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alongside play therapy for at risk youth**

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BRINGING THE BODY INTO TREATMENT: EXAMINING THE CLINICIAN'S
EXPERIENCE OF A TRAUMA INFORMED, BODY BASED INTERVENTION
ALONGSIDE PLAY THERAPY FOR AT RISK YOUTH

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2016

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Bringing the Body into Treatment:
Examining the Clinician's Experience
of a Trauma Informed, Body Based
Intervention alongside Play Therapy for
At-Risk Youth

ABSTRACT

This experimental, mixed-method study investigates the clinician's experience of integrating a trauma informed, body based intervention alongside play therapy for at-risk children ages 2 ½-7. Through a weekly online survey, 12 clinicians from two different mental health agencies-Bayview Associates Outpatient clinic in Quincy, Ma and The Home for Little Wanderers' early intervention program- participated in providing 4 weeks of data. Six clinicians, 5 from Bayview and 1 from HFLW, used the online survey to report their experience of including a trauma informed, body based intervention alongside their traditional play therapy practice. The same survey was given to the clinicians in the comparison group, who reported on clients that were not receiving the intervention during those 4 weeks.

The themes that emerged from the data led to major findings being determined. These findings showed that the addition of a mind-body intervention to sessions does not appear to enhance the clinician's perception of child progress and process any more than regular play therapy. Also, the mind-body intervention, given in the format of a card deck with various interoceptive exercises that the child clients may choose, does not appear to be effective for children after the second week due to being too structured.

ACKNOWLEDGEMENTS

This thesis is dedicated to the memory of my beloved Nana, Irma E. Webster. You have always guided me towards my authentic self and I feel your loving presence each day of my life.

I want to acknowledge the special people in my life who supported me along the journey of developing this thesis. Thank you to my mother and father for inspiring me to follow my interests, and to embrace each obstacle as an adventure.

I also want to thank my mentors David Emerson and Jennifer Turner, founders of The Trauma Center Trauma Sensitive Yoga team. I hope that this research will add to contemporary research being done by our colleagues around the world and inspire future research.

To Sara Rose and Isabella, without you I would not have known that that this path, my path, existed.

To my fellow sorceress: you're grace, brilliance, and authentic spirit are appreciated more than words can express. I cherish our friendship and am so proud of what we have accomplished.

-Alexandra Leiter

This thesis is dedicated to my mother Tracy, who inspired me to appreciate spirit, and sparked the thoughts that guided me towards exploring the importance of less mainstream modalities in the helping field. I also dedicate tremendous thanks to my other half, for supporting me through this process and all of the hurdles along the way.

I appreciate the time and effort of all clinicians and staff at Bayview SSSMH Associates, The Home for Little Wanderers, and Smith College that participated in the data collection period and this project as a whole. I want to state special gratitude for Alexandra Leiter, who traversed alongside me in this journey and together, we accomplished great feats.

I have so much gratitude for all the bright young spirits that spent time with me throughout the year, in and out of the play therapy room.

-Erica Donahue

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CHAPTER 1

Introduction

The intention of this experimental, mixed method thesis was to determine whether adding a trauma-informed, body-based intervention to the therapeutic model of play therapy done at The Home for Little Wanderers and Bayview Associates at South Shore Mental Health, increases the effectiveness of the preexisting model, decreases the clinical effectiveness of the pre-existing model, or reflects no substantial change. What is meant by the reference to the *clinical effectiveness* of the play therapy model, is the clinician's professional observations of presenting symptomology prior to the intervention and then the clinician's assessment of any changes or movement in the therapeutic process and most importantly, symptom presentation. The clinical effectiveness of the play therapy model is evidence-based and therefore demonstrates validity in asserting a baseline assessed by the clinician prior to the intervention. This experimental study aimed to approach a critical debate in the field of child development, particularly seen in the Center for the Developing Child at Harvard University: When can mental health care professionals begin to address nonverbal or pre-verbal traumatic experiences, in order to build resilience in our youngest clients who have been determined "at-risk"?

Specifically, our research hopes to begin to gather evidence-based data around the clinical applicability and therapeutic benefit to symptomatology of introducing trauma-informed body-based integration within a standardized model used in both students' agencies. On the TCTSY model have an impact on symptomatology in young children? Through the lens of this mixed methods study, the hope was to assess the immediate effects of a mind-body based interoceptive intervention in the affect regulation,

engagement in therapy according to their individualized treatment plan, and clinical presentation in line with their diagnostic presentation, of child clients already enrolled in play therapy. This study explored the feasibility of integrating the body into a traditional clinical practice. In creating the experimental intervention, the larger question was: If we can teach children ways of alleviating the trauma response caused by toxic stress, would there be potential in “undoing the damage” to their brain development, improving the quality of both mental and physical health of the child later in life?

CHAPTER II

LITERATURE REVIEW

Relevant literature was sought to inform the research question, and to develop a plan for our study's methodology based on facts. Since we will be referencing, and utilizing concepts from yoga quite a bit in our experimentation, we will supply a working definition of what yoga means to us. When many people think of yoga, it is common to visualize various poses and breath work. However, *yoga* is much more: a belief system, a lifestyle, a way of thinking and being. Schonfeld's (2010) definition of yoga, is, "Yoga deals with the most profound of mysteries, the essential nature of the human being in relation to the universe. The term Yoga has its root in the Sanskrit word "yuj," which means to yoke, unite, integrate," and in our case, the integration is aimed to happen between the mind and the body for therapeutic benefit of traumatized children aged 2.5-7.

A Jeuland Ware (2007) article speaks of how interoception, as a component of yoga, can positively aid psychotherapy. *Interoception* is fundamental to the practice of physical yoga poses, or *asanas*, and is central to a number of mindfulness techniques such as "body scans." However, the current research on the practice of interoception in the context of a trauma-informed body intervention has been limited to studies done by The Trauma Center's Trauma Sensitive Yoga program. Although these studies focused on an adult population of individuals diagnosed with complex trauma, there is evidence that the practice of interoception is central to healing the constellation of symptoms that are associated with complex trauma, which often manifest in an individual who has experienced early childhood trauma. The article also suggests that children should have

choices even within the consistency whenever possible to “give them some sense of control and help to build self-confidence” (macmh.org, 2014, p. 2).

Hegarty (2011) tries to answer the question of whether or not yoga and meditation, as alternative therapies, can effectively treat teens with alcohol abuse and a complex trauma history. The research design was qualitative in nature, and data was collected through a web-based survey. An email was sent to a variety of people in the helping field, asking for participation with a link. The sampling consisted of 22 licensed clinicians, who reported on 36 of their clients who struggled with symptoms of trauma. The demographics of these clinicians weren't collected, and the results were submitted anonymously.

Measurement and data collection consisted of the researchers reviewing the results of the online survey, using the aid of Microsoft excel which coded for positive and negative attitudes. The data analysis and findings of the study resulted in 72% of the clinicians feeling that such yoga and meditation alleviated the most severe presenting symptoms for their clients. In addition, 77% of the clinician's clients found that such coping skills be used easily and help elsewhere, away from clinical settings. In conclusion, and the end discussion implies, alternative therapies like yoga and meditation can help acute symptoms in adolescents struggling with ETOH abuse and trauma symptoms, and can be used conveniently on an individual basis (Hegarty, 2011).

Limitations of Hegarty's study include the fact that the number of clinicians participating was rather small- implying that not many clinicians use these interventions. For this reason, it is hard to gauge how effective they are on a larger scale. Additionally, the clinicians came from all different backgrounds (drug abuse counseling, counselors,

social workers, rehabilitation counselors, etc., and come from quite a range of years in terms of practice). In this sense, the study did not seem narrow enough to really assess how effective such interventions are for trauma, specifically. Also, the participants who responded, seeing that the survey was about alternative therapies, may have had a bias, which urged them to partake in the study. In terms of bias to the sample, the participants had to be English-speaking clinicians. Also, the clinicians themselves who participated may have had bias because they knew what the study was about and chose to take part in it based on the topic being discussed. There were not any observed sources of oppression (Hegarty, 2011).

Descilo et al.(2010) explores if yogic breathing programs (which utilize interoception to help participants increase inner awareness of their breath and how breathing makes their body feel), can aid trauma reduction exposure techniques in helping individuals who have experienced trauma to heal. Specifically, the study focused on how such interventions may aid survivors of the 2004 tsunami. The research design was quantitative, because the researchers collected hard, empirical data. The researchers separated participants into three groups--just yogic breathing, yogic breathing with additional trauma work, or nothing at all. At intervals of 6, 12 and 24 weeks--the status and process of the participant's symptoms were taken using a posttraumatic checklist .

The sampling involved participants who were non-randomized in the sense that they were all survivors of the tsunami (183 in total), living in refugee camps after the disaster. Men and women of varying ages participated. Three of these camps comprised the sample, and each was randomly assigned one of the treatment groups mentioned. Additionally, the participants had to have scored at least a 50 on the posttraumatic

checklist. The data analysis was undertaken using ANOVA and mixed effects regression. Specific findings included a drastic change around week 6, supporting the conclusion that some treatment was effective. Those who had either yogic breath or yogic breath plus extra trauma work had important reduction in checklist scores. Additionally, these reductions in PTSD checklist scores remained after a 24-week follow up. Validity and reliability were also checked and were seen as accurate (Descilo, Vedamurtachar, Gerbarg, Nagaraja, Gangadhar, Damodaran, Brown, 2010).

The overall conclusion of the Descilo study is that it seems likely that yogic breath (which, if done and taught properly, necessitates the use of interoception), helps symptoms of trauma associated with a large-scale disaster such as the 2004 tsunami. Limitations of this study included the fact that there was no randomization of the groups, attendance wasn't taken during data collection (so any of the 183 participants may have been absent during these times), and because the conditions in the camp were rough, test timing sometimes took multiple days to complete. It is of note that the participants who were living in refugee camps were of minority status, few spoke English, and presumably- many of them had practiced yoga as a part of their culture and already had it as an established coping mechanism (ruling out its introduction as having any new effect). The lack of inclusion of this possibility demonstrates a potential ethnocentrism (Descilo et al, 2010).

Parker, Doctor and Selvam (2008) also discuss the 2004 tsunami. However, instead of yogic breath, this investigation highlights the application of bodywork to survivors. A great deal of research has been geared towards those affected by this event, as natural disasters often result in high rates of PTSD in survivors. Parker, et al (2008)

shed light on the fact that trauma takes residence in the nervous system, not in the memory itself. Therefore, it would make sense to attend to the nervous system when determining solutions for symptoms. Because of the fact that during trauma, lower brain flight or fight responses are activated, and executive functions slow down--one would imagine that helping regulate this response should also help with trauma symptoms . The method used was an uncontrolled field study. The participants were 204 volunteers from 13 different towns, 40 men, and 110 women--each of whom was prescreened for trauma symptoms using a PTSD checklist. The way these participants became part of the study was responding to local advertisements due to wanting treatment.

The average age was 41.6. These participants each received 75 minutes of somatic therapy as well as affect regulation and modulation for symptoms of intrusion, arousal and avoidance. The somatic work involved four stages: the first where the participant became aware of any physical arousal in response to the tsunami and attempting to slow it down while also trying to feel safe and grounded with the therapist. The second step was about allowing the participant to form stories about the traumatic experience with emphasis on body feelings. The third step was education around neurophysiological stress and how the body stores trauma. The fourth step was tracking the feelings associated to trauma in order to reach a resolution of the feelings (Parker et al., 2008). This set of interventions is a prime example of how the interoceptive component of yoga truly functions.

The original PTSD checklist was used to determine the success of the treatment, and stress improvement was measured with an SUD scale. The program of SPSS was used to analyze all of these results in tandem. The results Parker, et al's (2008) study

show that somatic therapy immediately reduces trauma symptoms, as well as at 4 months after. However, the most profound effects were seen at the 8-month follow up, where 90% of participants showed remission of symptoms. The fact that such a large number of participants benefited, even with just 75 minutes of treatment, indicates that somatic healing works.

Parker et al's study overlaps with the research question posed in this project as it specifically tests somatic based practices for effectiveness in victims of trauma. Although dissimilar in many ways, the symptom constellations for complexly traumatized individuals overlaps with the core symptoms required for a DSM-V diagnosis of PTSD. The drawback of the Parker et al study is the fact that natural disasters make the environment for research a challenge in terms of feasibility: the population is always shifting and environmental chaos can disrupt data . Due to circumstantial reasons beyond the control of the researchers, there was a lack of environmental stability, or at least a somewhat controlled environment, which can be measured to lend a level of predictability. In our own research, we would have the benefit of being able to provide a stable environment in which to introduce our intervention, preferably not ridden with chaos, in which to conduct our study.

Accelerated Resolution Therapy (ART) was explored as a treatment for combat veterans with PTSD symptoms. The method was randomized and controlled in its study of ART, in comparison to attention control- AC. Assignment to each group was randomly, determined by a number generator. There were 57 participants in total, the mean age was 41, and of note is that 68% of the participants had undergone treatment for

PTSD in the past. Each participant had a three-month follow up to assess symptoms. After the three months—self-reported symptoms were collected (Kip et. al, 2013).

For ART, 2 to 5 sessions consisting of two components and lasting roughly 60 to 75 minutes were given to participants. The primary ART component, Imaginal Exposure asked the participants to recall the trauma while focusing on physical sensations, thoughts, and emotions. This is an interoceptive process. While doing this, the certified clinician coached the participants to stay relaxed in their bodies. Directly after this step, participants were exposed to reactivation of the traumatic memory for 30-45 seconds. Any uncomfortable feelings were then encouraged to be processed, by thinking about the symptoms while following specific eye movements. The second component consisted of replaying the traumatic memory and visualizing changing it to be more favorable, while paying attention to bodily sensation (Kip et. al, 2013). In regards to those participants placed in the AC group, they underwent two one-hour sessions of fitness assessment or career planning, which was chosen by the participant.

Results were collected with baseline self-reported outcome measures to assess a range of psychological treatment response. Post-treatment evaluations were completed in person. The outcomes included important reduction in symptoms by participants in the ART group, and unimportant to no change in symptoms from those in the AC group. ART therefore proved to be an effective treatment for combat related PTSD symptoms (Kip et al, 2013).

Strengths of Kip, et al. (2013) study include special insight into combat related trauma that we have not seen in the other articles, as well as a highly standardized treatment protocol that we would likely consider applying to our own study. Limitations

include the fact that when certain participants could not hand in their results, they had to mail their evaluations in. This could jeopardize the validity- how would a researcher know they were the ones who truly filled it out? Also, the adverse effects were asked of the participants by the clinician. Perhaps the participants were not honest when being asked that, and felt uncomfortable being put on the spot-, which could have affected the validity of the results. Lastly, the gap in this study was that the AC group was not a traditional therapy group--which is really what our study would want to critique (the differences between somatic treatments and traditional therapeutic treatments). .

