*GL 2x weekly treatment for Ethan and his own weekly psychotherapy with the same therapist to adjunct Ethan's care. Michael was so satisfied with Ethan's healing and progress within the R*f*GL PPP groups that he did not hesitate to continue treatment despite multiple transfers of care.

During the Early phases of treatment, Ethan was withdrawn and wary of therapist. His play was not creative, symbolic or collaborative. He would spend the majority of his sessions walking around the therapy room directionless, talking about how he and the group would never like the new therapist. These behaviors were all interpreted as his difficulties in saying goodbye to the previous therapist and in forming a bond with the new therapist. Throughout the Early phase of this treatment period (being studied), the therapist focused on rapport-building and provided attachment-focused interventions. With time and consistency, Ethan returned back to homeostasis as he played with his peers. However, towards the end of the Early phase of treatment into the Middle phase, he began to test boundaries and the limits of the therapist, oscillating between behaviors such as withdrawing from play to attempting to hit the therapist.

As treatment persisted, Ethan saw that the therapist was safe, and could tolerate a range of his emotions while keeping him safe, and so, he began to form a bond with the therapist and engage

in extremely creative and collaborative play with his peers, which persisted through the Middle and Before Termination stages.

During the final goodbye, Ethan (along with his peers) struggled. This not only meant saying goodbye to yet another therapist who left him, but also the conclusion of R*f*GL PPP groups all together, ending at the school, as well as transitioning to a whole new school. However, like the rest of the group, he was able to utilize the strong peer relationships he built, along with creative and symbolic play to help play out his feelings about ending, integrating toys and social interactions.

Jamie, Veronica & Esther

Background: Jamie (ID 6) is a 5 year-old White and Puerto Rican girl living with her grandmother, Veronica (50 years old) and mother, Esther (22 years old), however, she was raised primarily by Veronica. Esther was 17 years old at the time of Jamie's birth, unemployed, abusing illicit drugs, and often away from home for days at a time. Additionally, Veronica reported that Esther suffered from what appeared to be an untreated Borderline Personality pathology.

Presenting issue & progression of treatment: Jamie was originally outreached to by one of the school's R*f*GL psychotherapists when she was 3.5 years old and first began daycare. During separations and transitions in the classroom, Jamie had severe crying spells lasting for approximately 30 minutes. In addition, when she would not get her way, she would disengage and ignore any type of soothing from teachers and other staff, proceeding to throw additional tantrums until she got her way. Like Ethan, Jamie initially started R*f*GL groups with a full time R*f*GL clinician for one year, and then was transferred to a trainee when the original therapist moved clinics. She stayed with the new trainee until she was 4.6 years old and then transferred to the next trainee (writer) at 4.8 years old until her graduation from the daycare into kindergarten. Due to

Jamie's initial presentation, Veronica eagerly and willingly consented to R*f*GL 2x weekly treatment for Jamie and but would not agree to her own psychotherapy to adjunct Jamie's care. Additionally, engaging in collateral work with Veronica or Esther, even monthly, was extremely difficult and near impossible, so much of the work was conducted solely with Jamie. However, like Michael, Veronica additionally was incredibly satisfied with Jamie's healing and progress within the R*f*GL PPP groups that she did not hesitate to continue treatment despite multiple transfers of care.

During the Early phases of treatment, like Ethan, Jamie was wary of the new therapist and withdrawn. Her play was not creative, symbolic or collaborative, and she would spend the majority of her sessions with minimal direction, talking about how she and the group should 'kill the therapist.' Like Ethan, her behaviors were all interpreted as her difficulties saying goodbye to previous therapist and forming a bond with the new therapist. Throughout the Early phase of this treatment period (being studied), the therapist focused on rapport building and provided attachment-focused interventions. With time and consistency, Jamie returned back to homeostasis as she played with her peers. However, towards the end of the Early phase of treatment into the Middle phase, she began to become fussy, throwing many tantrums and withdrawing into corners of the playroom when she would not get her way.

As treatment persisted, like Ethan, Jamie saw that the therapist was safe, and could tolerate a range of her emotions while keeping her safe, and so, she began to form a bond with the therapist as well as engage in extremely creative and collaborative play with her peers, which persisted through the Middle and Before Termination stages.

During the final goodbye, like Ethan, Jamie struggled. This not only meant saying goodbye to another therapist who left her and her group, but also her ending with R*f*GL PPP groups all together, ending at the school, as well as transitioning to a whole new school. However, like the rest

of the group, she was able to utilize the strong peer relationships she built, along with creative and symbolic play to help play out her feelings about ending.

Josefina, Maria & Eduardo

Background: Josefina (ID 7) is a 5 year-old Mexican and American girl living with her mother, Maria (35 years old) and father, Eduardo (37 years old). Maria and Eduardo were Spanish-speaking only, and thus it was difficult for the English-only speaking therapist to communicate for collateral and gathering of background information. However, they were extremely compliant and reliable with 2x weekly treatment for Josefina. Josefina's parents reported that she met all developmental milestones. Though much of Josefina's early presentation may have been due to possible English as a second language, her parents reported that she did in fact speak English fluently at home.

Presenting issue & progression of treatment: Josefina was originally outreached to by one of the school's R*f*GL trainee psychotherapists when she was 4.5 years old. Like Ethan and Jamie, Josefina initially started R*f*GL groups with a trainee clinician for five months until she was transferred to the next trainee (writer) at 4.8 years old until her graduation from the daycare into kindergarten. At time of outreach, Josefina would not speak to children, teachers or other adults, suggesting that she had issues with selective mutism. As this was extremely problematic for her social and academic development, Maria and Eduardo consented to R*f*GL 2x weekly treatment for Josefina. Similarly, like Michael and Veronica, Maria and Eduardo were incredibly satisfied with Josefina's healing and progress within the R*f*GL PPP groups that she did not hesitate to continue treatment despite multiple transfers of care.

During the Early phases of treatment, Josefina was wary of the therapist and withdrawn, however less so than her peers. Though she did not speak much during the Early phases of

treatment, she played with toys, such as dolls for extensive periods of time, albeit in solitude. Josefina did not join her peers in the "kill the therapist play," however, she kept a watchful eye on them, appearing interested in joining in. Throughout the Early phase of this treatment period (being studied), the therapist focused on rapport-building and providing attachment-focused interventions. With time and consistency, Josefina returned back to homeostasis as she played with her peers, and began forming strong bond with the therapist, which persisted through the Middle and Before Termination stages.

During the final goodbye, Josefina was able to express her emotions, connecting her painful affect to not wanting to say goodbye to the therapist and group. As mentioned, this was another goodbye to yet another therapist who left her and her group and also her ending with R*f*GL PPP groups all together, ending at the school, as well as transitioning to a whole new school. Like the rest of the group, she was able to utilize the strong peer relationships she built, along with creative and symbolic play to help play out her feelings about ending.

Vanessa & Blanca

Background: Vanessa (ID 8) is a 5 year-old Black and Dominican and American girl domiciled with her grandmother, Blanca (45 years old) and mother, Shaylene (22 years old), primarily raised by her grandmother. Vanessa's early childhood was filled with multiple and complex traumas, such as abuse and neglect, all resulting in early disruptions in attachments as she was removed from her primary caretakers from the ages of 2-3.5 by ACS. After the cases were closed, and Vanessa was returned home, her grandmother, Blanca took over primary care. Though Vanessa was living with her biological mother, she was either not around or was struggling with her own issues related to untreated mental illness.

Presenting issue & progression of treatment: Vanessa was originally outreached to by one of the school's R*f*GL trainee psychotherapists when she was 4.5 years old. Like Ethan, Jamie, and Josefina, Vanessa initially started R*f*GL groups with a trainee clinician for five months until she was transferred to the next trainee (writer) at 4.8 years old until her graduation from the daycare into kindergarten. At the time of outreach, Vanessa was originally diagnosed with Oppositional Defiant Disorder, Impulse Control Disorder and PTSD. For instance, it was reported that Vanessa had recurrent (multiple times per day) temper outbursts in the classroom when she would not get her way, would give the "silent treatment" to other children, and was generally incredibly defiant in the classroom. Additionally, these behaviors were also reported in the home, especially during times of transition.

Due to Vanessa's initial presentation, Blanca eagerly and willingly consented to R*f*GL 2x weekly treatment for Vanessa, but would not agree to her own psychotherapy to adjunct Vanessa's care. Engaging in collateral work with Blanca, even monthly, was extremely difficult and near impossible, so much of the work was conducted solely with Vanessa. However, like the other children's caretakers in group 2, Blanca additionally was incredibly satisfied with Vanessa's healing and progress within the R*f*GL PPP groups that she did not hesitate to continue treatment despite multiple transfers of care.

During the Early phases of treatment, like Ethan and Jamie, Vanessa was very wary of the therapist and withdrawn. Her play was not creative, symbolic or collaborative. Though the majority of her early sessions were directionless, she readily joined in with her peers about how she and the group should "kill the therapist." Like Ethan and Jamie, her behaviors were all interpreted as her difficulties in saying goodbye to the previous therapist and forming a bond with the new therapist. Throughout the Early phase of this treatment period (being studied), the therapist focused on

rapport-building and in providing attachment-focused interventions. With time and consistency, Vanessa returned back to homeostasis as she played with her peers. However, towards the end of the Early phase of treatment into the Middle phase, she began to become fussy. Like Jamie, she began to have many tantrums, throwing toys at other children, not leaving the room when playtime was over, and creating large messes in opposition.

As treatment persisted, like Ethan and Jamie, Vanessa began to see that therapist was safe, and could tolerate a range of her emotions while keeping her safe, and so, she began to form a bond with therapist and engage in extremely creative and collaborative play with her peers, which persisted through the Middle and Before Termination stages.

During the final goodbye, like Ethan and Jamie, Vanessa deeply struggled. As mentioned, this was yet another goodbye to another therapist who left her and her group, but also her ending with R*f*GL PPP groups all together, ending at the school, as well as transitioning to a whole new school. However, like the rest of the group, she was able to utilize the strong peer relationships she built, along with creative and symbolic play to help play out her feelings about ending.

GROUP 3

Christopher & Dominique

Background: Christopher (ID 217) is a 3.5 year-old Caucasian and Dominican boy, living with his mother, Dominique (21 years old), who was unemployed throughout the duration of treatment. Christopher never met his biological father, who was imprisoned for unspecified gang-related crimes before Christopher was born. Dominique reported that Christopher met all of his developmental milestones and did not have a family history of mental illness.

Presenting issue & progression of treatment: The school's R*f*GL psychotherapist outreached to Christopher as he had extreme difficulties separating from his mother during school

drop-off in the mornings. For instance, Christopher suffered from extensive crying spells, where he would retreat into the corner alone, refusing all soothing from teachers. Christopher would often not allow his mother to leave during drop-off, and thus Dominique was eager to consent to R*f*GL psychotherapy 2x weekly for Christopher. Though she also agreed to weekly collateral sessions with the same therapist to adjunct Christopher's care, she only showed up to four sessions throughout the duration of Christopher's treatment.

In the beginning of Christopher's treatment, he was extremely withdrawn, appearing as though he did not know how to play. Engaging with peers minimally, sitting in corners without playing marked his therapy sessions during the Early and Middle phases, and thus the therapist was extremely active in modeling play, encouraging creation, imagination and collaboration – all while following Christopher's lead.

As treatment progressed, he began to blossom, connecting with peers and the therapist. For instance, during the Before Termination stage, he initiated attachment-focused games, where him and his peers rode on a bus and said goodbye to their "mommies" (the therapist), playing out the inevitable separations and reunions of being a preschooler.

During the final goodbye, Christopher was able to utilize peer support and emotional identification in order to deal with painful emotions of saying goodbye. This all being said, as to be expected, he began to regress towards the ending, and required the therapist to help with tasks previously mastered. This was interpreted as his way of needing more care from therapist during painful emotional times.

Mason & Lola

Background: Mason (ID 216) is a 3.5 year-old Puerto Rican boy, living with his mother Lola, (28 years old) and father, Juan (33 years old). Lola reported that her and Mason had numerous, often undiagnosed, and unexplainable medical conditions. For instance, Mason had frequent stomach aches, possible Crohn's Disease and/or irritable bowel syndrome, along with allergies to all foods prepared by the school. Additionally, Lola reported her own medical conditions, including unexplainable weekly fevers, similar allergies to Mason, and frequent neck pains, requiring her to wear a neck brace a few times a month. Unlike Lola, Juan, (Mason's father), was not often involved with teachers or therapists at school for Mason. He often appeared as though he wanted to avoid talking with teachers and therapists, as he would sneak in and out of the school quietly during drop-off and pick-up hours.