Ford and Blaustein (2013) looked at the effects of traumatic stress the population of youth within residential Juvenile Justice programs, who often have been exposed to high levels of psychological trauma throughout their childhood years. The authors explore ways in which these youth may attain the ability to self-regulate for the purpose of maintaining an “allostatic balance in the body”. Prior studies of approaches to treating effects of psychological trauma and PTSD in this population were noted in order to present a consistent set of symptoms in line with the negative emotions that are central to the PTSD diagnosis: anxiety, dysphoria, anger, grief, and guilt (Ford & Blaustein, 2013). The “problem youth” in residential facilities have been shown to represent a population that started out life with many high-risk factors, including a high dosage of psychological trauma exposure.

Landry et al. present a relevant study to consider titled: *Enhancing Early Child Care quality and Learning for Toddlers at Risk: The Responsive Early Childhood Program*. The model of intervention is described as a “responsive, intentional approach to caring for young children...child care teachers to use strategies proven effective in a

random assignment intervention with parents in home settings, called Play and Learning Strategies” (Landry, 2013, p. 258). Landry explores on the question: “To what extent do the interventions produce greater gains in children’s social and emotional competence, language, early literacy, and early mathematical knowledge, as well as positive teacher–child relationships? (Landry, 2013, p.528).”

The measures used in this study provide an example for developing the measurement strategy for a trauma informed body based intervention in this study, as the populations and corresponding needs for assessment may be similar. Measurements were extensive and comprehensive, offering a diverse set of lenses to understand the data and implemented program. Landry’s study first used the Teacher Behavior Rating Scale (TBRS; Landry et al., 2000) to evaluate change in teacher responsiveness and instruction. Next, the emotional understanding of the individual child was measured using Izard’s (1975) procedures), adapted by Bullock and Russell (1985) in order to allow the task to be able to be used with children younger than age 3. “Core emotions” were evaluated and expressive, receptive, and the situational understanding of emotion was assessed. Of note, the authors added that “Prior to the start of the current project, the items were piloted and deemed appropriate for low-income 2- and 3-year-old (Landry, 2013, p. 532).” Children’s social competence was assessed with the 30-item Social Competence and Behavior Evaluation.

The Expressive One-Word Picture Vocabulary Test (EOWPVT; Brownell, 2000) was used to measure children’s expressive vocabulary skills. Finally, the Adult–Child Relationship Scale (Pianta, Nimetz, & Bennett, 1997) was used to measure teachers’ perceptions of their relationship with children at the final two time points. “Mediation

was tested using a bootstrapping process (Preacher & Hayes, 2008), where samples equal in size to the total sample, but taken with replacement, are selected from the total sample, and two models are tested for each outcome and mediator (Landry, 2013, p. 532).”

Holmes’, et al (2015) review of a program named Head Start Trauma Smart, (HSTS) offered us three standardized measurement tools to consider when evaluating the effectiveness of our intervention. Holmes et al. noted that although the methodology was not intended to be one driven by research, data was collected in order to ethically and empirically determine whether or not children were benefitting from the education/mental health cross-systems partnership designed to work within the child’s natural setting of The Headstart classroom. The measurement tools chosen by these writers were: the Childhood Trust Events Survey, Achenbach–Teacher Report Form and Child Behavior Checklist (CBCL) (version nationally normed for 1.5–5 years), and Classroom Assessment Scoring System (CLASS).

While certainly not without limitations, biases, and questions about validity that we have mentioned above, the pre-existing research we have examined supports our decision that implementing the trauma-informed yoga and body based intervention might be helpful, and has little risk of being harmful. Overall, we know there is empirical-evidence base for play therapy for children (Baggerly, 2009, p. 97). Additionally, there's recently been evidence that mind-body based interventions such as yoga are additionally helpful with adults and adolescents. We were eager to find out whether adding mind-body based interventions, specifically interoception, to the already known effectiveness of play therapy, helps children of young, pre-pubescent children (2.5-7). In sum, this

project is a way to find out if something that has already been proven effective for adults and teenagers can be effective for youth.

CHAPTER III

METHODOLOGY

The intention of this proposed experimental study was to determine the answer to the research question of whether adding a trauma-informed, body-based intervention to the therapeutic model of play therapy done at The Home for Little Wanderers and Bayview Associates at South Shore Mental Health, increased the clinical effectiveness of the preexisting model, decreased the clinical effectiveness of the pre existing model, or reflected no substantial change.

The term *clinical effectiveness* with regard to the play therapy model, was gauged in relation to the clinician's professional observations of their client's presenting symptomology prior to the intervention in comparison to the clinician's assessment of any changes or movement in the client's therapeutic process or symptom presentation. The clinical effectiveness of the play therapy model is evidence based, and therefore demonstrates validity in asserting a baseline assessed by the clinician prior to the intervention.

Through the lens of this mixed methods study, the immediate hope was to begin to gather "evidence-based" data around the clinical applicability and therapeutic benefit to symptomatology, of introducing a trauma-informed body-based intervention within a standardized model used in both students' agencies on the TCTSY model have an impact on symptomatology in young children? Another hope was to assess the immediate effects of a mind-body based interoceptive intervention in the affect regulation, engagement in therapy according to their individualized treatment plan, and clinical presentation in line with their diagnostic presentation, of child clients already enrolled in play therapy. The

assumption was that the more practice that the children had with being in their bodies, the less frightening their therapeutic experience would be, and therefore, the more positive the clinician's experience of the client's process and progress would be when the body based intervention was included in the regular play therapy treatment. The larger goals of this thesis are far reaching. If children can be taught ways of alleviating the trauma response caused by toxic stress, there might be potential in "undoing the damage" to their brain development, improving the quality of both mental and physical health of the child later in life.

In the following paragraphs, the sample will be discussed, followed by recruitment methods for this sample, ethics and safeguards, data collection, the interoceptive card deck, training clinicians, data analysis, benefits and risks, and limitations.

Sample

The sample population for this mixed-methods study was young, male or female, (2.5-7), at risk children residing in the Boston area who were new to the play based programs at The Home for Little Wanderers and Bayview. Because Erica and Alexandra's second year field placements are stationed at these agencies respectively, the following experimental design was quite feasible. The sample set of children was newly enrolled in therapy (one to three months of play therapy), rather than children that had been longtime clients of play therapy prior to when the research portion of the thesis began. This choice can be seen as a precaution to ensure that the results would not be jeopardized by prior progress from the child's involvement in the play based therapeutic program.

Recruitment

As a result of the lack of clientele at both agencies, the sample size for this study was also small. Also, because clinicians at each agency had fixed caseloads, random assignment to either the trauma informed body based intervention to the usual play therapy added, or the group where no additional intervention is added, was not possible. Instead, for the experimental group, the researchers utilized the sessions with the “criteria-meeting-clients” on their own individual caseloads to conduct the interventions. It is of importance to note that the guardians had to consent to the children’s involvement in this study, for both the control or intervention group; this will be discussed in further detail below. At Bayview, the six experimental group clinicians were not selected in any special way. They had volunteered to be a part of the study, selected on a “first come first service” model, whoever volunteered first. Only one clinician ran an experimental group at The Home, and that clinician was the intern researcher, co-author of this study.

For the control group, four volunteer clinician from The Home for Little Wanderers Preschool Outreach Program, the researcher and intern associated with The Home, two volunteer clinicians from Bayview, (selected, again, on a first come first serve, whoever volunteered first basis), and the researcher and intern associated with Bayview, collected results from “criteria-meeting-clients” on their caseload. Altogether (including both the control and experimental groups), data was collected from 18 clients. This estimated number of participants was achieved only by way of being able to use a pool of participants composed from the caseloads of multiple clinicians, at two agencies. The only obstacle was that caseloads from committed clinicians at either agency changed

by the time of data collection (or during), and the number of criteria meeting clients was dependent on the reality of the clinical makeup at the start of the study.

Ethics and Safeguards

In order to conduct the experiment, ethical preliminary steps were taken. First, the researchers received informed consent documents from the parents of the children involved, wherein the parents gave or denied permission that to allow their children to participate in the collection of data and the body based intervention. The Letter for Parental Consent is listed in Appendix A and Child Assent form is listed in Appendix B. Language of the pre-existing consent letter from Smith's Moodle page was tailored to include the following statement: "signing below means that you agree for your child to participate in brief 2-5 minute, trauma informed mindfulness, in addition to their regular play therapy session. It also means that we may ask your child about their experience, and collect data of the results."

Also included on the permission form was a note to the parents, outlining that if their child was not selected for the trauma informed body based intervention component, and if the initial results suggested that such an added intervention makes the regular play based program more effective, the results would be mentioned to the agency in hopes that they would begin to offer it to those children who were placed in the non-intervention (control) group. Children who have been involved with the play therapy program prior to the start of the experiment were also included in this offering, if the agency agreed .

The results from the clinicians' surveys were collected and stored in a separate, safe place, and extra precautions were taken to safeguard the participants' personal information. The researchers stated, "All research materials including recordings,

transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.” The principles of, justice, respect and beneficence were highly valued while collecting information and while working with human subjects.

In addition, a Clinician Confidentiality Form was created and distributed to clinicians. Clinicians signed this agreement to further protect client confidentiality and enhance ethics and safeguards in the context of this study. See Appendix C for this form.

Data Collection

Once the approval letter from the SCSSW HSR Committee was received (see Appendix D), both quantitative and qualitative information was gathered, making this a mixed methods study. For each child involved in the experimental group, the therapy spanned four weeks and was implemented during the first 2-5 minutes and final 2-5 minutes of each child’s individual session. The interventions, explained in detail during the “training clinicians in the intervention” section, are defined as “interoceptive exercises.” *Interoception* is a body-brain mechanism that is typically defined through an individual’s response to internal stimuli. Furthermore, interoception makes the sensory experiences and the emotional responses to the sensory experiences available to and interpretable by the conscious mind. When interoception is functioning properly, the person has a sense of agency concerning the event, which is a sense of ability to control his or her responses to the particular event and to others like it (van der Kolk, 2015, p.

95).” In consideration of the sample population, developmental trauma was the predominant challenge to the child’s ability to develop a healthy resilience.

The children in the control group received the regular play therapy with no added intervention for the four-week period. Clinicians involved in the control group in the 4-week study also assessed the child’s symptomatology using the same standardized measurement tools as the clinicians in the experimental groups for the purpose of collecting quantitative and evidence based data. The clinicians that ran the control group of the 4-week data collection period did so on a voluntary basis. Any clinician or intern who agreed to participate received thorough written and verbal explanations of this study’s methodology, guidelines of the intervention, and a brief background and training in trauma informed yoga.

The “Interoceptive Card Deck:” Combining Choice, Authentic Experience, and Measurable Variables

For the purpose of creating a measurable variable to conduct evidence-based research that has validity, an identical, standardized set of 5 physical cards that offered different trauma informed body based interventions were laminated and distributed to all participating clinicians (Appendix E). A choice was given to the child, whether or not they wished to pick a card, and which card they wished to choose. All five cards were double sided; the purpose being to serve as a guide for clinicians, to ensure that the intervention implemented by each involved clinician was in line with the trauma informed body based theory that guided this project, and to provide consistency among clinicians. Side A provided the child with a visual image and language to describe the interoceptive practice. Side B provided the clinician with the clear, core trauma informed

language that guided the intervention and also served to promote the authentic parallel practice that involves the authentic experience of the clinician.

Training Clinicians in Conducting the Intervention

Training was done with the group of the clinicians at Bayview who had volunteered to conduct the intervention. It was difficult to schedule Erica and Alexandra's schedules in addition to the clinician's schedules, so trainings took place separately and all parties involved in this training lasted no more than 45 minutes. Erica and Alexandra modeled the intervention at their respective agencies, and allowed time for questions and feedback from clinicians that were used in qualitative data section of results. (See Data Collection Section for further information).

The overall approach of the card-deck intervention was "trauma informed," modeled after the core principles used in Trauma Center Trauma Sensitive Yoga (TCTSY) Model from The Trauma Center in Brookline, Massachusetts. One of the researchers, Alexandra Leiter, is a 110- hour certified TCTSY instructor and has used the basic tenets to create a model to use with this specific population.

It is important to keep in mind that most of the clients in this sample carry the diagnosis of either adjustment disorder or PTSD, and one goal was to be sure to create the intervention appropriate for those with the diagnosis. The "Posttraumatic Stress Disorder Fact Sheet," published by the Minnesota Association for Children's Mental Health, discussed the importance of consistency to treat students with PTSD stating: "a regular pattern will help re-establish and maintain a sense of normalcy and security in the student's life" (macmh.org, 2014, p. 2). Knowing this, the technique of using mind-body

awareness exercises both to begin and to conclude each actual therapy session was intended to add this necessary structure by way of establishing regularity.

All of this positivity about consistency being said, the article also stated that “being forced to maintain the same level of activity for too long may cause the student to become restless and anxious” (macmh.org, 2014, p. 2). For these reasons, the intervention was only conducted for the first few 3-5 minutes, and the last 3-5 minutes, of each play therapy session. This choice was intended to prevent the participants from becoming bored or losing attention. Additionally, the article suggested to “incorporate large-muscle activities into the day” to “relieve anxiety and restlessness” (macmh.org, 2014, p. 2). The intervention was created with intention to bring awareness to and occasionally incorporate the use of both large and small muscle groups, and it therefore reinforces the fact that its involvement in play therapy might help anxious children or those that have experienced trauma.

Amongst the concepts discussed during the training, were some guidelines about clinician procedure. The child was to be given the choice through thoughtful language by the clinician at the start of the regular scheduled appointment. A clinician might have asked, for example, if the child would like to try “something new” along with the clinician.

The clinician was to be in authentic practice of the body based approach. Parallel authentic practice was the central component to this intervention. It was stressed as helpful to consider this intervention as “non-directive” and to follow the theoretical underpinnings of non-directive play therapy. No script was given to clinicians, as this was to be a truly authentic experience shared by the clinician and child. It was important

for the clinicians in the experimental group to reinforce the child's sense of control, using language like, "you chose this card!"

The child had the choice of whether or not to pick a card at the beginning of the session. If the child said no, it was important for the clinician to respect this decision, and to not push the matter further in order to keep the child's sense of control intact. The clinician was told to not ask again at the end of that session if the child wants to try the card. It was okay however, to ask the child again in the following session, if they would like to choose a card. If the child did choose to pick a card, the child would be asked both at the beginning of the session, and the end of section, if they would like to try the interoceptive exercise listed on the card they chose.

If the child gave feedback during the intervention, the clinician was to utilize standard non-directive language, using reflections that amplified the child's voiced experience in the body. Any response from the clinician was to aim to avoid language that detracts from the interoceptive experience of the child. For Example, if the child said, "I can feel my left toes more than my right toes even though I took both shoes off," the clinician may say, "you feel your left toes more today, right now than your right toes. That is something you noticed."

The clinician was guided to authentically experience their own feet on the ground and not direct the children to follow, not follow, or to even take part. The clinician was to pay attention to their internal sensory feeling of the body, or "interoceptive awareness" in order to model attunement for the child. Knowing that many children in the sample will have a diagnosis of PTSD, we stressed the importance of giving the children the options to decide for themselves how they were feeling when they participate in the

interventions, and we also stressed allowing them to pick from a deck of five cards to determine the exact mind body exercise they will be doing. For example, if a child was asked, “how does it feel to run your hands through the sand?” they would be able to determine and relay their own experience without being told, without an option, what to say or do. Additionally, effort was made to enforce the child’s power. For instance, if they chose awareness of hands, the clinician would reaffirm the child’s agency, saying something like, “you chose the card of noticing your hands!”

The trauma informed body based intervention utilized invitational language and trauma sensitive language. In line with this trauma informed model, there was to be no physical assists or physical contact typical in other yoga models, and language and postures were chosen to avoid triggers. Elements of spirituality were removed from the yogic principles to avoid ethical concerns, and if yoga “poses” or *asanas* are mentioned, were to be referred to as “forms.” Any forms or exercises were modified upon individual need, including the option for using a chair instead of a traditional mat.

The only time that a clinician was told that they could intervene with feedback is if the child's safety was at risk. Further, in this approach, the child was to be encouraged to develop both an awareness and a curiosity of what is happening in their bodies through the use of inquiry-oriented language, such as “notice,” “observe,” “investigate,” and “experiment.” This language framed postures with mindfulness, and most importantly, it encouraged a sense of agency and control over their body and how the children relate to themselves.

Data Analysis

To determine how the intervention was working, responses from participating clinicians were gauged. Collecting data from the child client's perspective was not reliable, due to the fact that the age group was so young, and had a limited capacity for complex thinking. Both quantitative and qualitative data was collected from involved clinicians. Whether these clinicians conducted sessions with a client who was part of the control group or the experimental group, they were asked to fill out a Qualtrics designed survey 4 times: once after each conducted session, for the 4 week data collection period. The questions on this survey were simple and while relevant, as easy as possible to answer. These questions can be found in Appendix F.

Qualitative data was also collected. At the end of the 4-week data collection period--a separate questionnaire was sent out, using a Microsoft Word document in the form of an open-ended questionnaire, to the clinicians conducting sessions with clients in the experimental group. See Appendix G for the questions that it included.

At the bottom of the Qualtrics survey, as well as the Microsoft Word questionnaire, the following statement was included; "All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period."

Also included were the statements, "The data collected from this study will be used to complete *our Master's in Social Work (MSW) Thesis*. The results of the study may also be used in publications and presentations" and "I have completed the

Collaborative Institutional Training Initiative (CITI) online training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.”

The researchers looked at the responses, and created an Excel spreadsheet including all of the quantitative data so that themes could more easily be seen in the form of an organized chart. This information, collected via the Qualtrics tool of measurement, was sent accordingly to the research analyst of Smith College, who read the Excel document into the SPSS program. The data analyst then ran descriptive frequencies (mean, median, mode and range). T-tests were run for question 8 to determine group differences.

With regard to the post-study questionnaire for clinicians conducting sessions with the experimental group, researchers also created an Excel chart to organize the data, and content theme analysis for qualitative data was conducted.

Benefits and Risks

Although the approach has been created to specifically avoid any discomforts or risks, it is possible that your child may experience discomfort in an increased awareness of experiences in the child’s body. The staff at The Home for Little Wanderers and Bayview will be available to you if you have any concerns about your child at any point during this intervention or afterwards.

The benefits of participation are that learning interoceptive exercises may serve as useful coping skills, or facilitate an increased awareness of feelings in the body and the child’s sense of control over the child’s own body. Additionally, if the hypotheses are correct, the exercises may improve the child clients’ affect regulation, engagement in

therapy according to their individualized treatment plan, and clinical presentation in line with their diagnostic presentation. The benefits to social work/society are: assessing the role, if any, for trauma informed body based intervention with at-risk toddlers in addition to the regular play based program.

The Methodology has been outlined. The following section will relay the major findings that were gathered in the experimental phase. First, the demographic characteristics of the sample will be given, then the quantitative week by week from The Home, then the quantitative data from both Bayview and The Home and the qualitative survey findings will be given: each from the researcher associated with The Home for Little Wanderers. After this section from the researcher associated with The Home for Little Wanderers--a separate Findings section from the researcher associated with Bayview SSMH Associates will follow.

CHAPTER IV

Findings

Findings: The Home for Little Wanderers

This chapter documents the findings from a 14 question quantitative survey, as well as an 8 question qualitative survey, given to mental health clinicians who were asked to give their experiences of sessions with at-risk preschool aged youth. The purpose of this study was to determine whether or not a trauma informed, body based intervention implemented by an experimental test group alongside a play therapy control group for at risk youth aged 2.5-7 seems to increase, decrease, or have no impact on the effectiveness of existing play therapy. The most important findings for the collective data from the Home for Little Wanderers and Bayview indicate that, while there is not a strong correlation in all questions from week to week in support of the hypothesis, there does appear to be existing trends, but only for certain questions. For instance, a major finding was that question number 12 yields almost entirely “disagree” answers for both the experimental and control groups. Additionally, the answers from the control group did not vary in any important way from those of the experimental group.

Another important finding was that for some questions, The Home’s most frequent response differed from Bayview’s. For example, Bayview had less agreement with the statement in question 8 “I noticed a productive difference in the content or tone of the child's play during this session” than The Home. The major finding about the collective responses from both the Home for Little Wanderers and Bayview is that the results do not follow the same trends or yield the same outcomes with regard to the

hypothesis as the results from The Home only do. , The data from the two agencies is not strongly correlated.

The various major sections below, in the order that they are presented, include the demographic characteristics of the sample, outline the quantitative results in detail (descriptive and inferential), and follow with the responses to the qualitative section of the survey.

Demographic Data about Participants

Demographic data for child client participants with whom the intervention was conducted, was gathered from 2010 and 2014 census data results. See Appendices for Table 1. Despite the fact that clients at each agency lived in different cities in the Boston area, basic demographic data reflecting the sample population can be separately described for the city in which each agency exists. At The Home, demographic statistics were gathered from Roslindale, MA. The total population per zip code is 29,826. The median age is 39.5. The percentage of population under 10 years of age (the study's sample) is 13%. The percentage of households with yearly income less than \$10,000 is 8.30%. The largest percentage of racial groups are broken down as 60% white, 26% black/African American and 13.3% other. (<http://factfinder2.census.gov/>).

At Bayview, demographic statistics were gathered from Quincy, MA. The total population per zip code is 55,055, nearly twice the size of Roslindale's. The median age is 40.2 years. The percentage of population under the age of 10 is 10%. The percentage of households with yearly income less than \$10,000 is 3.90%, nearly half of the percentage in Roslindale. The largest percentage of racial groups are broken down as 72% white,

19% Asian, 17% black/African American, which is quite a different population breakdown that in Roslindale (<http://factfinder2.census.gov/>).

Introduction to Patterns in Clinician Responses

For the purposes of brevity and clarity, the findings will outline those responses that were predominant. In other words, if for any given question, most of the responses are “agree”--that is what will be discussed below, as that is the important finding. That is not to say that those responses that stated, “disagree” are not important. It is to say that they do not guide us towards the hypothesis the same way the other results do, and will not be highlighted.

Important to note is the fact that the number of participants answering the survey per week fluctuated for various reasons, whether it was due to cancellations or other factors. It is also important to look at the data week by week, because the purpose of this study was to determine if there is any important difference made by the intervention that is perceived by clinicians. In terms of quantitative data, though the potential answers on the survey included “strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree,” the analysis of findings here will compile the answers into categories (disagree, neutral, agree) in order to promote precision in determining whether or not the findings support the hypothesis. Though this study has collected both quantitative and qualitative data from participants, the quantitative data will be outlined first.

Quantitative Data: Patterns in Clinician Survey Responses from The Home for Little Wanderers- Question 5

The following answers are with regard to control group responses at The Home to question 5 (whether or not the clinician felt that the child was able to express

herself/himself with appropriate language of feeling). For week 1, 3 out of 5 (60%) of control group clinicians answered in agreement. For week 2, 3 out of 4 (75%) agreed. For week 3, 3 out of 4 (75%) agreed, and for week 4, 2 out of 3 (67%) agreed.

To preface the following sections, it is important to note that the same clinician recorded all answers for the experimental group responses at The Home. With regard to the experimental group, for week 1, 2 out of 3 (67%) of sessions agreed. For week 2, 2 out of 3 (67%) of sessions disagreed. For week 3, 2 out of 3 (67%) agreed. For week 4, 2 out of 3 (67%) disagreed.

Overall, the most important findings for question 5 were in the control group, though there was a slight statistical increase between weeks 1 and 3 in the amount of answers recorded as “agree” (60%-75%), there was a slight statistical decrease between weeks 3 and 4 (75%-67%). For The Home’s experimental group question 5 in week 1, the majority of answers were recorded as “agree.” This changed in week 2, where the majority of answers were recorded as “disagree.” The statistical majority fluctuates again in week 3 where the majority of answers were recorded as agree. Lastly, the majority of answers for week 4 fluctuated again as they were recorded as disagree.

Analysis of question 5 follows. For question 5, the information from both agency’s control group indicates that overall, clinicians felt that the child was able to express his or her self with appropriate language of feeling in regular play therapy sessions without any mind-body intervention. The control group responses for question 5 solely from The Home were similar and supportive of the overall results.

Quantitative Data: Patterns in Clinician Survey Responses from The Home for Little Wanderers- Question 6

The following answers are with regard to control group responses at The Home to question 6 (whether or not the clinician felt that the child was able to regulate his or her affect throughout this session). For week 1, 4 out of 5 (80%) of control group clinicians answered in agreement. For week 2, 3 out of 4 (75%) agreed. For week 3, 4 out of 4 (100%) agreed. For week 4, 3 out of 3 (100%) agreed.

With regard to the experimental group, for week 1, 3 out of 3 (100%) of sessions agreed. For week 2, 3 out of 3 (100%) agreed. For week 3, 2 out of 3 (67%) disagreed, and for week 4, 2 out of 3 (67%) agreed. Again, as with question 5, the experimental group had more instances of disagreement with regard to this question than the control group did.

Overall, the most important findings for question 6 were that in the control group, there was a slight decrease in the amount of answers recorded as “agree” between weeks 1 and 2 (80%-75%). Between weeks 2 and 3, there was a slight increase in the amount of answers recorded as “agree” (75%-100%). The 100% of answers recorded as “agree” is maintained between weeks 3 and 4. For The Home’s experimental group, and with regard to question 6, week 1 and 2 yielded 100% of answers recorded as “agree,” and there was a drastic, important statistical shift in that between week 2 and 3, the majority of responses were recorded as “disagree” (67%). Between weeks 3 and 4, there was another important statistical shift with the majority of recorded responses fluctuating from “disagree” to 67% answering, “agree.”

Analysis of question 6 follows. The control group results suggest that clinicians in the control group who were not conducting the intervention felt that the child was able to regulate his/her affect throughout the session. The experimental group results suggest that

clinicians in the experimental group felt during the first 2 weeks of the intervention, more so than those clinicians recording for the first 2 weeks of the control group, that the child was able to regulate his/her affect throughout session. However, after the first 2 weeks, the experimental group clinicians shifted to 67% disagree in week 3, and 67% agree in week 4 (whereas the control group saw a steady increase between week 3 and 4 in the percentage of answers recorded as agree). These results may suggest that either the intervention works quite well initially, but then loses its effectiveness. The results may also suggest that the intervention has no effect at all on the clinician's perception of the child's regulation of affect during session--and that the first two weeks that the intervention was conducted, the child being recorded was merely having a good day.

Quantitative Data: Patterns in Clinician Survey Responses from The Home for Little Wanderers- Question 7

The following answers are with regard to control group responses at The Home to question 7 (whether or not the clinician noticed a productive difference in the content or tone of the child's play during this session). For week 1, 3 out of 5 (60%) agreed. For week 2, 2 out of 4 (50%) agreed and 2 out of 4 (50%) disagreed. For week 3, 2 out of 4 (50%) agreed, and 2 out of 4 (50%) selected neither agree nor disagree. For week 4, 2 out of 3 (67%) agreed.

With regard to the experimental group, for week 1, 2 out of 3 (67%) answered "neither agree nor disagree," for question 2, 2 out of 3 (67%) agreed, for week 3, 2 of 3 (67%) agreed, for week 4, 2 of 3 (67%) answered neither agree nor disagree. The experimental group had more instances of neutrality than the control group did.

Overall, the most important findings for question 7 were that in the control group, there was a slight decrease between week 1 and 2 (60%-50%) in the amount of responses recorded as “agree”--but 50% of responses in week 2 were also recorded as disagree, making week 2 statistically irrelevant with regard to determining whether or not the hypothesis can be supported by the data. In week 3, 50% of the amounts of responses were also recorded as “agree,” and 50% of responses in week 2 were recorded as “disagree,” making week 3 also statistically irrelevant with regard to determining whether or not the hypothesis can be supported by the data. For week 4, 67% of responses were recorded as “agree.” For The Home’s experimental group, and with regard to question 7, the majority clinician response was neutral for week one, and did not reflect any important information. Weeks 2 and 3 yielded the same majority percentage of 67% of clinicians recording the response as “agree.” Week 4 showed the same majority percentage (67%) of neutrality as week 1.

Analysis of question 7 follows. For question 7, in terms of control group responses, there is no observable trend here, and variance in responses may be due to natural fluctuations in the content or tone in the child’s play week to week. Because the experimental group responses did not follow a trend, and did not vary importantly from the fluctuating responses for week 7’s control group, no important findings were discovered from question 7.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 8

The following answers are with regard to control group responses at The Home for question 8 (whether or not the clinician felt that they did NOT notice any difference in

the affect regulation of the child during this session, compared to previous sessions). For week 1, 2 out of 5 (40%) answered agree, and 2 out of 5 (40%) answered disagree. For week 2, 3 out of 4 (75%) answered disagree. For week 3, 3 of 4 (75%) answered agree. For week 4, there was a different answer for each of the three sessions, so the results yield no important finding.

In the experimental group for week 1, though it was the same clinician recording all results each week for separate sessions, 3 of 3 (100%) answered agree. For week 2, all three sessions had different responses, so the results yield no important finding. For week 3, 2 out of 3 (67%) disagreed. For week 4, 2 out of 3 (67%) disagreed.