Presenting issue & progression of treatment: Mason was outreached to by the school's R*f*GL psychotherapist as Mason appeared extremely anxious, with many somatic symptoms, such as frequent stomach aches and not playing with children, only adults. Though he reported frequent and intense stomachaches, these symptoms only occurred after separations. During separations however, he did not show his upset, and in fact appeared un-feathered as though he was trying to shield his mother from his feelings. Though Lola did not appear concerned about Mason's presentation, she willingly consented to R*f*GL psychotherapy 2x weekly. Additionally, she agreed to weekly collateral sessions with the same therapist to adjunct Mason's care, however she was often out sick, and thus, many collateral, (but not group) therapy sessions were conducted over the telephone.

In the beginning of Mason's treatment, he was extremely withdrawn, appearing as though he did not know how to play. Like, Christopher, he engaged with peers minimally. Thus, the therapist

was extremely active in modeling play, encouraging creation, imagination and collaboration – all while following Mason's lead.

As treatment progressed, like Christopher, Mason opened up, and his potential began to become extremely apparent. He joined in on collaborative games, such as Christopher's bus game, elaborating on stories and the pretend play of the group.

Mason had a difficult time saying goodbye. He tested the therapist's boundaries and limits, creating large messes in room during goodbye sessions and tearing up the group's count-down calendar. This all being said, he was able to utilize what he learned throughout group, such as identifying and expressing his emotions. He also began to join with other group members and utilize peer support.

Jimena, Rosa & Blanca

Background: Jimena (ID 11) is a 3.5 year-old Dominican and American girl domiciled with her mother, Rosa (21 years-old), and her great aunt, Blanca (45 years-old), who was also Vanessa's (from group 2) grandmother. Rosa worked in fashion and was often not present at school, and thus Jimena was dropped off and picked up by Blanca. As Blanca was reluctant to join collateral session and Rosa was not present at school, the therapist was unable to consistently communicate with either of Jimena's caretakers. However, during intake, Rosa reported that Jimena met most developmental milestones, except speech, as she did not begin to speak until approximately 3.5 years of age. She displayed significant speech impediments throughout the duration of treatment, especially towards the beginning.

Presenting issue & progression of treatment: The school's R*f*GL psychotherapist outreached to Jimena as she appeared extremely shy, hesitant to play with other children, and exhibiting difficulties with speech. Though Rosa did not appear concerned about Jimena's

presentation, she willingly consented to R*f*GL psychotherapy 2x weekly, but was unable to attend weekly collateral sessions with the same therapist to adjunct Jimena's care due to her work schedule.

In the beginning of Jimena's treatment, like the other members, she was extremely withdrawn, appearing as though she did not know how to play. Like her peers, she engaged with others in the group minimally. Thus, the therapist was extremely active in modeling play, encouraging creation, imagination and collaboration – all while following Jimena's lead.

Like the other children in groups 1 and 2, Jimena had a difficult time saying goodbye. For instance, she tested therapist's boundaries and limits with Mason, creating large messes in room during goodbye sessions, tearing up the group's count-down calendar. This all being said, like Mason, she was able to utilize what she learned throughout group, such as identifying and expressing her emotions. She also began to join with other group members and utilize peer support.

Results

Rather than reporting measures of central tendency, a focus is placed on observations of individual scores and behaviors of each child. Graphs have been created for each child through the use of a charting tool (MATLAB), a program that allows for plotting of functions and data. Graphs are organized per each scale on the CIB scale by treatment phase (Early; Middle; Before Termination; and Ending), grouped by treatment phase, and the line of best fit was found and plotted across time.

Graphs of R*f*GL PPP children and descriptions of CIB Preschool Years Scales[1]

POSITIVE (EXTERNALIZING) SCALES

Object Oriented Play:

To what extent is the play focused on objects/toys.

GROUP 1 GROUP 2 GROUP 3

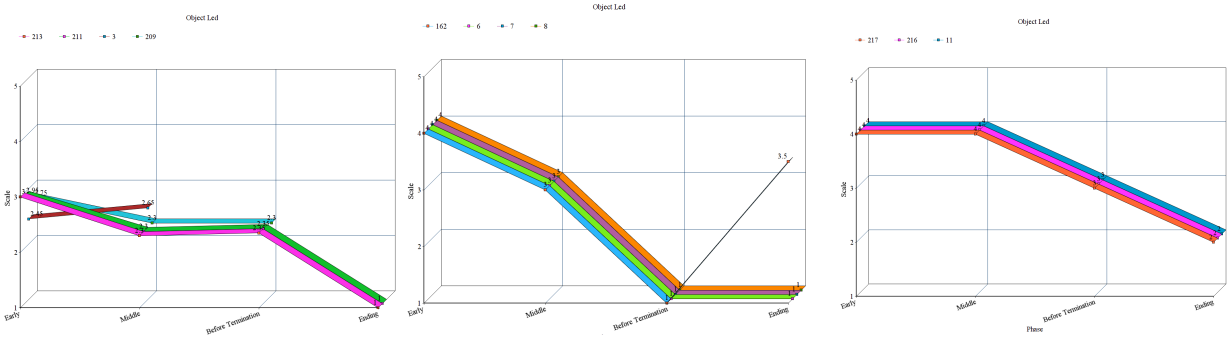

Table 1.0 Object Oriented Play

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.0	2.3	2.35	1.0
211	2.95	2.3	2.35	1.0
3	2.45	2.65	-	-
209	2.75	2.3	2.30	-
Group 2:				
162	4.0	3.0	1.0	3.5
6	4.0	3.0	1.0	1.0
7	4.0	3.0	1.0	1.0
8	4.0	3.0	1.0	1.0
Group 3:				
217	4.0	4.0	3.0	2.0
216	4.0	4.0	3.0	2.0
11	4.0	4.0	3.0	2.0

Group 1 *(Object Oriented Play):* Three out of the four children's scores decreased steadily overtime in regards to their focus on objects and toys during play, reaching a level 1 at the Ending phase, whereas one child was trending upwards until he removed from treatment.

Group 2 *(Object Oriented Play):* All children began at a high level (4) in the beginning of treatment in regards to their focus on objects and toys during play, trending downwards towards a level 1 towards the Before Termination and Ending phases. On the other hand, one child who was

[1] *Parent is changed to therapist throughout the CIB coding scheme

following the same trajectory as the other children peaked back up to a level 3.5 at the Ending phase of treatment.

Group 3 *(Object Oriented Play):* All three children followed the same trajectories at the same levels throughout treatment, as they went downwards from a level 4 to a level 2 between the Early and Ending phases of treatment in regards to their focus on objects and toys during play.

Social Oriented Play:

To what extent is the play socially focused

GROUP 1 GROUP 2 GROUP 3

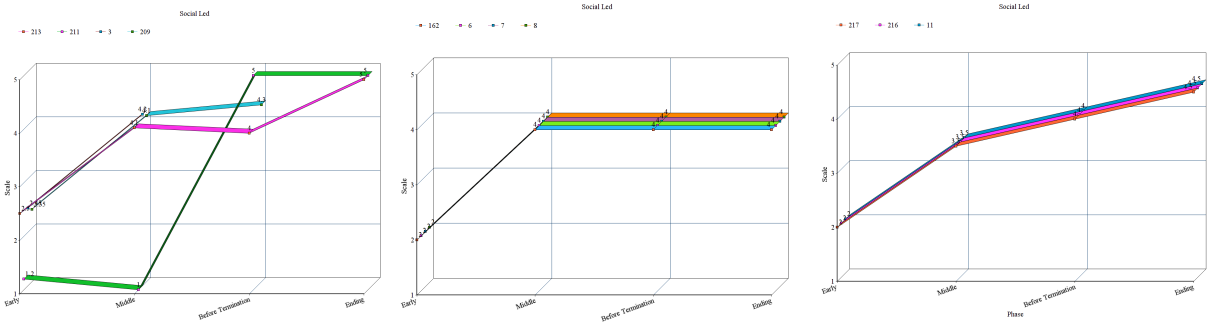

Table 1.1 Social Oriented Play:

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	2.5	4.1	4.0	5.0
211	1.2	1.0	5.0	5.0
3	2.45	4.2	-	-
209	2.35	4.1	4.3	-
Group 2:				
162	2.0	4.0	4.0	4.0
6	2.0	4.0	4.0	4.0
7	2.0	4.0	4.0	4.0
8	2.0	4.0	4.0	4.0
Group 3:				
217	2.0	3.5	4.0	4.5
216	2.0	3.5	4.0	4.5
11	2.0	3.5	4.0	4.5

Group 1 *(Social Oriented Play):* All children within group 1 trended upwards in regards to their focus on social interactions, going from levels ranging from 1.2-2.5 in the Early phase to levels 4.0-5.0 at the Ending phase.

Group 2 *(Social Oriented Play):* All children within group 2 trended upwards in regards to their focus on social interactions, going from levels 2.0-4.0 from the Early phase of treatment to the Ending phase.

Group 3 *(Social Oriented Play):* All children within group 3 trended upwards in regards to their focus on social interactions, going from levels 2.0-4.5 from the Early phase of treatment to the Ending phase.

Child Gaze/Joint Attention:

The child's gaze is consistently focused on the therapist or their joint play.

GROUP 1 GROUP 2 GROUP 3

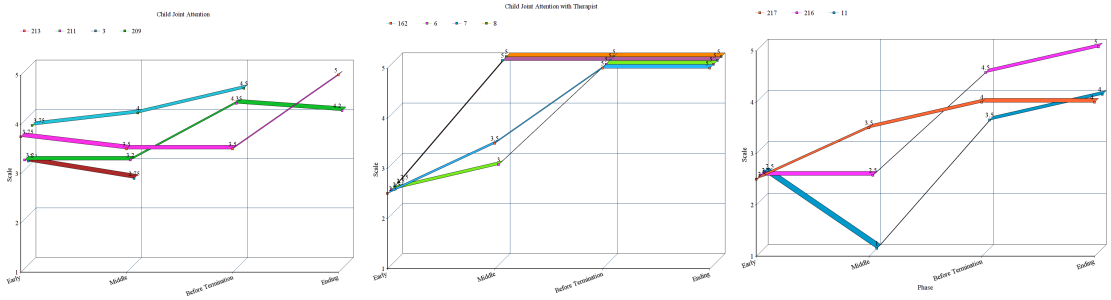

Table 1.3 Child Gaze/Joint Attention

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.75	3.5	3.5	5
211	3.2	3.2	4.35	4.2
3	3.1	2.75	-	-
209	3.75	4.0	4.5	-
Group 2:				
162	2.5	3.5	5.0	5.0
6	2.5	3.0	5.0	5.0
7	2.5	5.0	5.0	5.0
8	2.5	5.0	5.0	5.0
Group 3:				
217	2.5	3.5	4.0	4.0
216	2.5	2.5	4.5	5.0
11	2.5	1.0	3.5	4.0

Group 1 *(Child Gaze/Joint Attention):* The children displayed slightly different patterns in regards to their focus on therapist and/or joint play; however, three out of the four children trended upwards, ending with higher levels than they began with. Two children hit their peaks at the Before Termination phase, whereas one child hit their peak at the Ending phase of treatment.

Group 2 *(Child Gaze/Joint Attention):* All four children in group 2 trended upwards, hitting their largest inclines at the Middle phase and all synchronized at the highest level (5) between the Before Termination and Ending phases of treatment in regards to their focus on therapist and/or joint play.

Group 3 *(Child Gaze/Joint Attention):* The children displayed slightly different patterns, however, all children trended upwards in regards to their focus on therapist and/or joint play, ending with higher levels than they began with, increasing most rapidly between the Middle and Before Termination phases of treatment.

Child Positive Affect:

Child affect is positive. Child laughs, smiles, uses verbalizations, engages in creative/symbolic play, and appears relaxed and secure.

GROUP 1 GROUP 2 GROUP 3

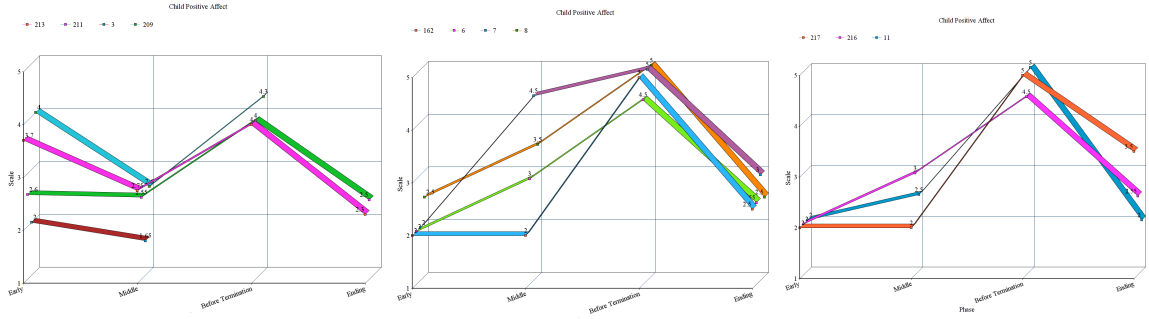

Table 1.4 Child Positive Affect:

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.7	2.75	4	2.3
211	2.6	2.55	4	2.5
3	2	1.65	-	-
209	4	2.6	4.3	-
Group 2:				
162	2.0	2.0	5.0	2.5
6	2.0	3.0	4.5	2.55
7	2.0	4.5	5.0	3.0
8	2.5	3.5	5.0	2.5
Group 3:				
217	2.0	2.0	5.0	3.5
216	2.0	3.0	4.5	2.55
11	2.0	2.5	5.0	2.0

Group 1 *(Child Positive Affect):* Three out of the four children ended up with lower scores in the Ending phase of treatment as compared to the Early phase in regards to displaying positive affect. Three out of the four children hit their highest levels at the Before Termination phase.

Group 2 *(Child Positive Affect):* The children within group 2 all ended up with slightly higher scores or the same scores from the Early phase to the Ending phase of treatment, and all reaching their highest points of displaying positive affect at the Before Termination phase.

Group 3 *(Child Positive Affect)*: The children within group 3 all ended up with higher scores or the same scores from the Early phase to the Ending phase of treatment, and all reaching their highest points of displaying positive affect at the Before Termination phase.

Child Affection to Therapist:

Unlike the Child Positive Affect scale, this scale does not relate to affect in general but to the specific affective expressions of the child toward the therapist. Affection to therapist may be expressed in the child's touch of therapist (child caressing therapist, leaning on therapist, kissing therapist), affection words, smiles, or proximity seeking.

GROUP 1 GROUP 2 GROUP 3

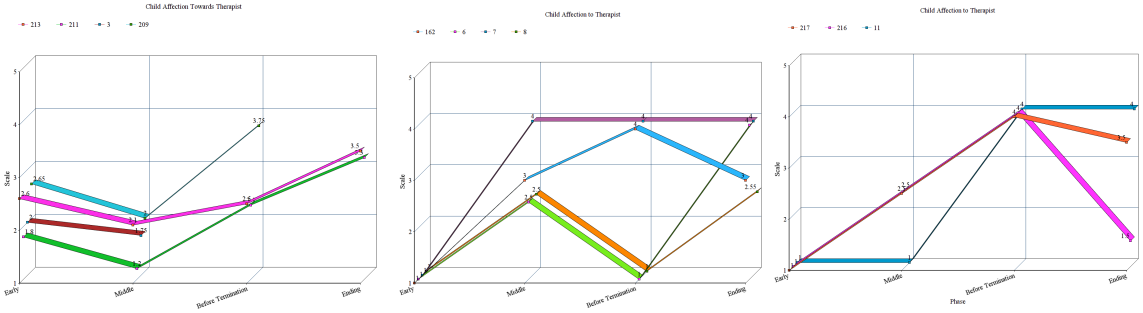

Table 1.5 Child Affection to Therapist

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	2.6	2.1	2.5	3.5
211	1.8	1.2	2.4	3.3
3	2	1.75	-	-
209	2.65	2.0	3.75	-
Group 2:				
162	1.0	3.0	4.0	3.0
6	1.0	2.5	1.0	4.0
7	1.0	4.0	4.0	4.0
8	1.0	2.5	1.0	2.55
Group 3:				
217	1.0	2.5	4.0	3.5
216	1.0	2.5	4.0	1.5
11	1.0	1.0	4.0	4.0

Group 1 *(Child Affection Towards Therapist)*: Three out of the four children ended up with higher levels of displaying affection towards the therapist at the Ending phase of treatment compared to the Early phase and hit their lowest points at the Middle phase of treatment.

Group 2 *(Child Affection Towards Therapist)*: The children of group 2 all varied in scores, however mostly trended upwards, reaching their highest points of displaying affection towards the therapist at the Before Termination and Ending phases of treatment.

Group 3 *(Child Affection Towards Therapist):* Within group 3, children's scores varied in trajectories, however all ended up with higher scores of displaying affection towards the therapist from the Early phase to the Ending Phase, and hit their highest points at the Before Termination phase, making their biggest gains between the Middle and Before Termination phases.

Child Alert:

Child is enthusiastic, attending, involved, and demonstrates high levels of positive arousal and activity. We may observe alert facial expressions, focused gaze, smiles, clear signs of joy and exuberance, energy, and "ready" posture, or in verbalizations, laughter and imaginary play. This scale estimates the highest level of alertness the child reached during the observation, not the average of the entire session.

GROUP 1 GROUP 2 GROUP 3

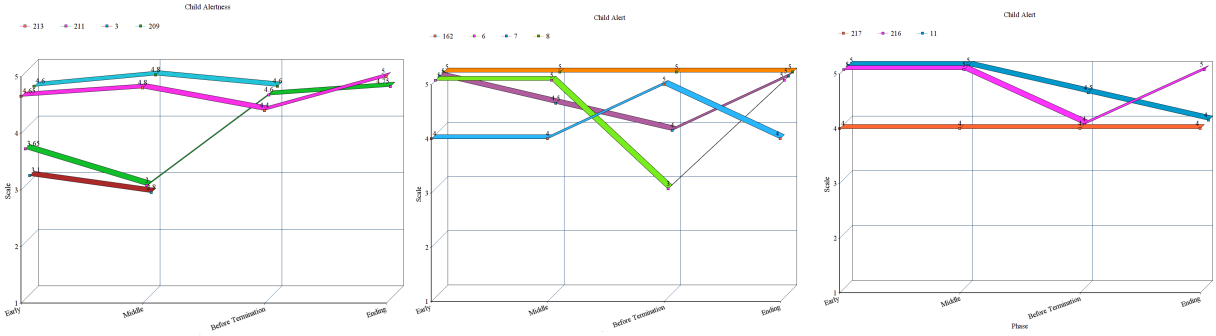

Table 1.6 Child Alert

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	4.65	4.8	4.4	5
211	3.65	3	4.6	4.75
3	3.1	2.8	-	-
209	4.6	4.8	4.6	-
Group 2:				
162	4.0	4.0	5.0	4.0
6	5.0	5.0	3.0	5.0
7	5.0	4.5	4.0	5.0
8	5.0	5.0	5.0	5.0
Group 3:				
217	4.0	4.0	4.0	4.0
216	5.0	5.0	4.0	5.0
11	5.0	5.0	4.5	4.0

Group 1 (Child Alert): Within group 1, three out of four children ended up at higher scores of alertness at the Ending phase of treatment compared to the Early phase.

Group 2 (Child Alert): Most children within group 2 remained above a level 4 of alertness throughout, however one child reached a level 3 at the Before Termination phase of treatment.

Group 3 (Child Alert): All children within group 3 remained above a level 4 of alertness throughout treatment.

Child Verbal:

Child vocalized; especially socially directed speech. Child communicates frequently. Vocalizations or speech may be directed toward the therapist, the toys, or him/herself. The goal of the child's verbalization is social: to communicate, connect and play jointly with the therapist (while the child is speaking, he/she also gazed towards the therapist or toward an object of join attention). This includes laughter. Note: Code positive vocalizations only. Screaming, yelling, or murmuring are not considered here but are incorporated in the negative/labile affect scales.

GROUP 1 GROUP 2 GROUP 3

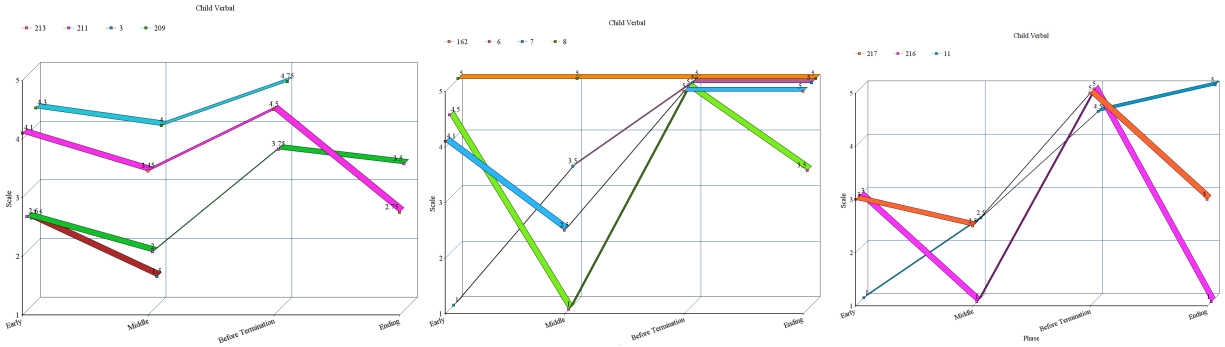

Table 1.7 Child Verbal

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	4.1	3.45	4.5	2.75
211	2.6	2.0	3.75	3.5
3	2.5	1.5	-	-
209	4.3	4.0	4.75	-
Group 2:				
162	4.1	2.5	5.0	5.0
6	4.5	1.0	5.0	3.5
7	1.0	3.5	5.0	5.0
8	5.0	5.0	5.0	5.0
Group 3:				
217	3.0	2.5	5.0	3.0
216	3.0	1.0	5.0	1.0
11	1.0	2.5	4.5	5.0

Group 1 *(Child Verbal)*: The children followed similar trends of displaying their positive verbal skills, at different point levels throughout, mostly all hitting their lowest points during the Middle and Ending phases of treatment and highest points at the Before Termination phase.

Group 2 *(Child Verbal)*: Two children followed similar trajectories at different levels displaying their positive verbal skills, whereas the other children varied. Two children reached their

lowest points at the Middle phase of treatment, whereas one child began at a level 1 and then quickly caught up to the rest between the Early phase and Middle phase of treatment.

Group 3 *(Child Verbal)*: Within group 3, children's scores varied in regards to display of positive verbal skills, where two children hit their lowest points during the Middle and Ending phases of treatment and reached their highest point during the Before Termination phase, whereas one child started at the lowest point (1) and then quickly caught up to the rest between the Early phase and Middle phase of treatment.

Child Initiation:

Child initiates mutual activities and expects the therapist to follow his/her lead. Initiation can be verbal or non-verbal. The child may verbalize his/her wishes, try and capture the therapist's attention, or move towards the therapist. The child initiates the social interaction with the therapist, and the therapist follows the child's lead (with or without toy). When the child reacts to a toy (that the therapist may present) and manipulates it, continues to explore what has been given – code higher on initiation.

GROUP 1 GROUP 2 GROUP 3

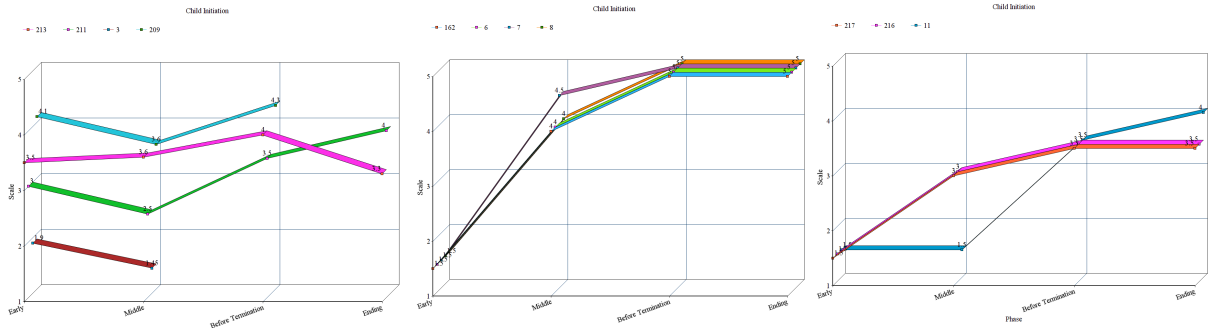

Table 1.8 Child Initiation

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.5	3.6	4	3.3
211	3	2.5	3.5	4
3	1.9	1.45	-	-
209	4.1	3.6	4.3	-
Group 2:				
162	1.5	4.0	5.0	5.0
6	1.5	4.0	5.0	5.0
7	1.5	4.5	5.0	5.0
8	1.5	4.0	5.0	5.0
Group 3:				
217	1.5	3.0	3.5	3.5
216	1.5	3.0	3.5	3.5
11	1.5	1.5	3.5	4.0

Group 1 *(Child Initiation):* Three of the children followed similar trends at different levels throughout the treatment phases in regards to initiation mutual activities during play, reaching their highest points at the Before Termination phase of treatment, and three out of the four children reached their lowest points at the Middle phase.