Overall, the most important findings for question 8 were that in the control group, week 1 yielded a 50%/50% split between clinicians who answered, “agree” and clinicians that answered “disagree.” There was a shifts in week 2, where the majority (75%) answered, "disagree." The majority results drastically fluctuated again in week 3, where 75% of clinicians answered, “agree.” Week 4 is non-important due to the lack of a majority answer. For The Home’s experimental group, and with regard to question 8, week 1 yielded an important majority response (100%) of agree, week 2 did not yield important results. For both week 3 and 4, the majority (67%) of responses recorded were “disagree.”

Analysis of question 8 follows. For question 8, there is no observable pattern in the data of the control group, and variance in responses may be due to natural fluctuations in the content or tone in the child’s play week to week. The findings from the experimental group may suggest that after week 2, the additional intervention begins to contribute to a difference in the affect regulation of clients compared to previous

sessions. Question 6 asks if the clinician if they noticed that the child was able to regulate his or her affect throughout this session--gathering the same information as question 8, but using different wording. The results from question 6 keeping with the results from question 8. The fact that these results seem to match question 8's results amplifies the validity of the findings from question 6.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 9

The following answers are with regard to control group responses at The Home for question 9 (whether the clinician felt they did not notice a difference in the content or tone of the child's play during this session). For week 1, 4 out of 5 (80%) disagreed. For week 2, 2 out of 4 (50%) disagreed, and 2 out of 4 (50%) agreed. For week 3, 3 out of 4 (75%) agreed. For week 4, there was a different answer for each of the three sessions, so the results yield no important finding. In the experimental group, for week 1, 2 out of 3 (67%) answers disagreed. For week 2, 3 out of 3 (100%) disagreed. For week 3, 2 out of 3 (67%) disagreed. For week 4, 2 out of 3 (67%) disagreed.

Overall, the most important findings for question 9 were that in the control group, week 1 had an important finding with the majority (80%) of clinicians answering "disagree"--but this shifts in week 2, where the results are not important because results are divided between agree and disagree (50%/50%). For week 3, the majority answer shows 75% of respondents choosing "disagree" and week 4 yields no important finding due to no majority answer. Also, for The Home's experimental group, and with regard to question 9, all 4 weeks showed the majority of clinicians recording their response as "disagree."

Analysis for question 9 follows. Control group responses for week 9 do not show a trend, and variance in responses may be due to natural fluctuations in the content or tone in the child's play week to week. There are more respondents answering, "disagree" for question 9 in The Home's experimental group than in The Home's control group. This may mean that the addition of the intervention created a change during play therapy sessions that caused clinician's to notice a difference in the content of tone of the child's play, or it may mean that (although a rare scenario, based on Erica Donahue's experience in conducting play therapy sessions), the child being recorded for had rapidly changing content of play for 4 weeks in a row. Nevertheless, these are important findings.

As with questions 6 and 8, 9 gathers the same information from the clinician as question 7, but the survey questions are worded differently. Question 7 specifically asks "did you notice a productive difference..." but unfortunately, one limitation of this study is that question 9 does not specify in which way (be it productive, or unproductive), that the clinician's perceived difference in the affect of the child is, and week 7 does not give any clue to whether or not the difference is productive. Therefore, while it can be said that there is potential that the intervention made a notable difference in affect regulation compared to other sessions, it cannot be said in which way this difference exists.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 10

The following answers are with regard to control group responses at The Home for question 10 (whether the clinician felt the session was productive). For week 1, 5 out of 5 (100%) agreed. For week 2, 3 out of 4 (75%) agreed. For week 3, 4 out of 4 (100%) agreed. For week 4, 3 out of 3 (100%) agreed.

In the experimental group, for week for week 1, 3 out of 3 (100%) answers agreed. For week 2, 2 out of 3 (67%) agreed. For week 3, 2 out of 3 (67%) agreed. For week 4, 2 out of 3 (67%) agreed.

Overall, the most important findings for question 10 were that in the control group, all 4 weeks showed the majority of clinicians recording their responses as “agree.” For The Home’s experimental group, and with regard to question 10, all 4 weeks showed the majority of clinicians recording their responses as “agree.”

Analysis of question 10 follows. The information from question 10’s control group indicates that without the included mind-body intervention, clinicians felt that their sessions were productive. The information from the experimental group indicates that with the addition of the mind-body intervention, clinicians felt that their sessions were productive. These findings may show that the addition of a mind body intervention does not hinder the productivity of a regular play therapy session. However, because question 10’s control group and question 10’s experimental group yielded the same majority answer of “agree” for all four weeks: it is likely that regular play therapy sessions, with or without added interventions, are what makes the time therapeutic time spent with children seem productive to clinicians.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 11

The following answers are with regard to control group responses at The Home for question 11 (whether the clinician felt the session was *not* productive). For week 1, 5 out of 5 (100%) disagreed. For week 2, 3 out of 4 (75%) disagreed. For week 3, 4 out of 4 (100%) disagreed. For week 4, 3 out of 3 (100%) disagreed. In the experimental group,

for week 1, 3 out of 3 (100%) answers disagreed. For week 2, 2 out of 3 (67%) disagreed. For week 3, 2 out of 3 (67%) disagreed. For week 4, 2 out of 3 (67%) disagreed.

Overall, for The Home's control group, and with regard to question 11, the most important finding was that all 4 weeks showed the majority of clinicians recording their responses as "disagree."

Analysis of question 11 follows. The control group responses for question 11 indicate that the majority of clinicians running a control group felt that their session was productive, even without an added intervention. As with questions 7 and 9, and questions 6 and 8, question 11 assesses the same information from the clinician as question 10, but it is worded differently. Because of the fact that for each of the 4 weeks, the majority response of participants was "disagree," the results are in keeping with the results from question 10. The fact that these results seem to match question 10's results amplifies the validity of the findings.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 12

The following answers are with regard to control group responses at The Home for question 12 (whether the clinician perceived that the session was not importantly different than any other session). For week 1, 3 out of 5 (60%) disagreed. For week 2, 2 out of 4 (50%) disagreed and 2 out of 4 (50%) agreed. For week 3, 2 out of 4 (50%) agreed, and the other two responses were each different. For week 4, 2 out of 3 (67%) agreed. In the experimental group, for week 1, 2 out of 3 (67%) answers agreed. For week 2, 2 out of 3 (67%) disagreed. For week 3, 2 out of 3 (67%) agreed. For week 4, 2 out of 3 (67%) disagreed.

Overall, the most important findings for question 12 were that in the control group, there was a slight decrease in the amount of clinicians that answered “disagree” (60%-50%). For week 3, half agreed (50%) and half disagreed (50%). In week 4, the majority of participants answered “agree.” For The Home’s experimental group, and with regard to question 12, the results fluctuate quite a bit and do not follow a trend. The majority of participants in week 1 disagree, in week 2 and 3 the majority agree, in week 4, the majority once again disagree. These experimental group responses for question 12 are different from the control group responses for question 12.

Analysis of question 12 follows. The control group results for question 12 indicate that without the added intervention, clinicians felt for the first few weeks of data collection that there was not an important difference in the session. However, the results also indicate that between week 3 and 4--clinicians begin to feel that they notice a difference in the session. There is no pattern for the experimental group in question 12, whereas there appears to be a gradual, change in sessions week by week in the control group. So, while it can be said that while control group clinicians noticed a change as weeks went on, and experimental clinicians did not, what change occurred cannot be determined, since the survey question does not specify how the session may have been different (more productive, less productive, etc.) This is one limitation of the study.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 13

Question 13 (whether the clinician felt that the child appeared genuinely willing to try out the body based intervention), is unique in that it only applies to experimental group participants. For week 1, though it was the same clinician recording all results each

week for separate sessions, 3 out of 3 (100%) answers agreed. For week 2, 3 out of 3 (100%) agreed. For week 3, 2 out of 3 (67%) selected that the child was not willing to engage in the intervention. For week 4, 3 out of 3 (100%) selected that the child was not willing to engage in the intervention.

Overall, the most important findings for week 13 were that The Home's experimental group shows a majority of clinicians answering, "agree" for both week 1 and 2. Also, for weeks 3 and 4, the majority of clinicians answered that "the child was not willing to engage in the intervention."

Analysis for question 13 follows. The experimental group results for question 13 may indicate that for the first two weeks, the children were willing to engage in the intervention, but for an unknown reason, decided not to engage as time went on. In fact, while week 3 had 67% of clinicians answering that children didn't want to engage, week 4's percentage of clinicians answering that the children didn't want to engage rose to 100%, further validating the conclusion that the children were not as receptive to the intervention as the study had designed it to be.

Patterns in Clinician Survey Responses from The Home for Little Wanderers:

Question 14

Question 14 (whether the clinician felt that the child was *not* willing to try out the intervention), is also unique in that it also only applies to experimental group participants. For week 1, though it was the same clinician recording all results each week for separate sessions, 3 out of 3 (100%) answers disagreed. For week 2, 3 out of 3 (100%) disagreed. For week 3, 2 out of 3 (67%) selected that the child was not willing to engage in the intervention. For week 4, 3 out of 3 (100%) selected that the child was not willing

to engage in the intervention. The overall quantitative findings for The Home have been given.

Overall, the most important findings from question 14 were that The Home's experimental group showed a majority of clinicians answering, "disagree" for weeks 1 and 2. Like questions 6 and 8, and 7 and 9, and 10 and 11; question 14 assesses the same information as question 13, but they are worded differently and these results are in harmony with question 13's major findings.

Analysis of question 13 follows. The results of question 14's experimental group are in keeping with the findings from question 13, and further reinforce the conclusion that the children may not have been as receptive to the intervention as the study had designed it to be.

The findings from The Home have been discussed. Now, the researcher associated with The Home for Little Wanderers will discuss the findings from both The Home and Bayview collectively.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 5

In discussing the overall collective findings from both The Home and Bayview only the response given by the majority of respondents in a given week will be recorded as the important finding. The following answers are with regard to control group responses at both The Home and Bayview for question 5 (whether the clinician felt that the child was able to express herself/himself with appropriate language of feeling). For week 1, the majority (5 out of 8) clinician responses from both agencies were recorded as "disagree." For week 2, the majority (6 out of 7) of clinician responses from both

agencies were recorded as “agree.” For week 3, the majority (5 out of 6) of clinician responses from both agencies were recorded as “agree.” For week 4, the majority (3 out of 4) of clinician responses from both agencies were recorded as “agree.”

The following answers are with regard to the experimental group at both The Home and Bayview. For week 1, the majority (5 out of 8) clinician responses from both agencies were recorded as agree. For week 2, the results were split, half; 3 of 6 clinicians responding “agree” and 3 of 6 clinicians responding “disagree.” For week 3, the majority (4 out of 7) clinician responses from both agencies were recorded as agree. For week 4, the majority (4 out of 6) clinician responses from both agencies were recorded as agree.

Overall, the most important findings for the collective control group responses to question 5 for The Home and Bayview, was that the majority response for each of the 4 weeks was “agree.” Additionally, for the collective experimental group responses to question 5 for The Home and Bayview, there was a majority of agree answers for week 1, week 2 had split results, the majority of week 3 answers shifted back to agree, and the majority of week 4 answers were recorded as “agree.”

Analysis of question 5 follows. The experimental results from question 5 at both agencies are sporadic and do not show a trend that would hold implications for the hypothesis. However, there were more “agree” responses in the control group. For this reason, it may be that in regular play therapy sessions (without an intervention), clinicians see more incidence of children being able to express themselves with appropriate language of feeling than do sessions with added interventions.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 6

The following answers are with regard to control group responses at both The Home and Bayview for question 6 (whether the clinician noticed that the child was able to regulate his or her affect throughout the session). For week 1, the majority (5 out of 8/63%) clinician responses from both agencies were recorded as “agree.” For week 2, the majority (5 out of 7/71%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority (6 out of 6/100%) of clinician responses from both agencies were recorded as “agree.” For week 4, the majority (4 out of 4/100%) of clinician responses from both agencies were recorded as “agree.”

The following answers are with regard to experimental group responses at both The Home and Bayview for question 6. For week 1, the majority (7 out of 9/78%) clinician responses from both agencies were recorded as “agree.” For week 2, the majority (6 out of 6/100%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority (5 out of 7/71%) of clinician responses from both agencies were recorded as “agree.” For week 4, the majority (5 out of 6/83%) of clinician responses from both agencies were recorded as “agree.”

Overall, the most important finding for the collective control group responses to question 6 for The Home and Bayview was that there was a majority of "agree" answers for each of the 4 weeks. The percentage of clinicians answering, “agree” for each week steadily increased (63%-71%-100%-100%). For the collective experimental group responses to question 6 for The Home and Bayview, there was a majority of agree answers for each of the 4 weeks.

Analysis of question 6 follows. For question 6, the control group results from both agencies indicate that clinicians felt that even without an intervention, children had a steadily increasing rate of being able to regulate their affect during session. The results from both agency's experimental groups indicate that clinicians felt that with the intervention, children had a steadily increasing rate of being able to regulate their affect during session. These results are similar to the control group, and match the results found solely for The Home.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 7

The following answers are with regard to control group responses at both The Home and Bayview for question 7 (whether the clinician noticed a productive difference in the content or tone of the child's play during this session). For week 1, the majority (4 out of 8/50 %) clinician responses from both agencies were recorded as "agree." For week 2, the majority (4 out of 7/57%) of clinician responses from both agencies were recorded as "agree." For week 3, the majority half of clinician responses from both agencies were recorded as "agree" and half were recorded as "neither agree nor disagree." For week 4, the majority (3 out of 4) of clinician responses from both agencies were recorded as "agree."

The following answers are with regard to experimental group responses at both The Home and Bayview for question 7. For week 1, the most common answer was "neither agree nor disagree" (4 out of 9/44%). For week 2, the majority (3 out of 6) of clinician responses from both agencies were recorded as "agree." For week 3, the majority (5 out of 7/71%) of clinician responses from both agencies were recorded as

“agree.” For week 4, the common answer (3 out of 6/83%) of clinician responses from both agencies was recorded as “neither agree nor disagree.”

Overall, the most important findings for the collective control group responses to question 7 for The Home and Bayview, the majority response for the first 2 weeks and week 4 was “agree.” Week 3 was inconclusive, with half answering agree and half answering “neither agree nor disagree.” Also, for the collective experimental group responses to question 7 for The Home and Bayview, the important finding was that the majority response for week 1 was “neither agree nor disagree.” The majority response for week 2 was “agree.” The majority response for week 3 was “agree.” The majority response for week 4 was “neither agree nor disagree.”