Group 2 *(Child Initiation):* All children's scores all trended upwards at similar points in regards to initiation mutual activities during play, making their biggest gains between the Early and Middle phases of treatment, and all synchronized at the Before Termination through the Ending phases of treatment.

Group 3 *(Child Initiation):* All children's scores increased overtime in regards to initiation mutual activities during play, where two children followed the same trajectories at the same levels throughout, and the other child caught up to the other children between the Middle and Before Termination phase.

Compliance to Therapist:

Child is cooperative with therapist and complies readily with the therapist's requests and suggestions (do's) or prohibitions (don'ts). Note: Emde's work on the "do's" and "don'ts" of early moral development (1991) and Kochanska's extensive research is applicable in this context.

GROUP 1 GROUP 2 GROUP 3

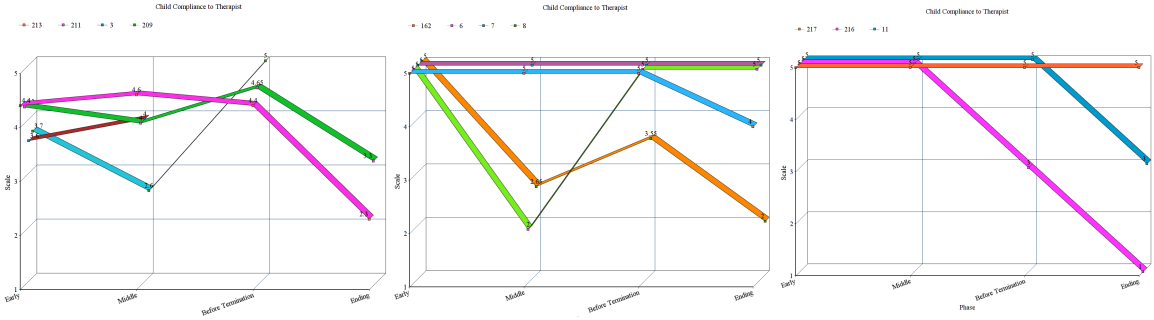

Table 1.9 Compliance to Therapist

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	4.4	4.6	4.4	2.3
211	4.3	3.9	4.65	3.3
3	3.6	4	-	-
209	3.7	2.6	5	-
Group 2:				
162	5.0	5.0	5.0	4.0
6	5.0	2.0	5.0	5.0
7	5.0	5.0	5.0	5.0
8	5.0	2.65	3.55	2.0
Group 3:				
217	5.0	5.0	5.0	5.0
216	5.0	5.0	3.0	1.0
11	5.0	5.0	5.0	3.0

Group 1 *(Child Compliance to Therapist):* The children's levels of complying with the therapist varied throughout the year, however, were mostly synchronized during the Before Termination phase and went down after the Before Termination phase until the Ending phase, reaching the lowest relative points.

Group 2 *(Child Compliance to Therapist):* In the Early phase of treatment, all children within group 2 started at the highest level of complying with the therapist, whereas two remained at a level 5 until the Ending phase and the other two decreased rapidly at the Middle phase. Two out of four children then remained at high levels (5), whereas two decreased at the Ending phase and reached their lowest points.

Group 3 *(Child Compliance to Therapist):* All children began at a high level of compliance with the therapist through the Early and Middle phases of treatment, where one remained throughout and the two others decreased rapidly, reaching their lowest points between the Middle and Ending phases of treatment.

Vignette: Testing Limits & Individuation

Within group 2, during the Ending Phase, the therapist picked up the children from the classroom. Abruptly, Vanessa and Jamie ran as fast as they could to the therapy playroom in the opposite direction. The therapist swiftly sprinted behind them, gripping Josefina and Ethan by the hand. All of a sudden, Vanessa and Jamie locked the therapy room door behind them as a testament to their ability to individuate, to 'shut out' the therapist, to convey anger and sadness about another therapist 'leaving them.' These behaviors ultimately drove down the Compliance to Therapist scores.

Reliance on Therapist for Help:

High scores on this scale implies that the child seeks therapeutic assistance to complete any task or achieve any goal that can been achieved independently (for instance, getting a block to build). High reliance on therapist often occurs when child shows litter self-assuredness, confidence, or initiation.

GROUP 1 GROUP 2 GROUP 3

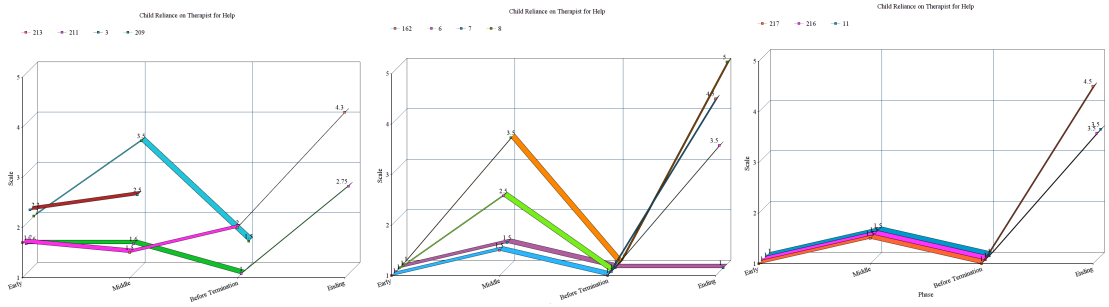

Table 2.0 Reliance on Therapist for Help

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.7	1.5	2	4.3
211	1.6	1.6	1	2.75
3	2.2	2.5	-	-
209	2	3.5	1.5	-
Group 2:				
162	1.0	1.5	1.0	4.5
6	1.0	2.5	1.0	3.5
7	1.0	1.5	1.0	1.0
8	1.0	3.5	1.0	5.0
Group 3:				
217	1.0	1.5	1.0	4.5
216	1.0	1.5	1.0	3.5
11	1.0	1.5	1.0	3.5

Group 1 *(Child Reliance on Therapist):* The children of group 1 mostly all had similar trajectories at different levels, following a bimodal trend in regards to relying on therapist for help. The children generally reached their highest points at the Middle and Ending phases of treatments, and the lowest points at the Early and Before Termination phase.

Group 2 *(Child Reliance on Therapist):* Three out of four children followed a similar bimodal trajectory, at different levels in regards to relying on therapist for help, reaching their relatively highest points in the Middle and Ending phases of treatment, and whereas one child remained at a level 1 throughout the entire treatment.

Group 3 *(Child Reliance on Therapist):* All children followed a similar bimodal trajectory, at different levels in regards to relying on therapist for help, reaching their relatively highest points in the Middle and Ending phases of treatment.

Vignette – Goodbyes require help

During the last ending session of group 1, the therapist wrote goodbye letters to each of the children. As the letters were read out loud, Destiny's face turned red, and her eyes welled up with tears. While reading Daniel's letter, Destiny quickly stomped over to therapist and ripped the letter out of her hands, tearing Daniel's goodbye letter into pieces. Daniel immediately began to cry and throw toys at Destiny. The therapist quickly limit-set for safety, validated, and helped to scaffold the children's affect and emotions. Then, the children regressed and pretended to be infants, requiring direct help from the therapist with things like tying shoes, drinking water, and acquiring toys. This ultimately drove up the scores on the Reliance on Therapist for Help.

On-Task/Persistence:

Child persists in one activity until completed and does not skip from one activity to the next. During interaction that involves problem solving or structured tasks, child maintains attention to the task until completed. Child plays with persistence and diligence. Important: the degree or persistence in one task or game increases with age and marked development in persistence is observed from 3 to 6 years. It is important to code this scale in relation to the child's developmental stage.

GROUP 1 GROUP 2 GROUP 3

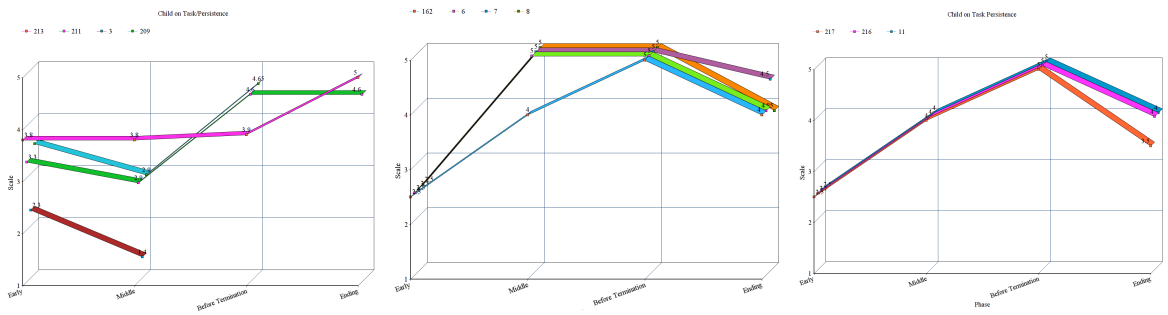

Table 2.1 On-Task/Persistence

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.8	3.8	3.9	5
211	3.3	2.9	4.6	4.6
3	2.3	1.4	-	-
209	3.5	2.9	4.65	-
Group 2:				
162	2.5	4.0	5.0	4.0
6	2.5	5.0	5.0	4.0
7	2.5	5.0	5.0	4.5
8	2.5	5.0	5.0	3.85
Group 3:				
217	2.5	4.0	5.0	3.5
216	2.5	4.0	5.0	4.0
11	2.5	4.0	5.0	4.0

Group 1 *(Child on Task/Persistence):* The children all trended upwards in regards to persisting with one activity, ending with higher scores from the Early to Ending phases of treatment.

Group 2 *(Child on Task/Persistence):* The children all followed similar trajectories at nearly the same levels throughout in regards to persisting with one activity, ending with higher scores from the Early to Ending phases of treatment, and having higher levels during the Middle and Before Termination phases of treatment.

Group 3 *(Child on Task/Persistence):* The children all followed similar trajectories at nearly the same levels throughout in regards to persisting with one activity, ending with higher scores from

the Early to Ending phases of treatment, and reaching their highest levels at the Before Termination phase of treatment.

Competent Use of Environment:

Child is using toys or other objects in the environment in a curious, creative, exploratory, masterful, motivated, and competent fashion. Child shows age-appropriate levels of mastery, motivation, exploration, and coordination.

GROUP 1 GROUP 2 GROUP 3

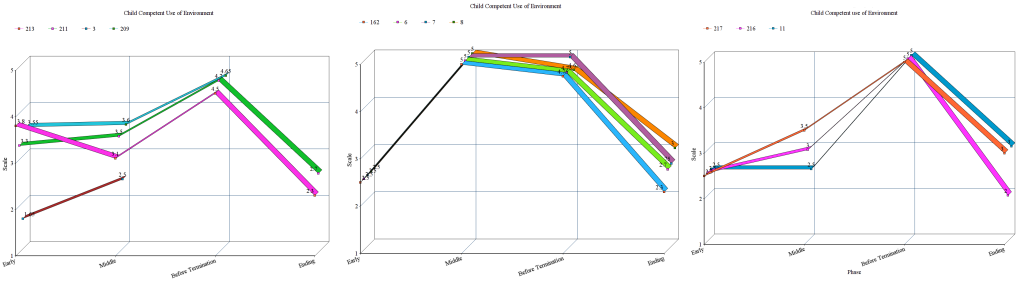

Table 2.2 Competent Use of Environment

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.8	3.1	4.5	2.3
211	3.3	3.5	4.7	2.7
3	1.65	2.5	-	-
209	3.55	3.6	4.65	-
Group 2:				
162	2.5	5.0	4.75	2.3
6	2.5	5.0	4.75	2.7
7	2.5	5.0	5.0	2.75
8	2.5	5.0	4.65	3.0
Group 3:				
217	2.5	3.5	5.0	3.0
216	2.5	3.0	5.0	2.0
11	2.5	2.5	5.0	3.0

Group 1 *(Child Competent Use of Environment):* Three out of the four children followed a similar trajectory and slope in regards to competently using their play environment, scoring highest Before Termination. Between the Before Termination phase and the Ending phase of treatment, the remaining children hit a downward slope, reaching their lowest points.

Group 2 *(Child Competent Use of Environment):* All children followed similar trajectories at slightly different levels throughout in regards to competently using their play environment. The children all had their lowest points at the Early and Ending phases of treatment and their highest levels at the Middle and Before Termination phases.

Group 3 *(Child Competent Use of Environment):* All of the children's scores of using their play environments competently decreased from beginning to end and reached their highest levels at the Before Termination phase.