Analysis of question 7 follows. For question 7, the information from both agency’s control groups indicates that overall, clinicians felt that there was a productive difference in the content or tone of the child’s play during session without an intervention. The control group results for question 6 solely from The Home were similar and supportive of the overall results. However, there is no major difference between overall control group results and overall experimental group results for both agencies. For this reason, it cannot be said that clinicians feel the mind-body intervention is the cause of the clinician’s perceived productive difference in the child’s content or tone of play. Implications for the hypothesis would be that including the intervention in session does not appear to negatively affect the productivity of the session.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 8

The following answers are with regard to control group responses at both The Home and Bayview for question 8 (whether the clinician did NOT notice any difference in the affect regulation of the child during this session, compared to previous sessions.). For week 1, the majority (5 out of 8/63%) clinician responses from both agencies were recorded as “disagree.” For week 2, the majority (5 out of 7/71%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority consisted of half of clinician responses from both agencies were recorded as “agree” and half recorded as “neither agree nor disagree.” For week 4, the majority (2 out of 4) of clinician responses from both agencies were recorded as “disagree.”

The following answers are with regard to experimental group responses at both The Home and Bayview for question 8. For week 1, the most common answer was “agree” (6 out of 9/67%). For week 2, the majority (3 out of 6) of clinician responses from both agencies were recorded as “disagree.” For week 3, the majority (5 out of 7/71%) of clinician responses from both agencies were recorded as “disagree.” For week 4, the common answer (5 out of 6/83%) of clinician responses from both agencies was recorded as “disagree.”

Overall, the most important finding for the collective experimental group responses to question 8 for The Home and Bayview, was that the majority response for week 1 was “agree,” but the last 3 weeks had a majority answer of “disagree.”

Analysis for question 8 follows. For the collective control group responses to question 8 for The Home and Bayview, the results did not follow a clear trend week to

week. Because of this sporadic nature, no finding was discovered. However, the experimental group results from question 8 at both agencies are different from the control group results, which were much more sporadic. This fact has implications for the hypothesis, as it may indicate that the intervention caused the involved clinicians to perceive some change in affect regulation of the child during session, starting after week 1. While this is an important finding, it is not possible to determine what change these clinicians perceived.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 9

The following answers are with regard to control group responses at both The Home and Bayview for question 9 (whether the clinician did not notice a difference in the content or tone of the child's play during this session). For week 1, the majority (6 out of 8/75%) clinician responses from both agencies were recorded as “disagree.” For week 2, the majority (4 out of 7/57%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority response was “agree” (4 out of 6/67%). For week 4, the majority (2 out of 4/50%) of clinician responses from both agencies were recorded as “disagree.”

The following answers are with regard to experimental group responses at both The Home and Bayview for question 8. For week 1, the most common answer was “agree” (5 out of 9/56%). For week 2, the majority (4 out of 6/67%) of clinician responses from both agencies were recorded as “disagree.” For week 3, the majority (5 out of 7/71%) of clinician responses from both agencies were recorded as “disagree.” For

week 4, the common answer (4 out of 6/83%) of clinician responses from both agencies was recorded as “disagree.”

Overall, the most important finding for the collective experimental group responses to question 9 for The Home and Bayview, was that the majority response for week 1 was “agree,” but the last 3 weeks had a majority answer of “disagree.”

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 10

The following answers are with regard to control group responses at both The Home and Bayview for question 10 (whether the clinician felt the session was productive). For week 1, the majority (7 out of 8/88%) clinician responses from both agencies were recorded as “agree.” For week 2, the majority (6 out of 7/86%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority response was agree (6 out of 6/100%). For week 4, the majority (4 out of 4/100%) of clinician responses from both agencies were recorded as “agree.”

The following answers are with regard to experimental group responses at both The Home and Bayview for question 10. For week 1, the most common answer was “agree” (9 out of 9/100%). For week 2, the majority (5 out of 6/83%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority (6 out of 7/86%) of clinician responses from both agencies were recorded as “agree.” For week 4, the common answer (4 out of 6/83%) of clinician responses from both agencies was recorded as “agree.”

Overall, the most important findings for the collective control group responses to question 10 for The Home and Bayview were that all 4 weeks yielded a majority result of

agree. Also, for the collective experimental group responses to question 10 for The Home and Bayview, the majority response for all 4 weeks was also “agree.”

Analysis for question 10 follows. For question 10, the results from both agency’s control groups did not follow a clear trend week to week in week 10. Because of this sporadic nature, no finding was discovered.

The experimental results from both agency’s experimental groups are different from the control group results, which were much more sporadic. This fact has implications for the hypothesis, as it may indicate that the intervention caused the involved clinicians to perceive some change in the content or tone of the child’s play, starting after week 1. While this is an important finding, it is not possible to determine what change these clinicians perceived.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 11

The following answers are with regard to control group responses at both The Home and Bayview for question 11 (whether the clinician felt the session was NOT productive). For week 1, the majority (7 out of 8/88%) clinician responses from both agencies were recorded as “disagree.” For week 2, the majority (6 out of 7/86%) of clinician responses from both agencies were recorded as “disagree.” For week 3, the majority response was “disagree” (6 out of 6/100%). For week 4, the majority (4 out of 4/100%) of clinician responses from both agencies were recorded as “disagree.”

The following answers are with regard to experimental group responses at both The Home and Bayview for question 11. For week 1, the most common answer was “disagree” (9 out of 9/100%). For week 2, the majority (5 out of 6/83%) of clinician

responses from both agencies were recorded as “disagree.” For week 3, the majority (6 out of 7/86%) of clinician responses from both agencies were recorded as “disagree.” For week 4, the common answer (4 out of 6/ 67%) of clinician responses from both agencies was recorded as “disagree.”

Overall, the most important findings for the collective control group responses to question 11 for The Home and Bayview were that the majority response for each of the 4 weeks was “disagree.” This information indicates that overall, clinicians felt that the session was productive without any mind-body intervention. Also, the control group for question 5 solely from The Home was similar and supportive of the overall results. Additionally, for the collective experimental group responses to question 11 for The Home and Bayview, there was a majority of disagree for each of the 4 weeks. These results do not differ from the control group results, nor do they differ from The Home’s results. While these results do imply that the addition of the intervention does not hinder the productivity of sessions in the opinion of the clinician, it does not directly support or disprove the hypothesis.

Analysis of question 11 follows. For question 11, the results from the collective control group is in keeping with the findings from The Home’s control group responses for question 10 only and is therefore in keeping with its implications with regard to the hypothesis. Additionally, because the collective experimental results are not different from the collective control group responses for question 10, no important finding was discovered here. Regular play therapy sessions, with or without added interventions, are what makes the time therapeutic time spent with children seem productive to clinicians. There was no important finding with regard to question 12.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 12

The following answers are with regard to control group responses at both The Home and Bayview for question 12 (whether the clinician felt that the session did not seem to be importantly different than any other sessions). For week 1, the majority (4 out of 8/50%) clinician responses from both agencies were recorded as “disagree.” For week 3, the results were inconclusive because the majority 2 out of 7 (29%) of clinician responses from both agencies were recorded as “agree” and 2 out of 7 (29%) of clinician responses were recorded as “disagree.” For week 3, the majority response was “agree” (6 out of 6/100%). For week 4, the majority (2 out of 4/50%) of clinician responses from both agencies were recorded as “agree.”

The following answers are with regard to experimental group responses at both The Home and Bayview for question 12. For week 1, the most common answer was “agree” (7 out of 9/78%). For week 2, 3 out of 6 (50%) of clinician responses from both agencies were recorded as “agree” and 3 out of 6 (50%) answered, “disagree.” For week 3, the majority (4 out of 7/58%) of clinician responses from both agencies were recorded as “agree.” For week 4, the common answer (4 out of 6/83%) of clinician responses from both agencies was recorded as “disagree.”

Overall, the most important finding for the collective control group responses to question 12 for The Home and Bayview was that the majority response varied throughout the 4 weeks. No pattern was identified. Also, for the collective experimental group responses to question 12 for The Home and Bayview, the answers were similar to the control group and therefore, no important finding came to light.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 13

The following answers are with regard to experimental group responses at both The Home and Bayview for question 13 (whether the clinician felt that the child appeared genuinely willing to try out the body based intervention). For week 1, the most common answer was “agree” (7 out of 9/78%). For week 2, 6 out of 6 (100%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority (3 out of 7/43%) of clinician responses from both agencies were recorded as “agree.” For week 4, the common answer (3 out of 6/83%) of clinician responses from both agencies was recorded as “the child was not willing to engage in the intervention.”

Overall, the most important findings for the collective experimental group responses to question 13 for The Home and Bayview, were that the answers the majority answer for the first 3 weeks was “agree”--but this shifts in week 4 where the majority answer is “the child was not willing to engage in the intervention.”

Analysis of question 13 follows. For question 13, it appears that the clinicians felt that the child was willing to engage in the intervention for the first 3 weeks, but in week 4, something shifts and most clinicians feel that the child does not wish to engage. For question 14, it appears that the clinicians felt that the child was willing to engage in the intervention for the first 2 weeks, but in week 3 and 4, something shifts and most clinicians feel that the child does not wish to engage. These results are similar to question 13, which asks the same question with different wording.

Patterns in Clinician Survey Responses from both The Home for Little Wanderers and Bayview: Question 14

The following answers are with regard to experimental group responses at both The Home and Bayview for question 14. For week 1, the most common answer was “agree” (8 out of 9/89%). For week 2, 6 out of 6 (100%) of clinician responses from both agencies were recorded as “agree.” For week 3, the majority (4 out of 7/57%) of clinician responses from both agencies were recorded as “disagree.” For week 4, the common answer (3 out of 6/83%) of clinician responses from both agencies was recorded as “the child was not willing to engage in the intervention.”

Overall, the most important findings for the collective experimental group responses to question 14 for The Home and Bayview, were that the answers the majority answer for the first 2 weeks was “disagree”--but this shifts in week 4 where the majority answer is “the child was not willing to engage in the intervention.” Analysis for question 14 suggests that the child opts out of the intervention a week earlier (week 3, rather than 4).

Qualitative Data Findings: The Home for Little Wanderers

For The Home’s qualitative data, since only one clinician ran experimental groups, one clinician completed a qualitative survey. That clinician suggested that the intervention may benefit from being changed by “less structured, less specific guidelines.” While that clinician felt that the children’s large imaginations and wide range of choice in terms of activities in play therapy served as barriers to the intervention, the clinician stated that they would still use the components of this trauma-informed,

mind-body intervention on cards, and did not feel the intervention was in any way harmful to the participating clients.

Qualitative Data Findings: SSMH Bayview Associates

For Bayview's qualitative data, 4 of the 5 clinicians stated that they did not have any suggestions for changing the intervention or how it was implemented. However, the 1 clinician that did, answered in agreement with The Home's clinician, "I think I might have been more comfortable with more streamlined verbal directions like "make your body a star" rather than a long "you may do this" or "you may feel like doing this." Another clinician mentioned it felt "difficult to remember." While the majority clinicians mentioned being excited and optimistic about conducting interventions, there were some mentions of children not being receptive. For instance, one clinician stated, "I was excited to do it, but I was disappointed that the kids in the age range who were eligible to participate were not as interested," and another mentioned, "some showed resistance in engaging" as time went on.

Overall, all clinicians stated that they would be willing to include a similar mind-body component in their future sessions. However, it seemed that clinicians felt more comfortable conducting the intervention, and that the children were more apt to participate, when the clinician adapted the way the intervention was given based on the individual needs of the child, and when the verbal directions were less structured.

Conclusion

The findings above were analyzed and written by the researcher associated with The Home for Little Wanderers. Overall, it was discovered that while mind-body interventions may be effective for children, structured mind-body interventions do not

suit children's short attention spans. In the following paragraphs, the findings that were analyzed and written by the researcher associated with SSMH Bayview Associates will be given.

Findings from SSMH Bayview Associates

The purpose of this empirical research study was to explore the clinician's individual experience of integrating a trauma-informed, interoceptive intervention into play therapy with clients ages 2 1/2 to 7. The research questions addressed by this study are: How do clinicians from our study feel about incorporating a trauma-informed, mind-body intervention into their play-therapy practice? Does clinical setting affect applicability of integrating the body into a clinician's practice? Is a clinician's personal attitude towards trying something new in their practice a predictor of reporting positive clinical results? How do young clients respond to the adapted model of trauma-informed interoception based on The Trauma Center Trauma-Sensitive Yoga? What do the participating clinicians recommend?

Demographics

Participants of the study included both the participating clinician and client. The client demographics are identified only by site, Bayview outpatient clinic or Home for Little Wanderers early-intervention program, and by age as children six years and older are required to sign consent for participation. Inclusion criteria required clients to be engaged in play therapy with the participating clinician on a regular basis. It is important to note that the clinicians at HFLW early intervention program were working with a predetermined "at-risk" population in an urban landscape. As a result, the early intervention program at HFLW represented a much younger pool of clients than

Bayview’s outpatient clinic, where children are at least 4-years old. South Shore Mental Health has a separate location for children that fall within the domain of early intervention.

I identified the clinicians within my agency that saw children under the age of 8 and approached them directly. There were clinicians who expressed interest in taking part in the study, but were unable to due to the age criteria. Ultimately, clinicians volunteered to administer the mind-body intervention in a 4-week study. The weekly survey yielded a total of twelve participating clinicians: seven from Bayview, and five from the Home for Little Wanderers. Clinicians could choose to remain anonymous, and are not identified by name in this thesis. Clinicians were asked to identify themselves by professional title in question 1 of the weekly Qualtrics survey. The breakdown of participating clinicians by profession is reflected in Table 2.

Table 1
Professional Makeup of Total Participating Clinicians from Bayview and HFLW

	Intern	Social Worker	Psychologist
HFLW	3	2	
Bayview	2	4	1

Quantitative Data

Introduction to the Quantitative Data

The research analyst at Smith College School did statistical analysis of quantitative data for Social Work. Both researchers then examined the findings. The average responses to the weekly survey showed no statistically important differences between the experimental group and comparison group. In reporting the trends in

responses to the weekly survey questions, data will be presented by the question asked and the corresponding responses by week. Again, the purpose of this study is to determine if clinicians perceived the intervention to add to the therapeutic benefit of their standard practice. For the purposes of brevity and clarity, the findings will outline those responses that were predominant. In other words, if for any given question, most of the responses are “agree”--that is what will be discussed below, as that is the important finding.

The number of participants who responded to the survey varied by week; in total there were 12 complete entries from all 4 weeks. At least one clinician did the intervention with two clients, which is reflected in the first week’s findings. For the majority of the survey questions, participants were asked to respond with the following scale: “strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree.” However, the analysis of findings herein will compile the answers into categories (disagree, neutral, agree) in order to promote precision in determining whether or not the findings support the hypothesis. Five Bayview clinicians participated in the experimental group, two including myself, had partial data for the comparison group. Due to incomplete data in the comparison group for Bayview responses, the quantitative data will reflect the experimental responses from Bayview only.