Child Symbolic Play:

This scale addresses the level of creativity, imagination, and symbolization in the child's play. Symbolic play refers to using objects (dolls, toys) to represent mental stages, "images," or feelings. Its main aspect is the recreation of the child's inner thoughts, emotions, and desires though the use of the environment in creative, individual ways. The score indicates the level of complexity, coherence, amount, and combination of symbolic elements in the child's output. Both the complexity and frequency of the child's symbolization are considered. At the preschool age, children should be involved in complex symbolic acts when present in a free play session with toys. Consider the flexibility and range of topics, child's language, ability to shift between roles, and complexity of imagination. Note: A range of psychoanalytic (e.g., Winnicot) and developmental (e.g. Piaget) have written on symbolic play. Pay attention to both the cognitive/developmental level and the richness of the affective expression.

GROUP 1 GROUP 2 GROUP 3

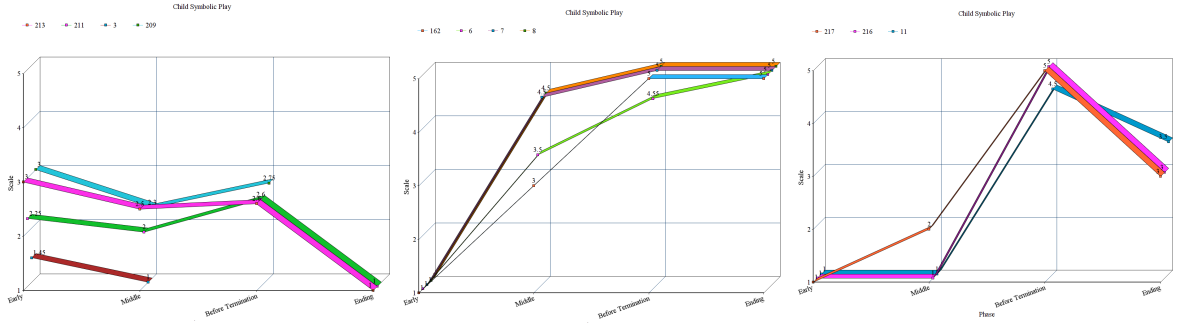

Table 2.3 Child Symbolic Play

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	3.0	2.5	2.6	1.0
211	2.25	2.0	2.6	1.0
3	1.45	1	-	-
209	3.0	2.3	2.75	-
Group 2:				
162	1.0	3.0	5.0	5.0
6	1.0	3.5	4.55	5.0
7	1.0	4.5	4.5	5.0
8	1.0	4.5	5.0	5.0
Group 3:				
217	1.0	2.0	5.0	3.0
216	1.0	1.0	5.0	3.0
11	1.0	1.0	4.5	3.5

Group 1 *(Child Symbolic Play):* The children followed similar trajectories at different levels of displaying symbolic play, ending at lower points than at the beginning, however all increased from the Middle to Before Termination phases.

Group 2 (Child Symbolic Play): All children followed the same trajectories at similar levels of displaying symbolic play throughout, trending upwards from a very low level (1) to a high (5) from the Early to Ending phases of treatment.

Group 3 *(Child Symbolic Play):* All children followed the same trajectories at similar levels throughout of displaying symbolic play, ending at a higher level than at the beginning, all trending upwards from a very low level (1) to a high (5) from the Early to Before Termination phases of treatment, with a dip at the Ending phase.

NEGATIVE (EXTERNALIZING) SCALES

Child Negative Emotionality/Fussy:

Child expresses clear signs of negative affect: crying, fussing, angry expressions, or angry words and rejection toward the therapist.

GROUP 1 GROUP 2 GROUP 3

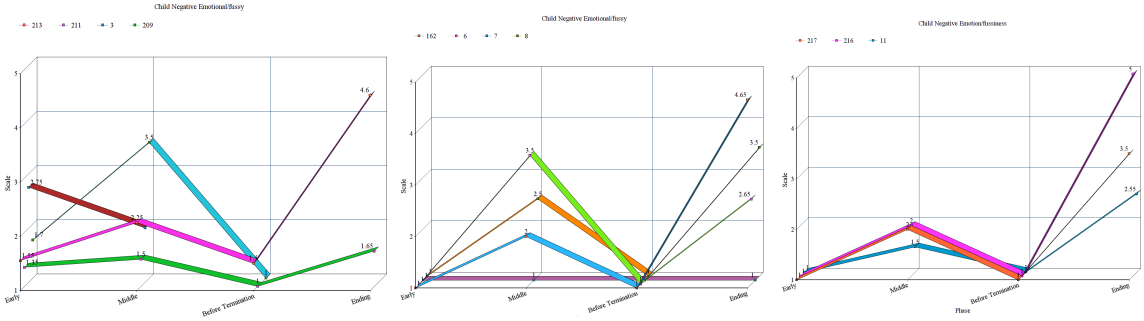

Table 2.4 Child Negative Emotionality/Fussy

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.55	2.25	1.50	4.6
211	1.35	1.5	1	1.65
3	2.75	2	-	-
209	1.7	3.5	1	-
Group 2:				
162	1.0	2.0	1.0	4.65
6	1.0	3.5	1.0	2.65
7	1.0	1.0	1.0	1.0
8	1.0	2.5	1.0	3.5
Group 3:				
217	1.0	2.0	1.0	3.5
216	1.0	2.0	1.0	5.0
11	1.0	1.5	1.0	2.55

Group 1 *(Child Negative Emotional/fussy):* Three out of the four children followed similar trends of displaying negative emotions and fussiness, at different levels, having bimodal peaks at the Middle and Ending phases, and reaching lowest points at the Before Termination phase.

Group 2 *(Child Negative Emotional/fussy):* Three out of the four children followed similar trends displaying negative emotions and fussiness, at different point levels, having bimodal peaks at the Middle and Ending phases of treatment, and reaching lowest points at the Early and Before Termination phases. One child scored at a low level 1 throughout.

Group 3 *(Child Negative Emotional/fussy):* All children followed similar trends displaying negative emotions and fussiness, at different point levels, having bimodal peaks at the Middle and Ending phases of treatment, and reaching lowest points at the Early and Before Termination phases.

Child Labile Affect:

Child affect is labile and quick shifts in mood and emotional expression are observed. Child shifts from engagement to disengagement or from negative to positive emotionality with no obvious reason and not in response to situational events. It is possible that you may detect the reason for the child's shift in mood, but the child's reaction is disproportionate to the event. For instance, child is playing with a puzzle and is successful and happy but upon the smallest difficulty, the child throws the game, gets angry, cries, or disintegrates. Lability of affect may also be related to momentary failures in the therapist's empathic stance.

GROUP 1 GROUP 2 GROUP 3

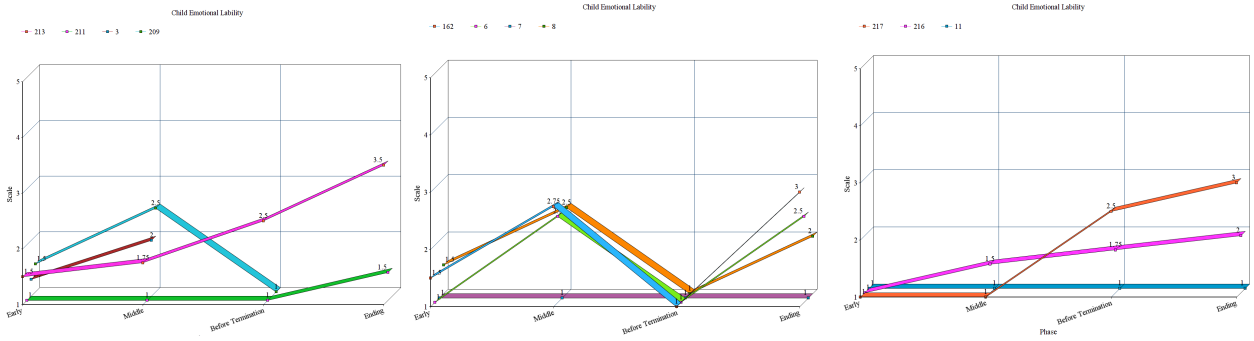

Table 2.5 Child Labile Affect

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.5	1.75	2.5	3.5
211	1	1	1	1.5
3	1.3	2	-	-
209	1.5	2.5	1	-
Group 2:				
162	1.5	2.75	1.0	3.0
6	1.0	2.5	1.0	2.5
7	1.0	1.0	1.0	1.0
8	1.5	2.5	1.0	2.0
Group 3:				
217	1.0	1.0	2.5	3.0
216	1.0	1.5	1.75	2.0
11	1.0	1.0	1.0	1.0

Group 1 *(Child Emotional Lability):* The children's scores of emotional lability varied at different trajectories throughout, however mostly were low in the Early and Before Termination phases and higher at the Middle and Ending phases.

Group 2 *(Child Emotional Lability):* Three out of the four children followed similar trends, at different point levels, having bimodal peaks of emotional lability at the Middle and Ending

phases of treatment, and reaching lowest points at the Early and Before Termination phases. One child scored at a low level 1 throughout.

Group 3 *(Child Emotional Lability):* Two children trended upwards in regards to emotional lability throughout treatment, whereas one child scored at a low level 1 throughout.

Simultaneous Display of Contradictory Behaviors:

Child displays simultaneous contradictory behaviors toward the therapist. The child's actions, vocalizations, and/or body language are contradictory. These behaviors are in reaction to the therapist, and are directly linked to the child's efforts to maintain a connection to the caregiver. Contradictory behaviors can either be observed in the same modality (e.g. contradictory tone of voice; yelling "no" to the caregiver, while continuing the same sentence in a gentle tone of voice), or in different modalities. (e.g. vocalizations that are contradictory with body language; child saying "yes mommy", while shaking their head "no".). Note: Mary Main's (1986) work on the disorganized/disoriented attachment classification is applicable in this context.

GROUP 1 GROUP 2 GROUP 3

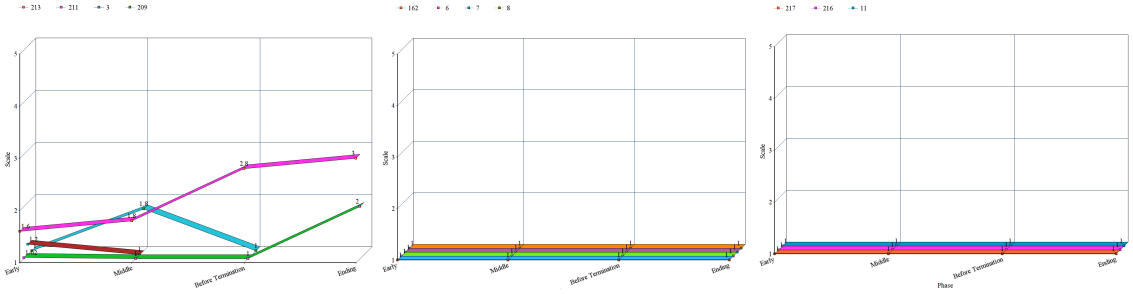

Table 2.6 Simultanious Display of Contradictory Behaviors

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.6	1.8	2.8	3
211	1.02	1	1	2
3	1.2	1	-	-
209	1	1.8	1	-
Group 2:				
162	1.0	1.0	1.0	1.0
6	1.0	1.0	1.0	1.0
7	1.0	1.0	1.0	1.0
8	1.0	1.0	1.0	1.0
Group 3:				
217	1.0	1.0	1.0	1.0
216	1.0	1.0	1.0	1.0
11	1.0	1.0	1.0	1.0

Group 1 *(Child Contradictory Behavior):* No children scored above a level 3 in regards to display of contradictory behaviors throughout. Two out of the four children displayed increases over the course of treatment, whereas one child peaked at the Middle phase of treatment.

Group 2 *(Child Contradictory Behavior):* No children within group 2 scored on the Contradictory Behavior scale at any point.

Group 3 *(Child Contradictory Behavior):* No children within group 3 scored on the Contradictory Behavior scale at any point.

NEGATIVE (INTERNALIZING) SCALES

Child Withdrawal:

Child withdraws from the interaction, appears detached from the environment. Child is uninvolved in the joint activity, does not initiate, and does not respond to the therapist's bids. Affect is typically flat and the child looks "closed up." Note: children may be involved in repetitive play (non-symbolic) and remain withdrawn.

GROUP 1 GROUP 2 GROUP 3

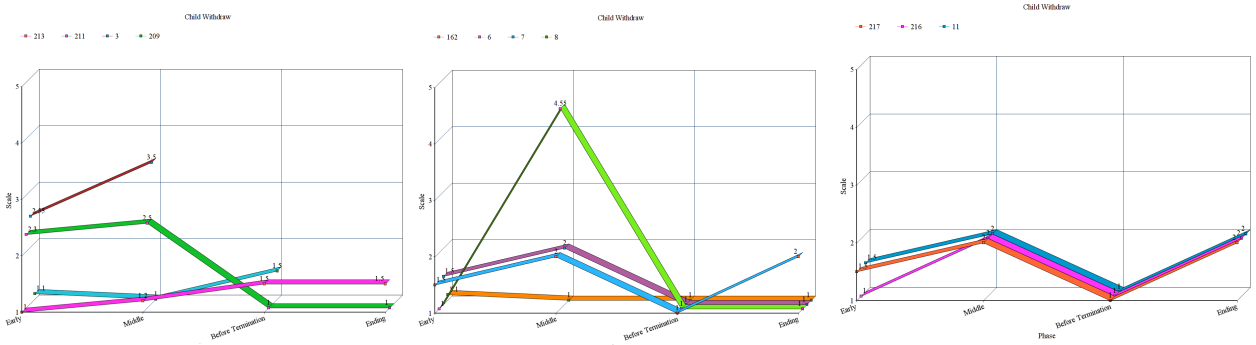

Table 2.7 Child Withdrawal

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.0	1.2	1.5	1.5
211	2.3	2.5	1.0	1.0
3	2.55	3.5	-	-
209	1.1	1.0	1.5	-
Group 2:				
162	1.5	2.0	1.0	2.0
6	1.0	4.55	1.0	1.0
7	1.5	2.0	1.0	1.0
8	1.10	1.0	1.0	1.0
Group 3:				
217	1.5	2.0	1.0	2.0
216	1.0	2.0	1.0	2.0
11	1.5	2.0	1.0	2.0

Group 1 *(Child Withdrawal):* Children's scores of withdrawal varied throughout, where one child decreased from the Early Phase to Ending phase, whereas one child increased from Early to Middle phases and two other children remained at a very low level (<2) throughout treatment.

Group 2 *(Child Withdrawal):* Children's scores of withdrawal mostly followed similar trends at different levels, reaching their peaks at the Middle phase of treatment. Three children reached a level 1 at the Ending phase, whereas one child reached a level 2.

Group 3 *(Child Withdrawal):* The children followed the same trajectories at similar levels throughout of withdrawal, all synchronizing from the Middle to Ending phases, and had bimodal peaks at the Middle and Ending phases of treatment.

Fatigue:

The general level of tiredness is considered: how tired was the child (level) and the proportion in which fatigue was the predominant state (frequency).

GROUP 1 GROUP 2 GROUP 3

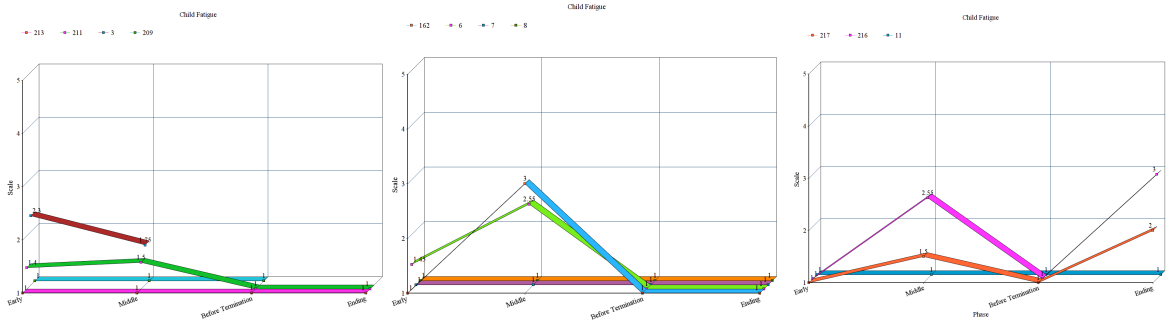

Table 2.8 Fatigue

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1	1	1	1
211	1.4	1.5	1	1
3	2.3	1.75	-	-
209	1	1	1	-
Group 2:				
162	1.0	3.0	1.0	1.0
6	1.45	2.55	1.0	1.0
7	1.0	1.0	1.0	1.0
8	1.0	1.0	1.0	1.0
Group 3:				
217	1.0	1.5	1.0	2.0
216	1.0	2.55	1.0	3.0
11	1.0	1.0	1.0	1.0

Group 1 *(Child Fatigue):* The children remained at mostly low levels of fatigue throughout, where two children remained at a level 1, and two children never passed a 2.3, however both decreased overtime.

Group 2 *(Child Fatigue):* Two children remained at a level 1 of fatigue throughout the treatment, where two children reached their peaks at the Middle phase of treatment, however leveled out to a 1 by the Before Termination until Ending phases of treatment.

Group 3 *(Child Fatigue):* One child remained at a level 1 of fatigue throughout the treatment, whereas two children had bimodal peaks at the Middle and Ending phases of treatment and scored at level 1 during the Early and Before Termination phases of treatment.

Avoidance of Therapist:

Child avoids the therapist's proximity and shows clear discomfort in the therapist's presence. For instance, child sits as far away from the therapist as possible, avoids the therapists touch, protests when the therapist touches him/her, averts gaze from the parents but not from the experimenter, does not respond to therapist's bids. Child may or may not be involved in play or other activities, but the impression is that the therapist's presence is the source of the child's discomfort. Note: Consider attachment theory's conceptualizations on avoidant attachment and the behavioral expressions of avoidance during reunion (Ainsworth et al., 1978).

GROUP 1 GROUP 2 GROUP 3

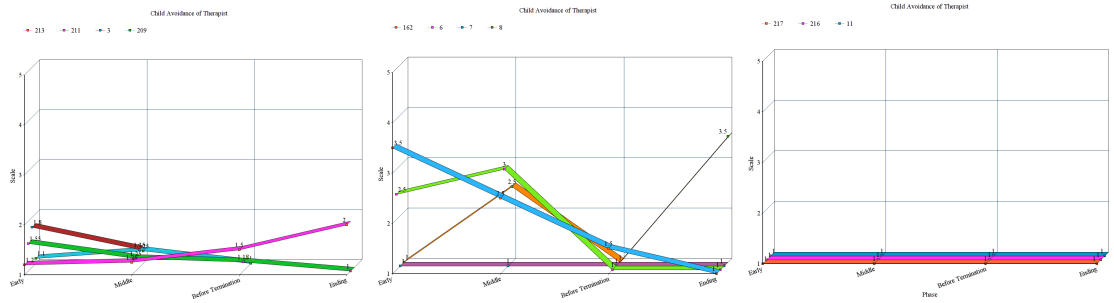

Table 2.9 Avoidance of Therapist

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.2	1.25	1.5	2.0
211	1.55	1.25	1.18	1
3	1.8	1.35	-	-
209	1.1	1.25	1	-
Group 2:				
162	3.5	2.5	1.5	1.0
6	2.5	3.0	1.0	1.0
7	1.0	1.0	1.0	1.0
8	1.0	2.5	1	3.5
Group 3:				
217	1.0	1.0	1.0	1.0
216	1.0	1.0	1.0	1.0
11	1.0	1.0	1.0	1.0

Group 1 *(Child Avoidance of Therapist):* Three out of four children's scores of avoiding the therapist decreased over the course of treatment, whereas one child's scores increased, however never surpassed a level 2 throughout.

Group 2 *(Child Avoidance of Therapist):* Two out of four children's scores of avoiding of therapist decreased over the course of treatment, peaking at the Middle phase, whereas one child's scores reached higher levels at the Middle and Ending phases and one child remained at a level 1 throughout.

Group 3 *(Child Avoidance of Therapist):* No children within group 3 scored for Avoidance of Therapist throughout the duration of treatment.

Fear:

Child demonstrates frightened behavior in response to the parent and/or the environment. These behaviors can be observed through frightened vocalizations (e.g. screaming), facial expressions, and body language (e.g. freezing). Efforts to maintain distance from the parent or external stimuli, which elicit fear in the child, may be observed.

GROUP 1 GROUP 2 GROUP 3

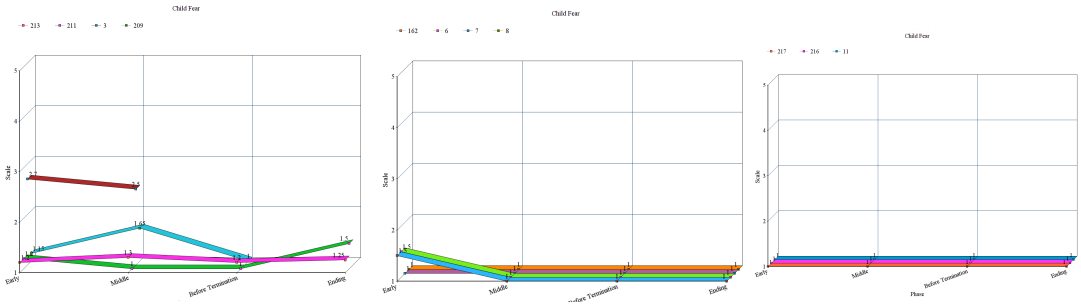

Table 3.0 Fear

Child ID	Early	Middle	Before Termination	End
Group 1:				
213	1.2	1.3	1.2	1.25
211	1.2	1	1	1.5
3	2.7	2.5	-	-
209	1.15	1.65	1	-
Group 2:				
162	1.5	1.0	1.0	1.0
6	1.5	1.0	1.0	1.0
7	1.0	1.0	1.0	1.0
8	1.0	1.0	1.0	1.0
Group 3:				
217	1.0	1.0	1.0	1.0
216	1.0	1.0	1.0	1.0
11	1.0	1.0	1.0	1.0

Group 1 *(Child Fear)*: Three out of four children maintained a very low level of fear throughout, whereas one child began at a relatively higher point.

Group 2 *(Child Fear)*: Two children began at a very low level (1.5) of fear and then leveled out to the rest of the group by the Middle phase of treatment, maintaining a level 1 throughout.

Group 3 *(Child Fear)*: No children within group 3 scored for Child Fear throughout the duration of treatment.

Vignette – "Away from Mommy is deathly frightening"

Brandon, from group 1, had an extremely difficulty acclimating to the therapy room. During the first 5 sessions, Brandon cried uncontrollably for approximately 10 minutes, tightly holding onto the doorpost as he entered the room, and eventually trying to climb out of window. The therapist returned him back to the classroom for a few sessions and then requested his teacher to join the beginning stages of the other sessions, in order to help serve as a safe base and transitional person (object). As such, these behaviors drove up Brandon's fear score.

Discussion

This study is a contribution to the limited, yet growing literature on group therapy for at risk preschool children, by '*zooming in'* to the topography of the Relationships for Growth & Learning Peer Play Psychotherapy (R*f*GL PPP) treatment modality through the use of an exploratory & dynamic systems theory approach (Hayes and Strauss, 1998) across a therapy year. By actively reporting upon the non-linear and unique trajectories that each child has taken, researchers can: better identify agents of change; gain opportunities to report upon progress potentially impacting efficacy; and understand the R*f*GL PPP in greater depth.

There have been numerous papers describing R*f*GL, highlighting the treatment modalities' clinical strengths and conceptual base (i.e., Shahmoon-Shanok, R. S., Welton, S., & Lapidus, C., 1989; Shahmoon-Shanok, R., Bekar, O., Fried, E. & Steele, M., 2012), including an efficacy paper (i.e., Bekar, Ö., Shahmoon-Shanok, R., Steele, M., Levy, J., deFressine, L., Giuseppone, K., & Steele, H, 2016), through the use of pre-posttest measurements, (i.e., questionnaires and other research measures). However, this current paper has aimed to unpack and provide insight into what occurs between pre-posttest treatment measurement by '*zooming in'* through the use of micro-analyzing videotaped therapy sessions and exploring the treatment across time.

Studies that have systematically examined the efficacy of R*f*GL PPP have been *enormously* helpful in collecting large amounts of vital data (i.e., Bekar et al., 2016); however, relying upon pre-posttest measures *only* can serve to restrict our understanding of the dynamics of the therapy, which differentiate it from other types of treatment modalities. As mentioned, it has been suggested that a dynamic systems theory be used to provide a conceptual framework for the study of change in psychotherapy (Hayes and Strauss, 1998), arguing that treatment research should "move beyond simple pre–post designs and toward more sophisticated growth curve analyses that generate

trajectories of change in individual and by group" (p. 945). Relying *only* on pre-post testing measures may inadvertently obscure the dynamic and discontinuous nature of individual change patterns (Pascual-Leone, A., 2009) and opportunities to report upon progress made throughout the year are lost, potentially impacting funding and the prospective for donors and grants to expand and disseminate the R*f*GL PPP which are vital to helping children and families in need.