Trends in Experimental Group Responses to Weekly Survey: Bayview

In order to understand the quantitative data, we created an excel spreadsheet with responses to weekly survey questions by clinician. Questions 1, 2, and 4 asked clinicians to identify the week, their location, and Question 3 asked clinicians: Do you already use mind body interventions when you conduct your regular play therapy sessions? Four out

of six clinicians responded, yes in week 1. Their responses to this question in the following three weeks are not necessary to report, as it did not change. In examining the data in a spreadsheet format, we did not find differences in the average responses between the clinicians who reported using “mind-body interventions” prior to the intervention for the purpose of this thesis.

The following section, Table 2- Table 11, reflects responses by Bayview experimental group clinicians from weekly survey questions (5-14.) Question 5 in the weekly survey asked the clinician to gauge how well the child was able to express himself using “appropriate language of feeling.” Table 2 reflects the weekly responses, showing a progression over the 4 weeks.

Table 2

Bayview Experimental Responses by Week: The child was able to express herself/himself with appropriate language of feeling.

<i>Response</i>	<i>Week 1</i>	<i>Week 2</i>	<i>Week 3</i>	<i>Week 4</i>
Disagree	2	1	2	
Neutral	1			
Agree	3	2	2	3

Table 3

Bayview experimental responses by week: I noticed that the child was able to regulate his or her affect throughout this session.

<i>Response</i>	<i>Week 1</i>	<i>Week 2</i>	<i>Week 3</i>	<i>Week 4</i>
Disagree	1		1	
Neutral	1			
Agree	4	3	3	3

Table 4

Bayview experimental responses by week: *I noticed a productive difference in the content or tone of the child's play during this session.*

Response	Week 1	Week 2	Week 3	Week 4
Disagree	2	1	1	1
Neutral	2	1	1	1
Agree	2	1	2	1

Calculating for human error, participants were asked questions in the inverse form. Positive trends are reflected in the pair of questions reflected by Table 3 and Table 5.

Table 5

Bayview experimental responses by week: *I did NOT notice any difference in the affect regulation of the child during this session, compared to previous sessions.*

Response	Week 1	Week2	Week 3	Week 4
Disagree	1	2	3	3
Neutral	2			
Agree	3	1		1

Table 6

Bayview experimental responses by week: *I did NOT notice a difference in the content or tone of the child's play during this session*

Response	Week 1	Week 2	Week 3	Week 4
Disagree	1	1	3	2
Neutral	2			
Agree	3	2	1	1

Table 7

Bayview experimental responses by week: *This session seemed productive to me*

Response	Week 1	Week 2	Week 3	Week 4
Disagree				1
Neutral				
Agree	6	3	4	2

Table 8

Bayview experimental responses by week: *This session did NOT seem productive to me*

Response	Week 1	Week 2	Week 3	Week 4
Disagree	6	3	4	2
Neutral				
Agree				1

Table 8 shows both trends seen elsewhere: progression over the 4 weeks positively, and client inconsistency: a topic which will be explored in the next chapter. Client inconsistency is understood by: client no-shows, cancelled appointments, insurance problems, or client choosing not to engage in the exercise.

Table 9

Bayview experimental responses by week: *This session did NOT seem to be importantly different than any other sessions.*

Response	Week 1	Week 2	Week 3	Week 4
Disagree	1	1	3	2
Neutral				
Agree	5	2	1	1

Table 10

Bayview experimental responses by week: *The child appeared genuinely willing to try out the body- based intervention.*

Response	Week 1	Week 2	Week 3	Week 4
Disagree	2		1	1
Neutral				
Agree	4	3	3	2

Table 11

Bayview experimental responses by week: *The child was NOT willing to try out the body- based intervention.*

Response	Week 1	Week 2	Week 3	Week 4
Disagree	5	3	3	2
Neutral				1
Agree	1		1	

Trends in Responses: Interns vs. Clinicians

The data analyst uploaded responses from the weekly survey and used it to create an SPSS file with response frequencies. There were two important findings when the clinician's responses are broken down into two groups: the interns and clinicians, either psychologists or social workers. There was an important difference in question 6: ($t(55.94) = 2.793, p=.007$, two-tailed). The interns had a mean of 4.09 compared to a mean of 5.15 for the clinicians. There was an important difference in q7 ($t(48.76)=2.586, p=.013$, two-tailed). The interns had a mean of 4.56 compared to a mean of 5.42 for the clinicians. There were no important differences in the rest of the survey.

Qualitative Data from the Researcher at Bayview Associates

After the 4-week study, the clinicians who participated in the experimental group were given a final survey where they were able to describe their individual experience through open-ended questions. All five participating experimental group clinicians from Bayview provided feedback through this final questionnaire. Erica also provided her own reflections to this questionnaire for her experience implementing the intervention in her placement.

This next section highlights major themes from the responses. Verbatim responses have been included to shine light on the purpose of this study: to explore the clinician's experience of including this intervention in their practice. The first question addressed the general methodology and implementation design of our experiment.

Was there anything that the clinician would suggest changing about the intervention itself, or the way it was implemented?

One clinician responded simply, "no," while the other responses follow:

No, the consent forms was clear and easy to understand. It was helpful to have conversation suggestions on the back of the cards.

No, it was well done. Potentially extend the age range.

The first time that I tried the intervention with my four year-old client, I read the prompts directly from the card as an invitation for her to participate, mostly because I was acquainting myself with implementing the intervention for the first time and wanted to make sure I was implementing it "correctly." I quickly found that it was hard for a four year-old with important challenges with impulse control and attention to maintain her attention when I was reading from the card "as is," with longer sentences. Since she had already lost her attention when I was reading the card on "Hands and Fingers," she wasn't interested in examining her hands and fingers but did respond to the prompt on feeling textures, which was consistent with her tendency to be sensory-seeking....The second time I tried the intervention with my client, I used shorter, more direct and simple sentences, as well as what I knew about my client in order to engage her. For example, I knew that she responded to tactile inputs, so when we sat facing each other on the

ground to practice the “Breathing” exercise, I would lightly put my hand on her arm in order to ground her and to help her focus on the activity. Although the “Additional Notes” specified, “Try to avoid copying the child or guiding the child,” I found that when I was modeling breathing through my nose and mouth for my client, she was much more willing to try this as well. Because she tended to be tactilely responsive, when I showed her that she can feel her own breath by putting her hand close her mouth, she was very interested in doing so herself and wanted me to feel the breath from her mouth (on my face and fingers). In this way, she was definitely “interoceptive” engaged. At this point, I had her interest, so she followed along when I modeled for her putting her hand on her stomach to practice belly breathing. By the end of this exercise, my hyperactive and impulsive client was yawning and was noticeably calmer.

I think I might have been more comfortable with more streamlined verbal directions like "make your body a star," rather than a long: "you may do this," or, "you may feel like doing this." - I usually skipped the verbal prompts with my clients.

How did you feel about conducting interventions with your clients?

I was looking forward to trying the intervention with my client, as she has difficulties with self-regulation. As mentioned previously, the first time I tried the intervention, because I was anxious about implementing the intervention with fidelity, I ended up reading the prompts “as is,” rather than adapting it to the needs of my client. After this first try, I became more comfortable with adapting the intervention based on what I knew about my client, which allowed her to more effectively engage with the body-based exercise. Unfortunately, my client’s family was thrown into crisis when the father walked out on the family unexpectedly, so my client did not come to session for a few weeks; as a result, we were not able to have additional trials of the TC-TSY beyond the first two sessions. I would say that I am now more confident with implementing the intervention as the result of those first two sessions.

I was excited to do it, but I was disappointed that the kids in the age range who were eligible to participate were not as interested.

It felt difficult to remember to implement the intervention into my routine with my client, which I think was more about my own lack of familiarity (and therefore, comfort) with body-based interventions than anything else.

I felt confident in using the interventions with clients, but that may be because I already use body-based interventions with many of my clients. The instructions on the cards were clear and straightforward. All clients were excited about trying something new at the beginning, and then some showed resistance in engaging in certain weeks.

It felt a little more directive than I sometimes am in play therapy, but I think the intervention is helpful and needed in certain cases. The activities were fun and it became a relational experience to do it together.

At this point in time, do you see yourself continuing to integrate any of the components (or cards) of the trauma-informed, body-based intervention?

All clinicians responded, “yes” to this question. One clinician added:

Yes, I've even used it with other clients who weren't involved in the study. I like the cards as options for kids to choose from.

Are there any barriers you experienced or foresee experiencing in using interoceptive components in therapeutic work, particularly within a play therapy model?

Getting the kids to embrace it. The two kids who were enrolled in the study were not as interested in doing it and tend to be oppositional. Other kids who I work with were more interested in it, so it is unfortunate that they were not in the age range.

Even though the experiment design worked to make it as non-directive as possible it is still more directive than my usual style.

The fact that it's more directive than many play therapy techniques, some children refuse to engage, but that barrier is not specific to this intervention.

For children who struggle with self-regulation or attention difficulties, one barrier I experienced but worked through was figuring out how to adapt the intervention in order to sustain her attention. This had to do with the implementation of the intervention rather than simply the implementation itself. Once my client became engaged in the exercise, she was able to increase her awareness of the sensation of her own breath on her fingers, as well as practice belly breath, both of which helped to her to down regulate.

For clients with trauma histories in particular, I can foresee potential obstacles of not getting into power struggles with clients and not inadvertently triggering clients. As I note below for Question #8, I think these exercises in of themselves are fairly trauma-sensitive, but there is no way to know ahead of time all of clients' triggers. What's important is to stay attuned to clients' responses to be aware of any traumatic reactions, as well as to respect their desires with regard to whether or not they want to complete the exercise. Since individuals with trauma histories have often experienced a sense of powerlessness and helplessness, it is especially important to help those clients feel an ownership over their bodies and a sense of agency with regard to decisions relating to their bodies. This is where avoiding a power struggle with clients when participating in these exercises is crucial. When I was a first year Social Work Intern, working as a Child and Adolescent Therapist Intern at a local domestic violence agency, I introduced yoga exercises using Baron Baptiste's "My Daddy is a Pretzel," hoping to

implement body-based exercises as a part of a routine during our therapy sessions. My client was an 8 year-old boy who had witnessed instances of both domestic and community violence, in addition to multiple losses, moves, and life transitions, including living at a domestic violence shelter. As to be expected, my client experienced some difficulties with self-regulation, hyper vigilance, and hyperactivity. Each week, he participated in our weekly play therapy sessions with great excitement, such as hiding in the room and attempting to jump onto my back when he jumped out from hiding. The first time I introduced “My Daddy is a Pretzel” book, he was interested in the exercises. However, when I tried to incorporate the yoga exercises as a routine element to our sessions, I found that he became bored and protested doing the yoga exercises every time, as he was more eager to simply play. I learned that engaging a power struggle regarding this was counter-productive to the therapeutic process. Through my experience with this client, I learned about creating a balance of fostering nurturance and emotional safety through the therapeutic relationship, setting limits regarding to safety, offering structure and containment through the regularly scheduled weekly session, as well as providing ample opportunities for choice and self expression, such as through sand play, my client’s favorite activity. These lessons were exemplified in my experience of introducing a body-based activity but learning to take my client’s lead in the process.

Would you be willing to develop your own practice related to this intervention?

All clinicians responded, “yes,” and three clinicians reflected further:

Yes, absolutely. I loved having the five laminated cards that clients can choose from, as well as having additional simple, mind-body exercises that I can introduce to clients and adapt according to my client’s development level and clinical characteristics and needs. I also like that this intervention is easy to carry around and thus mobile, as well as easy to understand. I would also love to learn more about the version for TSY for adults, as another mind-body based intervention to add to my clinical tool kit!

Yes, I definitely plan to continue to integrate body-based work, especially with anxious children. I like the model of offering cards for the child to choose options.

I wouldn't feel comfortable generating my own, but I have integrated, modified/combined activities into my practice in the past.

Would you say that you already have a body-based practice that includes interoception?

As was noted in the quantitative data findings, four out of five clinicians from the Bayview experimental group reported that prior to this intervention, they used a body-based practice with clients that included interoception. One clinician expounded:

I would say that I had encouraged clients to use interoception when practicing yoga, body scans, breathing, and progressive relaxation exercises during therapy sessions with me. Through participating in this study, however, I learned more

about how to practically keep the language or discussion as “body” based, rather than “mind” based, as possible. I would interested in reading more studies or resources comparing the efficacy of body-based practices that focuses primarily on interoception with mind-body exercises that use mind based interventions such as guided imagery. Does the investigator have any suggestions?

Do you have concerns about integrating this intervention as was presented to you during the 4-week study?

Two out of five clinicians responded, “no.” One clinician shared a helpful suggestion based on her experience with her client, and another clinician expressed her frustration with implementing such an intervention within the constraints of the time available.

I think the directions were helpful. I also appreciated that the investigator was responsive to specific questions that I had regarding implementing the interventions. One suggestion I would make is to perhaps make a note in the directions that clinicians may need to and should feel free to adapt the language in order to age-appropriate or attuned the particular needs of the client, as long as the critical elements of the intervention (interoception-focused, stressing free choice, etc.) remain the same. One question I had was whether or not modeling for the child took away from my own engagement with the exercise, as I found that this was very effective in helping my 4 year-old client become more interested in trying the exercise. However, I took care to focus her attention on how body felt during the exercise, rather than telling her how to feel.

Unfortunately the children did not attend each week. One of the clients only comes every other week and the other one had an insurance issue and then needed to cancel, so she also only attended twice within the month.

No, I felt comfortable because the material provided a clear explanation.

Do you think this intervention has the potential to be harmful to young clients?

Four out of five clinicians felt that this intervention was not potentially harmful to young clients. One clinician responded yes, and gave an example of where her concerns were located.

No. As noted previously, I think all of the exercises are fairly trauma-sensitive, as opposed to some yoga poses, which may be potentially triggering. Of course, there is no way to know all of our clients’ triggers ahead of time, so what’s important is to stay attuned to their responses to be aware of any traumatic reactions, as well as to respect their desires with regard to whether or not they want to complete the exercise. Since individuals with trauma histories have often experienced a sense of powerlessness and helplessness, it is especially important to help those clients feel an ownership over their bodies and a sense of agency with regard to decisions relating to their bodies. This is where avoiding a power struggle with clients when participating in these exercises is crucial.

No-not when done with the way you encouraged. If this kind of work was forced then it could be. But we did it sensitively and always offering the child options.

Yes-only in that body-based interventions could be triggering for clients with trauma histories and a non-trauma informed clinician could be unprepared to recognize symptoms of trauma responses and respond appropriately; I think it would be important to be trauma aware in implementing this practice.

No- only if it is integrated unwillingly and the child is forced to continue doing it because it's how the therapist practices.