The following sections will explore main themes discovered throughout this dissertation, including: non-linear therapeutic progress, important themes found across the positive and negative scales of the CIB coding scheme, and lastly, limitations, implications, and directions for future research.

Treatment progress is not linear

Importantly, we learned from this study that treatment progress is not linear, which is aligned with other research. For instance, much of the progress can be identified between treatment phases, and often, patients appear to get "worse before they get better" (Grey, M., 2003; Evans, C., 2012; Hayes A.M., & Harris, M.S, 2000; Pascual-Leone, A., 2009). For the children within this study, the majority of treatment progress was most commonly found at the Before Termination phase, whereas the least progress was most commonly found during the Middle and Ending phases of treatment. These findings helped to support the study's original hypotheses; firstly, that treatment progress would *not* be linear, and secondly, most progress would be found at the Before Termination phase, whereas the least would be at the Middle and Ending phases.

These findings are particularly important for clinicians and researchers who are studying or teaching R*f*GL PPP. Clinicians in a supervisory role who are teaching new and less experienced supervisees may use these findings to help prepare their trainees to anticipate and expect a non-linear and unique trajectory for each child within this population, and not expect that children

improvement follows an unwavering upward path. Researchers who are conducting efficacy studies with this population may also want to specifically note *timing* of treatment evaluation. This study suggests that a target time to evaluate efficacy for this population is at the Before Termination stage as compared to the Ending phase. Future research can further evaluate if the treatment progress persists past the Ending phase during a follow up, which may also be a target time to evaluate change and progress.

Positive (externalizing) scales

When exploring the positive scales on the CIB, trajectories were found along the following discrete patterns: a) Increase in scores from the Early phase to Ending phase; b) Highest points demonstrated at the Before Termination stage; c) Different patterns found across groups; and lastly, d) Inverse relationships found with complementary scales.

Select positive (externalizing) scales generally increased in scores across groups from the Early to Ending Phases of treatment. The Child Gaze/Joint Attention scale, as identified by a child's gaze, consistently focused on the therapist, and the Child Affection to Therapist scale, as identified by expressions of physical, verbal, and proximal affection, increased from the Early phases to Ending phases of treatment, suggesting that an expected bonding, therapeutic relationship, and general security were formed with the therapist across groups and throughout the duration of treatment (Shirk and Karver, 2003). Relatedly, children's scores rapidly increased during the Ending phase on the Reliance on Therapist for Help scale. High scores on this scale can be identified by 'help-seeking' behaviors that can be achieved independently, often occurring when children show little self-assuredness or confidence. It can be hypothesized that the children across groups were regressing towards the Ending phases and looking towards a Safe Haven during high

stress and intense emotion times (Marvin, R., Cooper, G., Hoffman, K., & Powell, B., 2002; Verschueren, K., & Koomen, H. M., 2012).

Children's scores similarly demonstrated an increase over time on the On-Task/Persistence scale, which can be identified by the child's persistence with one activity until completed. Though the scores of all groups increased from the Early to Ending phases of treatment, groups 2 and 3 demonstrated the most progress at the Before Termination stage. It is important to note the impact of development on this scale, which was accounted for within the coding process, as suggested by the CIB scale.

As mentioned previously, treatment progress is not linear and the highest points of progress were mostly identified at the Before Termination mark of treatment. For instance, children were found to experience the most positive affect (as scored on the Child Positive Affect scale), at this phase. High scores on this scale can be identified by a child's laughing, smiling, and positive verbalizations, while engaging in creative and symbolic play, appearing related and secure throughout. It is highly likely that exploring feelings around goodbyes and endings impacted the scores during the Ending phase, making the children's 'post treatment' scores appear much lower than they began with.

The Child Verbal scale, Competent Use of Environment and the Compliance to Therapist scales also displayed the highest points of progress at the Before Termination mark. Importantly, the Child Verbal scale demonstrated that children who were identified as either *totally nonverbal* or struggling with issues related to speech caught up to their developmentally appropriate verbal peers. It is also important to note for the whole scale that high scores are marked by *positive verbalizations only,* which explains why scores did not continue to increase through the Ending phase when experiencing painful goodbyes. Children's scores on the Competent Use of Environment scale

similarly decreased by the Ending phase. Reasons for this may again be due to natural feelings around terminations, and/or the children's focus on social interactions with one another (Lieberman, A. F., & Van Horn, P., 2005). As will be explored in a later section, it was found that there was a major increase in socially focused play and decrease in object/toy led focus on play across groups and throughout the therapy year. The children's Compliance to Therapist scores were generally also highest at the Before Termination mark, and decreased at the Ending phase, likely again due to termination. Additionally, this lack of compliance was interpreted to be developmentally healthy for individuation (Mahler, M. S., 1971).

Three scales had varied trends across groups, including the Child Alert, Child Initiation, and Child Symbolic Play scales. In regards to the Child Alert scale, as identified by enthusiasm and exuberance, one theme found was that initially internalizing children appeared to catch up to their externalizing peers, however all children generally remained at a high level of alertness throughout.

In regards to Child Initiation, which is identified by a child's beginning of mutual activities, with a general expectation of collaboration by therapist, the scores varied across groups. Groups 2 and 3 demonstrated increases in initiation of activities throughout the duration of treatment. On the other hand, group 1 generally demonstrated their highest levels at the Before Termination stage, however, one child decreased at the Ending Phase. As has been explored throughout this paper, the outlier, Destiny, experienced a trauma within the school at the Middle phase of treatment which very likely impacted her scores throughout, especially when engaged with caretakers within the school setting, therapist included. It is also important to take note of the developmental level and treatment dosage of group 2, who had 2 years of treatment prior to this studies' exploration.

The Child Symbolic Play scale, as identified by creativity, imagination, and symbolization within the child's play, demonstrated varied scores across groups again, yet all children displayed

similar trajectories within their respective groups. For instance, groups 1 and 3 decreased in symbolic play towards the Ending phase, yet demonstrated high levels at the Before Termination stage. On the other hand, the children of group 2 were all synchronized in their progress, maintaining an upward trend towards the highest level of symbolic play to be scored within the CIB scale throughout the duration of treatment. As mentioned, group 2 had the most treatment of the groups. Developmental levels have also likely lead to an increase in these scores, however this was taken into account during the coding process.

Object Oriented Play and Socially Oriented Play

A particularly important finding was that across all three groups of children, the focus of object led play decreased over time and increased in socially focused led play. This finding helps to demonstrate a major aim of the R*f*GL PPP therapy, which ideally aims to help children build 'relationships for growth and learning,' as the name suggests (Shahmoon-Shanok, R. S., Welton, S., & Lapidus, C., 1989; Shahmoon-Shanok, R., Bekar, O., Fried, E. & Steele, M., 2012).

Negative (externalizing) scales

When exploring the negative, externalizing, and clinical facets of the CIB scale, general themes and patterns were found across scales. Firstly, on the Child Negative Emotionality/Fussy scale, identified by clear signs of negative affect, children displayed a similar pattern across groups, demonstrating the highest scores during the Middle and Ending phases, and the most progress (lowest scores) during the Before Termination phase, which again, supports the studies' general progress trajectory hypotheses. Similarly, on the Child Labile Affect scale, which can be identified by quick shifts in mood and emotional expressions, it was found that the highest scores were found generally during the Ending phases, likely as a result feelings around termination (Novick, J., Benson, R., & Rembar, J., 1981). However, groups 1 and 2 displayed the least amount of labile

affect at the Before Termination phase, again supporting the hypothesis that most progress can be seen at the Before Termination phase.

In regards to the Simultaneous Display of Contradictory Behaviors scale, identified by actions, vocalizations and/or body language that are contradictory, Destiny of group 1 displayed the most behaviors, which can be directly linked up to the time right after her teacher physically abused her (Lieberman, A. F., & Van Horn, P., 2005). Daniel of group 1 also displayed contradictory behaviors at the Ending phase, albeit lower scores than Destiny, yet likely due to feelings around endings and goodbyes (Holmes, D. S., & Urie, R. G., 1975; Verschueren, K., & Koomen, H. M., 2012; Novick, J., Benson, R., & Rembar, J., 1981). The children of groups 2 and 3 displayed no scores within this scale.

Negative (internalizing) scales

Varied patterns were found within the Child Fatigue, Avoidance of Therapist, and Fear scales across groups. For instance, on the Fatigue scale, which can be identified as level of tiredness, children of groups 2 and 3 displayed medium levels of fatigue during the Middle phase, and group 3 had an additional peak of fatigue during the Ending phase. This all being said, all three groups demonstrated the most progress at the Before Termination phase, suggesting minimal fatigue and more exuberance during this phase of treatment. In a similar fashion, children demonstrated a similar pattern on the Child Withdrawal scale, as identified by instances of detachment from environment, displaying most progress at the Before Termination stage of treatment (low scores) and the most signs of withdrawal during the Middle phase.

In regards to the Avoidance of Therapist scale, to be identified by a general avoidance of the therapist's proximity, different patterns were found across the three groups; namely, groups 1 and 3 displayed minimal avoidance of therapist, (besides Destiny, which was likely related to the teacher

abuse incident), whereas group 2 displayed a general increase during the Middle phase, likely due to multiple terminations of therapists across the entire duration of R*f*GL PPP treatment.

In regards to Fear, identified by frightened vocalizations, facial expressions and body language, only group 1 displayed scores on this scale. Namely Brandon – incredibly frightful of group when he first began – displayed the highest scores on this scale until he was removed from treatment. Additionally, Madison displayed some frightened behaviors during the Middle phase of treatment, as a result of having to get surgery on her ears, which made her extremely nervous.

Limitations & Future Research

While this paper provides insight into the non-linear trajectories of each child from an exploratory & dynamic systems theory approach (Hayes and Strauss, 1998), it utilized only one type of measurement and did not compare their scores to other research measures used. Anecdotally, while assisting in the larger efficacy study for R*f*GL PPP, many of the clinical children's posttest questionnaire and research protocol results were not aligned with and supported by the therapeutic change observed by the R*f*GL therapists as well as the writer of this dissertation. Future research should explore and report upon these discrepancies.

Through videotaping R*f*GL PPP sessions, this study provided a rich and in-depth exploration of the child's treatment topography within one treatment term of R*f*GL PPP. Coding and micro-analyzing the data set the stage for the exploration of qualitative measures assessed over time, not previously examined in research. However, the sample size of children used is small, and therefore the results cannot be generalized to a larger population. Despite this, it has been suggested in research that a patient-level focus can help to facilitate evidence-based practice by providing clinicians with practice information for decision-making to improve care and by integrating research design into clinical care (Graham, et al., 2012). However, along these lines, it should also

be stated that the results pertain only to the group that was looked at, that is, at-risk and low-income preschool children.

Conclusion

This study helped to contribute to the expanding research on group therapy for at risk preschoolers by being the first to a explore R*f*GL PPP through an exploratory & dynamic systems theory approach (Hayes and Strauss, 1998). It examined the therapy's non-linear topography between pre-posttest measurements by *zooming in* to videotaped psychotherapy sessions – analyzing the treatment in its most *naturalistic form*: in the therapy room and during the R*f*GL treatment. We learned from this study that therapeutic progress is not linear. The majority of therapeutic progress can identified between pre-posttest measurement periods and children most often display their most progress *before ending* compared to the middle and ending phases of treatment. This study has provided a rich opportunity to unpack the unique topography and previously underreported therapeutic growth of 11 children who greatly benefited from the Relationships for Growth and Learning Peer Play Psychotherapy modality by *zooming in.*

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APPENDIX A

PURPOSE OF STUDY

Briefly describe the purpose of the proposed research.

1) This research project aims to investigate the efficacy of the Peer Play Group Psychotherapy, a service provided by the Relationships for Growth and Learning Training and Services Program (RfGL). The RfGL currently operates in three Head Start and day care centers located in the upper-west side of New York City. Peer Play Group Psychotherapy has been long provided in these centers, and establishment of this intervention dates back to early 1960s (Shanok, Welton & Lapidus, 1989). RfGL conducts biweekly Peer Play Group Psychotherapy sessions with children who are identified as in need of services in these three centers. We aim to investigate the effect of this intervention on children's socialization skills, verbal and non-verbal communication, school readiness and emotion regulation.

2) Early childhood education provided by Head Start and day care centers has been subject to extensive research in the past decades (Pungello et al., 2010; Campbell et al., 2001; Karoly, Kilburn & Cannon, 2005; D'Onise, Lynch, Sawyer & McDermott, 2010). This research project aims to contribute to this literature by exploring the relationships between families' demographic characteristics, parenting practices, and children's psychosocial development. More specifically, we aim to shed light to possible links between caregiver's and children's emotion regulation and reflective functioning skills.