Other Findings

It is of note that we chose to work with what is considered one of the most vulnerable populations, the youngest clients who have already been determined to be “at-risk” on an agency or governmental level. The process of receiving approval to work with this population presented many learning opportunities as well as frustrations (see Appendix H for SSMH Bayview Associates approval letter, and see Appendix I for The Home for Little Wanderers approval letter. It was necessary for us to prove the potential value of our intrusion upon institution, agency, and interpersonal professional spaces. The entire process beginning with introducing a preliminary proposal to our agencies in the fall, offered a rich perspective for both researchers in which we interacted within the channels that lead to change within institutions. Finally, as a joint-thesis, we gained a multi-institutional perspective, rich with clinical While these findings may be useful in future research design, these findings are beyond the scope of our study and therefore will not be included within the findings chapter of this thesis. The following chapter will primarily focus on a discussion of the findings presented within this chapter. However, the process of implementing this experimental intervention will be included within the larger discussion.

Conclusion from both Researchers

The next chapter will include a discussion of these findings, with more thorough analysis of important themes and patterns that were found. Also discussed will be strengths, limitations, comparison of the findings to previously reviewed literature, as well as their implications for this study and for the field of social work as a whole, recommendations for future research, and validity of this study.

CHAPTER V

DISCUSSION

The Findings chapter disconfirmed the hypothesis, but lent some interesting implications with regard to the research question. For instance, the hypothesis that the interoceptive card deck would improve the clinician's perception of the child's affect and emotional regulation appeared incorrect. While it was discovered that mind-body interventions may indeed be effective for children, structured mind-body interventions do not suit children's short attention spans. This gives hope to the original idea about interoceptive exercises being able to be used in this vulnerable population.

This Discussion chapter will contain two sections: one from the researcher at The Home for Little Wanderers, and one from the researcher at Bayview SSMH Associates. Each section from each researcher will contain the following: a compare and contrast, section by section, the study's findings with the previous literature, a summary, implications for social work practice, implications for theory, strengths and limitations, and recommendations for future research.

Part 1: From the Researcher at The Home for Little Wanderers

Key Findings: Comparison with the Previous Literature

This section compares previous literature to the findings, and contains my assumptions about why some findings were substantiated, and why some were not. It is worth stating that there is a lack of research surrounding the use of mind-body interventions with this young population. Therefore, it is difficult to compare and contrast every finding--as oftentimes, there is no prior literature to support or disprove it.

Quantitative findings in comparison with the literature are presented first, followed by qualitative findings.

The major finding of this study was that overall, the addition of a structured mind-body intervention to sessions does not appear to enhance the clinician's perception of child progress and process any more than regular play therapy. These findings are contradictory to the majority of the literature presented.

The Jeuland Ware article speaks of how interoception, as a component of yoga, can positively aid psychotherapy (Jeuland Ware, 2007). While this may be true, this study's findings seem to support only that an interoceptive intervention, introduced to an aged 2.5-7 population, does not seem to hinder the progress of the already effective play therapy treatment.

The Minnesota Association for Children's Mental Health article suggests that children, even when attending sessions that are consistent in terms of content, should have choices whenever possible to "give them some sense of control and help to build self-confidence" (macmh.org, 2014, p. 2). Knowing this, it would be expected that when children were given the options to decide for themselves how they are feeling when they participate in the interventions, and they will pick from a deck of five cards to determine the exact mind body exercise they will be doing, that they would be receptive.

However, as the study's results indicate, while it was important to offer choice--the children did not gravitate to the choice of the cards that they were given after the first few weeks. Perhaps this could be due to a lack of variation. Children seem to enjoy a variety of activities, rather than a routine each week. This idea is also supported by the article, which states, "being forced to maintain the same level of activity for too long may

cause the student to become restless and anxious” (macmh.org, 2014, p. 2). Even though the intervention lasted for the first few and last few minutes of each session--it may have been too lengthy for short attention spans.

Overall, this study’s findings are not in alignment with prior research. This specific type of mind-body intervention does not seem as effective for trauma in children in the same ways the prior literature suggests it can be for teens and adults with trauma history. This misalignment is likely due to the fact that prior research reviewed in this study is focused on adults, rather than children.

Implications for Social Work Practice

Other research and scholarly work would benefit from keeping in mind this study’s implications for social work practice. It does not seem, from the findings in this study, that the mind-body intervention used in this study is necessarily appropriate for the preschool aged population. It may be that the intervention is too structured for the very unstructured format of play therapy. Most often, a child entering a regular play therapy session is encouraged to have free reign with the materials and to explore their creative flow. It would be productive to future research to look into an interoceptive intervention that is less structured. Because other literature seems to support the addition of mind-body interventions in therapy and specifically in trauma-work, it is worth exploring why the intervention did not work, and how it could be edited and integrated in sessions with this age group to support the original hypothesis.

Strengths and Limitations

Strengths of this study include a carefully thought out methodology. Additionally, the two clinicians that created the study had much knowledge of both mind-body

practices and trauma work. The instruction sheet with regard to how to conduct the interventions, given to clinicians, was reported on the qualitative survey to be “clear” and “understandable.” Also, the sample was demographically adequate, representative, and diverse enough to be generalizable. The carefully laminated cards are another strength; they enabled the intervention to be presented in a visually appealing and professional manner to both clinicians and their clients. The clinician surveys, created electronically with the Qualtrics program, allowed the results to be gathered in a way that was clear and concise--and without the burden of asking clinicians to fill out individual, printed surveys by hand.

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We did not gauge the children’s responses and opinions to the interoceptive interventions, because children so young bring questions about reliability. This is a limit of our study. Another limitation is a possible ethical issue in data collection from the

children: the fact that it involves potential elements of coercion. All coercion can be avoided by using neutral, non-persuasive language. As clinical social work interns placed at these agencies for the upcoming year, we will be considered one of the clinicians. We can imagine this may lead to coercion if the children develop a positive transference, and when asking them in sessions if they enjoy what they have done, they may answer positively in order to please us. To avoid this situation, we will encourage the children to participate in the interoceptive exercises on the 5-card deck honestly, based only on what they feel. The intervention must not consume the therapy session beyond the time allotted, and should be seen as bookends to the play therapy session that already exists between child and clinician.

We must state that there is also the potential of coercion with the children's parents, when sending out the initial consent form, into agreeing to allow their child to participate. We say this because the parents may believe, that in order to get their children the best therapy, and the best clinicians, they must agree to the offered intervention therapy. We will add a disclaimer to consent forms stating that whatever their decision may be, it will not affect the level of care their child receives from the agency, and that they should not feel pressured or obligated to answer either way.

The findings gathered did not result in any clear support or the hypothesis. Therefore, something in this study's design may have been flawed. The most pertinent factor that may have led to the lack of confirmation of the hypothesis is the fact that the experimentation stage lasted only 4 weeks. Perhaps, if the intervention were conducted for longer than 4 weeks, different findings would have been gathered.

While the measurement tools were reliable, there were some questions of validity. Limitations of this study include potential bias. The two clinicians that created the survey and developed the methodology and hypothesis also took part in running control and experimental groups. Additionally, some of the clinicians running control and experimental groups already used mind body interventions when conducting their regular play therapy sessions (question 3).

Out of the 13 clinicians that participated in the study, 5 stated that they already use mind-body interventions when conducting regular play therapy sessions (all of whom were from Bayview). Four out of those 5 clinicians also stated that they specifically used interoceptive components. It is a possibility that the two clinicians, who created the methodology, as well as those who already used mind-body interventions, may have had survey answers skewed more towards supporting the hypothesis. It may also be true that those clinicians who did not use mind body interventions prior (8 out of 13), may have had survey answers skewed more towards disproving with the hypothesis. In other words, perhaps these clinicians may have been biased towards not including mind-body interventions, or maybe they could have been biased towards non mind-body based interventions.

Another limitation of this study is that a few of the quantitative survey questions weren't worded as specifically as they could have been. This lack of specificity could have confused the clinicians, and therefore may have skewed the validity of their answers. Additionally, there were absences of clients in sessions, and missed weeks could account for missing results, or a gap in therapy that may have created some barriers in treatment, and therefore some differences in how the intervention worked.

Another issue of validity is that despite the fact that the overall data from both control and experimental group participants from both agencies lends important collective findings, sometimes, Bayview's collective percentage for that particular question does not agree with the overall finding. This fact suggests that the data was skewed by the fact that there were 16 control group recorded responses from The Home, and 9 recorded answers for this question from Bayview. For instance, even though the overall majority answer from both agencies was "agree," for question 5, only 11% of Bayview clinicians running control groups answered agree. Additionally, the data analyst Smith College ran a T-test for question 8, which showed marked differences between Bayview and The Home. Bayview had less agreement with question 8 ("I noticed a productive difference in the content or tone of the child's play during this session") than did The Home.

Despite the fact that the original clinician waiver asked participants in the experimental group to answer the survey questions in a way that was as true to their experience as possible, it could be that the clinician's experience of the session was influenced for better or worse by clinician's biases or preconceived notions about mind-body therapies. This may have caused recorded responses to be skewed.

For example, if a clinician already used mind-body therapies in their regular play therapy sessions (question 4 on the survey), chances are they have a positive opinion about such an intervention. Perhaps, even if the session did not go well, and if the clinician were unable to separate their positive opinion about mind-body interventions from the reality of the experience, they may have recorded that the session including the intervention was more productive than it actually was.

Vice versa, if a clinician did not use mind-body therapies in their regular play therapy sessions, and they had a feeling that such an intervention would not make a difference--even if the session including the intervention went quite well, and if the clinician were unable to separate their negative opinion about mind-body interventions from the reality of the experience, they may have recorded that the session including the intervention was less productive than it actually was.

There is a concern with regard to whether or not the experimental clinicians conducted the intervention in alignment with the methodology instructed to them. For instance, one Bayview clinician stated, "I usually skipped the verbal promptings with my clients." Additionally, a separate Bayview clinician stated, "After this first try, I became more comfortable with adapting the intervention based on what I knew about my client, which allowed her to more effectively engage with the body-based exercise.

This study involved the addition of a 4-week intervention consisting of an interoceptive, mind-body component, to regular play therapy sessions with at-risk children in the Boston area. The intention of the study was to determine whether or not the clinician's experience of the child client's process and progress was affected in any way by the added intervention. Overall, it was discovered that the addition of a mind-body intervention to sessions does not appear to enhance the clinician's perception of child progress and process any more than regular play therapy. Also, the mind-body intervention, given in the format of a card deck with various interoceptive exercises that the child clients may choose, does not appear to be effective for children after the second week due to being too structured.

Biases towards the topic on behalf of the researchers are important to acknowledge. Due to lack of staff, we were two of the primary clinicians conducting the interventions. Alexandra is a certified trauma informed yoga teacher, and Erica has practiced yoga for years. Erica feels very positively about yoga, bodywork, and non-traditional therapeutic techniques, and this could impact her feelings of the study's effectiveness. Alexandra has a connection to the Trauma Center Trauma Sensitive Yoga Program, as she is a substitute teacher for the women's classes at the Trauma Center, and has helped to introduce TCTSY at a transitional living program for adolescents program within JRI. Therefore, it is important to acknowledge her strong bias towards this particular model.

In order to avoid bias, it is important to state that this methodology was designed specifically to protect against bias, as it is very objective and very standardized. The methodology is therefore the best path for avoiding bias, because there is the presence of the control group, nothing will be done that isn't standard protocol for the research itself, the data that will be analyzed by a third objective party. The discussion section herein will further explore the presence and prevention of bias in this study.

My personal hopes include continuing to involve mind-body components in my clinical work and personal practice. I feel it is crucial to include the body in treatment (in a careful way) no matter the client's age or diagnosis, in a field so historically dominated by focusing on the mind. More specifically, I hope to develop, and implement, a more effective way to include a mindfulness component in work with children, keeping in mind their busy and creative thought processes and often intense levels of activity, as that is a population I wish to work with professionally in the future.

Recommendations for Future Research

Because many of the participating clinicians stated in the qualitative survey that they supported the idea of a mind-body component in sessions with this population, but they mentioned wishing the intervention were less structured, recommendations for future research in this area include examining how less specific, less structured interventions may aid the effectiveness of play therapy. Specifically, as recommended by clinicians in the qualitative survey, perhaps a more simple, short verbal directive encouraging sensory awareness may work better than a card with a prompt. It is clear from the relevant literature that mind-body therapies can be very useful for clients who have experienced trauma, but because the majority of the findings in this study were inconclusive, and there wasn't a clear trend supporting or disproving the hypothesis, more research is certainly needed in this area.

Additionally, the literature reviewed speaks of how mind-body treatments may aid in healing from trauma from events like tsunamis or addiction to substances, and military exposure, but there isn't much research discussing ways that mind-body treatment may aid in trauma from domestic or community violence, sexual trauma, or racial trauma -- which many of the clients in this study's population struggle with. Therefore, future research could benefit from specifically examining how an interoceptive intervention may help in those cases.

Part 2: From the Researcher at Bayview Associates

Introduction

At the start of developing this experimental thesis, we hoped to explore the efficacy of a trauma-informed, body-based intervention, if any, through the clinician's

individual perspective. The population we were interested in examining was the youngest children who become identified as “at-risk youth” in both of our internship settings. Could introducing interoceptive skills to very young children improve a child’s ability to self-regulate into later childhood and adolescence? My research partner conducted this intervention at The Home for Little Wanderers’ early intervention program, which included the settings of preschools and homes as well as the program building itself, which was located in Roslindale, MA. I conducted the intervention at Bayview Associates, a community outpatient clinic in Quincy, Ma, which is a part of South Shore Mental Health.

In the project’s infancy, our intention was to collect data from 7 to 8 weeks with an assessment of our experimental intervention’s efficacy, if any. Our original age range was 2 ½ to 5, which required adjustment due to the average age of young clients within Bayview. By extending the age range to 7, I was able to recruit many more clinicians from my site. As our study was condensed into four weeks, our lens shifted. Instead of assessing symptom presentation and perceived changes in symptoms of clients, we chose to examine the weekly experience of adding a 2-5 minute intervention.

Play therapy was chosen as the channel by which to provide a trauma-informed introspective, body-based intervention. At Bayview, I spent months recruiting clinicians who worked with the population of children 7 years and younger. The clinicians that took part were gracious in taking the time to listen to my explanation of my thesis in person, sometimes more than once, and to read thoroughly through documentation required for the parent consent forms. Each clinician was given a set of five double-sided laminated cards, which I created for the purpose of this thesis. Clinicians were

responsible for identifying a child that they felt would benefit from a body-based intervention, as well as gathering the needed consent from the child's guardian.

In addition to the five cards, I created an additional document for all participating clinicians at Bayview. Due to the nature of outpatient therapy, clinicians have limited time between clients, if any, and I hoped to anticipate questions or concerns that clinicians might have and then provide directions or suggestions of what to do. This document also helped to clarify in writing for clinicians their role in the intervention. The additional document titled: "Additional notes for clinicians participating in experimental group" is included in the Appendix.