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SUBJECT SELECTION AND RECRUITMENT

Describe your criteria for subject selection including socio-demographic (age, gender, ethnicity, non-English speaking, etc.) and other characteristics of the individuals who will be recruited. Selection of subjects must be equitable. If you are excluding women or minorities from your subject pool, include a scientific justification for such exclusion.

Participants will be the children in Head Start and day care that the RfGL operates in and their primary caregivers (male or female). In addition, teachers will be asked to provide information about their students in their classes.

In three centers in which the RfGL provides services, we will recruit two groups of subjects in each center: children who receive peer play group psychotherapy and children who do not receive peer play group psychotherapy. .

If you are planning to use children, pregnant women, prisoners, or institutionalized mentally disabled persons as subjects, describe how you will fulfill special regulations governing the use of such protected populations in research. Contact the Chair of the New School for Social Research Institutional Review Board for further information regarding the regulated access to these special populations as subjects.

This research project collects information about children aged between two and five. Parent report, teacher report and observational procedures are employed.

Parental consent will be obtained for the child's participation.
This research project neither selects nor assigns children to therapy. Instead, it collects data from preschoolers and their families who are selected for the RfGL services by the RfGL clinicians. These children who receive mental health and consultation services from the RfGL is called Playgroup children. In addition, this project collects data from typically developing children who are not selected by the RFGL clinicians to receive services. These children are called Non-playgroup children.

Caregivers will be informed that participation in this research is voluntary. It will be explained that their decision whether to participate or not will not affect the services that their children will receive at the center, including the RfGL services.

Teachers are asked to complete questionnaires. Teachers' participation in this research is completely voluntary and their decision whether to participate or not will not lead to any negative consequences on their part.

Describe how subjects will be recruited. Where and how will initial contact with potential subjects occur? Include copies of recruitment letters, fliers, advertisements, script of oral request that will be used at time of recruitment.

Three Head Start and day care centers will participate in the study:

Goddard Riverside Day Care Center

St. Matthew's and St. Timothy's Day Care Center

St. Matthew's and St. Timothy's 83rd Street Preschool

Recruitment of Caregivers in the Intervention Sites:

A) Primary and occasionally secondary caregivers (when a primary caregiver is not available) of selected children in the intervention sites will be approached and informed about the study during the regular registration/intake process or open family meetings of the centers. The regular intake process in these sites is conducted by the family coordinator on an individual basis. During this meeting, the caregiver will be asked if s/he would be interested in participating in the study. The centers obtain documentation of caregiving rights before child can be admitted to attend the centers. Those who are not legally allowed to care take for the children are also not allowed to pick the children up at the end of the school day, and thus would not be subjected to our participation outreach.

C) If both the intake and the open family meeting processes have been completed yet the caregiver has not been informed about the study in none of these opportunities, s/he will be approached by New School RAs and RfGL therapists in person and on an individual basis.

Teachers:

Teachers will be informed about the study in the teachers' meeting that takes place regularly at the Head Start and day care centers.

The parent will be provided with the following information by the Head Start/day care staff, RfGL staff or the New School Research Assistant (RA):
:

- *Relationships for Growth and Learning Program is a non-profit initiative for our children's healthy development. Our goal is to track the development of our children at various centers and help them when there is a need.*
- *We ask some caregivers whose children attend our centers to complete these surveys at the beginning and at the end of the school year.*
- *These questions measure how children behave, learn and feel. It is not an assessment of your parenting skills or your home environment.*

- *As the caregiver, you are the one who knows your child the best. So we need your help to learn more about children at our centers. If we know more, we can develop better services, which will benefit your child. Although there is no monetary compensation for your participation, your responses will help your child by shaping our services.*

STATEMENT TO SUBJECTS

How will subjects be informed, before participating in the study, about the purpose(s) of the research and what they will be asked to do if they agree to participate? How will subjects inform the researcher of their decision to participate? Include below (or by attachment) the oral or written statement that will be made to subjects.

A consent form (please see attached) describing the study and procedures will be provided to the caregiver by the center staff, the RfGL staff or the New School RA. If the caregiver agrees to participate in the study, they will sign and return the consent form to the Head Start/day care or the RfGL staff.

INFORMED CONSENT

Describe procedure to be followed for obtaining subjects' written consent. Attach a copy of the consent form(s) to be used. If subjects are children, parental permission and an assent procedure are required and should be submitted. If video or audiotape procedures will be used, provide a rationale for using such procedures. If subjects will be compensated for their participation, describe the nature of the compensation. If subjects are non-English speaking, attach the translated consent form. Subjects must be given a copy of the consent form before their participation begins. The consent form must list contact information for the Principal Investigator *and* for a representative of the IRB (Madeline Bohm, IRB Coordinator, 212-229-5727 Ext. 3102). The investigator must retain copies of the completed forms for a period of at least three years following termination of the project. Informed consent tips and required elements of informed consent are available from The New School for Social Research, Department of Psychology and The New School Grants & Sponsored Projects website: http://www.newschool.edu/gf/psy/links_policiesandprocedures.htm.

Consent form will be presented to the caregiver by the New School RA, RfGL or the Head Start/day care staff during the intake process (please see the above section).

Participants will receive a gift certificate in the amount of $15 from CVS as a compensation for their time spent for completing the measures and observational protocols in the first time. In the second time of assessments, the compensation will be $20. It is expected that approximately 50% of our participants' primary language will be Spanish. Therefore, all forms and questionnaires have been prepared in both Spanish and English (please see the attached forms). In addition, this research team involves research assistants and therapists who speak Spanish fluently.

Upon obtaining written consent from the caregiver, the New School research assistant will work with the RfGL staff members to schedule video recordings with children and their caregivers. Video recordings during the Frog Story, Co-construction, Peer Delay of Gratification and Individual Delay

of Gratification Tasks will enable coding of these instruments, which will provide valuable information about the children in the analyses.

CONFIDENTIALITY

Describe how subjects' confidentiality will be protected (i.e., use of data coding systems; how and where data will be stored; protection of computer data; who will have access to data; what will happen to data after the study is completed).

Participation in this study is confidential. However, if information suggesting a threat of suicide, harm to others and/or child abuse is disclosed, it is mandated by law that it be reported. Transcriptions of video and audio taped procedures will not include any names or identifying information (other than the subject identification number assigned in the beginning of the study). Oral or written reports on this study will not include any identifying information. Any statements made by the participants will not be attributed to participant by his/her name.

Transportation of data from the centers to the Department of Clinical Psychology will be conducted by the research assistants at the New School. All data collected on sites will be kept in locked cabinets in the Department of Clinical Psychology at the New School.

Each participant will be assigned an identification number. This identification number will not be attached to participant's name in the dataset. All information stored in computers will be password protected that is known to research personnel only. All information will be destroyed subsequent to the conclusion of the study.

Occasionally, information gathered during research is used for teaching purposes. When this happens, participants are never identified by name or by any other identifying information. Faces are obscured. In these rare cases, information share is limited. Participation in this research is not dependent on this possibility. Participants can indicate that they do not consent to videotaping (see consent form). Participants will not be penalized for this in any way.

RISK OR BENEFIT TO SUBJECTS

Describe the risks (i.e. harm) and benefits of this research to subjects and the benefits to science or the public, with a discussion of the risk/benefit ratio if applicable. For approval of any study with more than minimal risk to the subject, the benefits must clearly be shown to outweigh the risks. Indicate if results will be disclosed to subjects.

This study involves no more than minimal risk to the participants. Yet, some questions in the Parenting Stress Index (PSI) and the ACE have the potential to invoke negative feelings/memories about caregiving experiences and negative past events for some respondents. In order to minimize this potential discomfort for the caregivers, questionnaires will be administered in the presentence of an RfGL therapists or a trained research assistant. Therapist support will be provided whenever deemed necessary and will be reported to the PI and RfGL directors.
Benefits of this research include the opportunity to discuss their relationship with their child and learn from a cooperative parent-child experience.
No foreseeable harm can come to children or caregivers from participating in this study.

COOPERATING INSTITUTIONS

List all cooperating institutions, including: hospitals and institutions of higher education (Institutional Review Board approval required); health care providers; schools; agencies; and associations. Attach IRB approval letters from appropriate authorized officials at all institutions listed.

This study will be conducted in collaboration with the Relationships for Growth and Learning Program (RfGL), which operates under the roof of Jewish Board of Family and Children Services (JBFCS).

Three Head Start and day care centers will participate in this study. RfGL provides mental health services in these centers and collects information from parents, teachers and children.

IRB approval of the JBFCS needs to follow the New School's IRB approval according to the rules and regulations of JBFCS. A letter of collaboration has been included in the initial application.

PROCEDURES TO BE FOLLOWED

Provide an outline of all procedures to be followed. Attach copies of questionnaires and/or interview questions with this application, including non-English translations.

All data collection will take place at the Head Start and day care Centers. It will be optional for participants to complete the Adult Attachment Interview (AAI). AAIs may be completed either at the NS Center for Attachment Research or at the Head Start/day care center, if the center has available space.

Procedures:

1) Caregivers will be informed by the RfGL therapist about the study in person when the caregiver comes to the center to pick up his/her child.
2) Consent form and questionnaires will be provided to the caregiver by the RfGL therapist or the New School RA. Any questions about the study or questions will be answered by the therapist or the RA at this stage.
3) If the participant agrees to tasks that include video recording, the RfGL therapist or the New School RA will make another appointment with the caregiver to complete the Frog Story, Co-construction and Delay of Gratification Tasks.

Teacher Reports

Teachers will fill out the PIPPS about their students. Academic assessments that are regularly completed by teachers on their students (as part of the regular curriculum) will be copied and used as data. These measures are Creative Curriculum, Brigance and Early Learn. Each site uses a different combination of these cognitive/learning scales, therefore only available data will be copied.

The New School RA will make a copy of the completed intake and academic assessment documents that are regularly used in the centers. S/he will bring the original questionnaires and video/audio recordings along with the copy of the intake and teacher evaluation documents to the New School, Department of Clinical Psychology.

Therapist Reports

In line with our research goal of assessing the efficacy/effectiveness of Peer Play Group Psychotherapy (Shahmoon-Shanok, Welton, & Lapidus, 1989), we will be using the program-based information (e.g., number of therapy sessions that the participant children attended at the RfGL, the diagnoses provided by the RfGL clinicians) in our research project. This will help us investigate the relative efficacy of the intervention under different conditions, such as different levels of treatment compliance. In line with our confidentiality procedures, no identifying information will be attached to these data. Only the participants' research-specific ID number will be utilized when collecting this information to be used in the analyses. Data will be collected by on-site, trained RAs from the New School, enrolled in the Psychology PhD or MA program. Data analyses are always conducted with confidential data.

Follow-up Data Collection:

All questionnaires/observational tasks that are completed by the caregivers, children and teachers in Time 1 will be completed one more time with the same individuals a year later. The New School RAs and RfGL clinicians will be responsible for tracking data collection.

ADDITIONAL PROCEDURES, AS NEEDED

If applicable, provide the following: 1) a description of debriefing procedures to be used (i.e., where deception has occurred); 2) a statement describing what actions will be taken should the research reveal the possibility of a medical or other potentially serious problem (e.g., threat to harm self, a child, or an incapacitated adult).

If information suggesting a threat of suicide, harm to others and/or child abuse is disclosed, it is mandated by law that it be reported. The PI will take necessary actions immediately to secure help from the appropriate authorities and ensure the safety of participants.

VIDEOTAPED/AUDIO-TAPED TASKS

Delay of Gratification Task: This task involves the child delaying the receipt of a reward for 10 minutes. This task will be videotaped. Task is repeated in the presence of another peer as well.

Co-construction Task: The purpose of this task is to look at how children interact during a specific building task with blocks. Participating in this task will involve two children in 10 minutes of activity and will be videotaped.

Frog Story Task: This protocol is based on a picture book by Mercer Mayer (1969). The book illustrates a boy who is looking for his frog that escapes from its jar. The boy goes through relatively complicated adventures in a forest and eventually finds his pet. In this task, we ask the

child to use this wordless book to tell a brief story in 3-4 minutes in the presence of an RA sitting next to the child. Next, the caregiver is asked to enter the room and sit with the child and tell his/her child a story based on the book, which takes between 3-5 minutes. All activity is videotaped.

Adult Attachment Interview: This is a 45 minute-1.5 hour structured interview administered by a trained clinician/researcher. In the interview caregivers are asked questions about their childhood experiences, early relationships with their caregivers and how these experiences and relationships might have affected their adult personality. AAIs are audio-recorded and then transcribed by trained New School RAs.

Psychotherapy sessions: When applicable, psychotherapy sessions of the therapy groups will be recorded for teaching, research and clinical purposes.

APPENDIX B