The discussion that follows will be organized into the following sections: Key findings vs. previous literature, strengths, limitations and biases, implications for clinical social work practice, implications for theory, and recommendations for future research.

Key Findings vs. Previous Literature

Previous literature offers insight into the challenges that are inherent in changing systemic clinical norms. As stated in other studies, more research is needed in order to legitimize body-based treatment, despite the social trends towards "alternative treatments."

The Trauma Center's initial study was the first "yoga research" funded by the National Institute of Health. The study titled, *Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder: A Randomized Controlled Trial*, offers a platform for our study (*Journal of Clinical Psychiatry*, 2014). Findings from this study were measured by PTSD scales and focused on symptom improvement. The 10-week study showed that "a yoga program compared with supportive therapy can significantly reduce PTSD

symptomatology in women with chronic treatment-resistant PTSD, with effect sizes comparable to well-researched psychotherapeutic and pharmacologic approaches.” While our research focus was on clinician experience of the intervention, quantitative survey data points to an upward trend in clinical efficacy when adding the body based intervention alongside play therapy. Just as we found limitations in a 4-week study, the Trauma Center study emphasizes the limitations of a 10-week study, as the practice of body awareness is in fact a practice and builds upon itself.

Strengths, Limitations and Biases

Before outlining limitations to the study, we must recognize that the application of the Trauma Center’s Trauma Sensitive Yoga to the population of children ages 2 ½ to 7, had not been studied prior to our thesis. The limitations inherent to a master’s level thesis must also be outlined for the purpose of context. As interns in our placements, my research partner and I had to effectively communicate what we wanted to do with this vulnerable, young population. This meant articulating our intentions to supervisors, directors, and administrators who we did not yet have relationships with. Building trust, and proving our professionalism was the first step.

The next challenge was finding the time and space to invite clinicians to be a part of the study. As is common in community mental health fee-for-service agencies, the turnover rate for clinicians is high. At any given time, there are approximately 60 clinicians, employed in the outpatient clinic, many of whom also work in the IHT program and work outside the office in the community many hours in a week. Other clinicians maintain private practices, or are employed part-time by other agencies in addition to working at the outpatient clinic. Simply put, I did not have access to all the

clinicians who saw children who met the requirements of our study. Those that I was able to meet were often difficult to track down, due to the culture that exists in a fee-for-service environment. It was my experience that most clinicians cannot afford to be in the office unless they are actively seeing clients back to back. Doors to offices are almost always closed, and if cancellations occur, clinicians use this time to meet the growing demands of clinical notes and paperwork.

There were a few clinicians who were unable to take on what would be required by our study, due to their level of stress from their current caseloads and required paperwork that had been recently introduced. In the past year, South Shore Mental Health began encouraging clinicians to be trained in, and conduct Feedback Informed Treatment (FIT). There was important pushback and ethical dilemmas by many clinicians, and as a result, the atmosphere during the first months of my internship were strongly impacted by what seemed to be a looming shift in clinical practice at the clinic. The impact and response to FIT was indeed a factor in my process of engaging clinicians in my study. Although the study only asked that the child be offered one card at the beginning and end of a session, for a total of five minutes tops, some clinicians struggled to commit to adding a standardized activity to their sessions.

Ultimately, the clinicians in the experimental group were all younger clinicians who believed in bodywork's efficacy. This is not to say that clinicians with more experience were unwilling to participate; in fact a handful of clinicians including my supervisor, were eager to participate but did not have clients within the age range of our study. Other clinicians who were involved would have been able to engage more of their clients if it was not for the strict age requirements. Although I was able to involve one

psychologist, and one psychology intern, the professional makeup was heavily made up of social workers. Psychiatrists were not interested, or were unavailable for me to meet with due to their schedules in the clinic. Therefore, when conclusions are made about clinician's willingness to try something new, for example, we are really speaking about new clinicians who are social workers. This information seems to support the hypothesis that clinicians who have recently been academically immersed are the most willing to try something new clinically and to give of their limited time.

Implications for Clinical Social Work Practice

Given the current fee-for-service pay structure, clinicians do not have much dedicated free time. At Bayview, I was surprised to find a handful of clinicians excited to try something new with their young clients; their enthusiasm and engagement in our study mirrors a trend towards integrating the body into treatment, seen in many mental healthcare agencies and communities.

As we learn in our education to become master's level clinical social workers, it is not only the content, which illuminates, but also, the process. This idea was innate to our study, as we continuously rephrased a central questions: what is this process like for you, the clinician. The content -or quantitative findings of our study, can neither stand-alone nor illuminate implications for clinical social work. It is the process-or qualitative findings that humanize, personalize, and make it possible to postulate on current clinical norms in social work.

The National Association of Social Workers defines the profession as “rooted in a set of core values” including, “service, dignity and worth of the person, importance of human relationships, and competence.” Our study examined the clinician's experience

while serving their client. We learned from the clinicians that indeed, competence and integrity of the clinician are central to the application of a trauma informed mind-body intervention. Positive trends in data correlate directly to the authenticity of the clinician in relation to the client.

Implications for Theory

Theory surrounding early childhood development, and the modality of play therapy were fundamental to our study. However, it is important to underscore the conflict that exists between a modality that is non-directive (play therapy) and empirical research, which requires a standardized methodology. The clinicians in our study eloquently highlighted this dilemma that they felt, despite the fact that all clinicians had been informed and reminded verbally, and through writing, that what was written on the back of the cards was not a script, and only suggestions of phrasing using choice-based language.

Besel van der kolk's conceptualization of developmental trauma and complex trauma informed the standardized methodology that we created. The Trauma Center's Trauma Sensitive Yoga (TCTSY), developed by David Emerson and van der kolk, Trauma Center Trauma-Sensitive Yoga (TCTSY) is an "empirically validated, adjunctive clinical treatment for complex trauma or chronic, treatment-resistant PTSD. Developed at the Trauma Center in Brookline, Massachusetts, TSY has foundations in Trauma Theory, Attachment Theory, and Neuroscience as well as Hatha Yoga practice with an emphasis on body-based yoga forms and breathing practices."

Although complex trauma has yet to be included in the DSM V, the mental health field as a whole is beginning to recognize the important distinctions and similarities

between traditional PTSD symptoms and those of early childhood traumas. Trauma Theory and Neuroscience recognize that complex trauma is many times the result of untreated early childhood trauma (including but not limited to neglect, maltreatment, or abuse).

Recommendations for Future Research

This experimental study is part of the beginning research in the application of a modified TCTSY intervention. Our study is unique in that it is the first academic research conducted with a young population and in the coupling of the intervention with play therapy. Research done within large agencies requires support from administrators and commitment from individual clinicians. We did not offer incentives for clinicians who participated, however, due to the climate of fee for service agencies in particular, even small monetary incentives may encourage participation in future research.

At the present time, the Trauma Center is in the third year of offering an 110-hour certification for yoga instructors from all around the world. Certified facilitators bring knowledge and skills back into their communities, and are encouraged to add to the body of research on integrating this modality into treating the constellation of symptoms associated with traumatic stress. Beyond the Trauma Center's Trauma Sensitive Yoga model, further research is warranted on the topic of integrating the body into traditional therapeutic treatments for at-risk youth.

Conclusion

In conclusion, we found that a five card interoceptive card deck with specific exercises may not be the best form of intervention for preschool aged youth that have experienced trauma. However, interoceptive exercises still seem valuable. This being

said, it seems probable that if the card-deck could be amended to include more fluid exercises with more choice, it may be more effective. The intention behind this study was to learn about the individual clinician experience of the applicability of an intervention as such.

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Appendix A

The Letter for Parental Consent

Parental-Guardian Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

Title of Study: Bringing the Body Into Treatment: Examining the Clinician's Experience of the Effects of a Trauma Informed Body Based Intervention Alongside Play Therapy for at Risk Youth

Investigator(s):

Alexandra Leiter (zzz) zzz-zzzz (office phone number Monday-Thursday (zzz) zzz-zzzz)
Erica Donahue (xxx) xxx-xxxx

Introduction

- Your child/child you are guardian for (referred to as ‘your child’ in this form) is being asked to be in a research study of the effects of adding a four week long, mind body exercises to the regular play based program.
 - S/he was selected as a possible participant as a new member of the play therapy program implemented by *The Home for Little Wanderers* Preschool Outreach Program, and the Bayview Associates at South Shore Mental Health.
 - I ask that you read this form and ask any questions that you may have before allowing your child to participate in this study.

Purpose of Study

- The purpose of the study is to learn if by adding these mind body exercises, the regular play based program will be more effective, less effective, or have no effect for your child.
 - This study is being conducted as a research requirement for our master’s in social work degree.
 - Ultimately, this research may be published or presented at professional conferences, and used in secondary analyses in later research studies.

Description of the Study Procedures

- If you decide to allow your child to participate in this study, we will be dividing the total group of children into two groups: referred to as intervention group (experimental group) or non-intervention group (comparison group).
 - Your child will either be in the group with the added mind body exercises, or the normal play based program that is offered at The Home for Little Wanderers and at Bayview.
 - If your child is not selected for the intervention group with the added mind-body exercise, *and if the initial results suggest that such an added exercise makes the regular play based program more effective*, the intervention will afterwards be offered to your child.

Benefits of Being in the Study

- The benefits of participation are learning mind body exercises that may facilitate an increased awareness of feelings in the body and the child's sense of control over the child's own body.
- The benefits to social work/society are: assessing the role, if any, for trauma informed body based intervention with at-risk toddlers in addition to the regular play based program.

Confidentiality

Your participation will be kept confidential. In addition, records of this study will be kept strictly confidential. Research records will be kept in a locked file and all electronic information will be coded and secured using a password-protected file. We will not include any information in any report we may publish that would make it possible to identify you or your child.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

Payments

- We are unable to offer you/your child will not receive any financial payment for participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you and your child. You are welcome to observe the intervention if you wish. Your child may refuse to take part in the study *at any time* and will not affect your relationship with the researchers of this study or Smith College. Your/your child's refusal to participate will not result in any loss of services from The Home for Little Wanderers or Bayview Associates. You/your child have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you/your child choose to withdraw, we will not use any of your information collected for this study. You must notify me of the decision to withdraw by email or phone by March 15, which is the end of the data collection period of the study. After that date, the information your child provided will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by us before, during or after the research. If you have any further questions about the study, at any time feel free to contact Alexandra Leiter at aleiter@smith.edu or by telephone at (zzz)-zzz-zzzz. Erica Donahue can be reached at edonahue@smith.edu or by telephone at (zzz+zzz-zzzz). If you would like a summary of the study results, a copy will be sent to you once the study is completed. If you have any other concerns about your child's rights as a research participant, or if you have any problems as a result of your child's participation, you may contact the

Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to allow your child to participate as a research participant for this study, and that you have read and understood the information provided above. Signing below means that you agree for your child to participate in brief 2-5 minute, mind body exercise, in addition to their regular play therapy session. It also means that we may ask your child about their experience, and collect data of the results. You will be given a signed and dated copy of this form to keep.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.
 - The data collected from this study will be used to complete *our Master's in Social Work (MSW) Thesis*. The results of the study may also be used in publications and presentations.
 - We, the researchers, have completed the Collaborative Institutional Training Initiative (CITI) online training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.
 - This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

.....
.....

Name of Parent/Guardian (print):

Signature of Parent/Guardian: _____ Date:

Signature of Researcher(s): _____ Date:

Signature of Researcher(s): _____ Date:

Appendix B

The Letter for Child Assent

CHILD (6-13) ASSENT TO PARTICIPATE IN RESEARCH STUDY

2015-2016

Child (6-13) Assent to Participate in a Research Study

Smith College School for Social Work • Northampton, MA

.....
Title of Study: Bringing the Body into Treatment: Examining the Clinician's Experience of the Effects of a Trauma Informed, Body Based Intervention alongside Play Therapy for at Risk Youth

Investigator(s): Erica Donahue and Alexandra Leiter

.....
I am doing a study to learn what play therapy is like when we do a few mind-body exercises at the beginning and end of our time together each week, for four weeks in total.

If you agree to be in my study, I will ask you choose one card at the beginning and end of each appointment, for no more than 5 minutes total.

What I learn in this research may help other children learn new types of body-based coping skills.

The questions I ask are only about what you think or feel. There are no right or wrong answers because this is not a test.

You may ask me questions at any time.

You may ask to not try out the mind-body exercises, or to stop at any time.

You may ask to end the study at any time, and no one will be mad at you.

If you sign this paper, it means you have read/have been told about my study and you want to be in it. If you don't want to be in the study, don't sign the paper. Being in the

study is up to you, and no one will be upset if you don't sign the paper, or if you change your mind later.

Child Name: _____ **DOB:** _____

Child's Signature _____ **Date**

Parent/Guardian Signature _____ **Date**

Researcher's Signature _____ **Date**

Appendix C

Clinician Confidentiality Agreement

**STATEMENT TO UPHOLD CONFIDENTIALITY BY PARTICIPATING
CLINICAL PROFESSIONALS**

“By signing the below, I state that I _____ will
uphold

Please print name/ clinical degree

confidentiality to all data collected for the purposes of this research study.”

Signature _____ **Date:**

Appendix D

The SCSSW HSR Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 17, 2016
Erica Donahue
Alexandra Leiter

Dear Erica and Alexandra:

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Staberg, Research Advisor

Appendix E

The Introspective Card Deck



YOU CHOSE THE CARD THAT HAS A PICTURE OF HANDS.

Now, for a minute or so, **if you want**, you could begin by looking at your hands and your fingers.

Do you want to wiggle your fingers? Maybe you don't want to wiggle your fingers.

Our hands do a lot for us all day long.

Our hands can be strong or gentle and **maybe** you could explore opening and closing your hand noticing how it feels to do this. **Just noticing.**

Sometimes **we can feel** texture - like the **bumpiness** of the rug, or the **smoothness** of the desk. **Sometimes we don't feel or notice feeling in our bodies and that is okay too.**

Here is an option to introduce playdough or another physical tool to increase sensory awareness in hands, however it is not necessary and may distract. This is up to you.

YOU CHOSE TO NOTICE THE BREATH

When you are ready, you might begin to bring your focus to your nose and mouth, and to your breath.

You might notice that you are breathing through your nose; or maybe you are breathing through your mouth! **We can breathe both ways.**

Now, **maybe** you notice which way of breathing you like best right now? (If you have a stuffy nose, maybe you will notice that you need a tissue.)

It's okay not to know which way of breathing feels the best right now. Both ways of breathing may feel the same!

So maybe you would like to do something else?

If you want to, you could take your *own hand* on your tummy and notice if your tummy is rising with each breath you take. Maybe you are holding your breath. **We all do that sometimes, and right now that is okay.**

A *second way* to notice the breath is by bringing your hand near your nose or mouth just close enough to see if you can feel the air moving in and out of your nose.

YOU CHOSE TO STAND LIKE A STAR!

When you are ready, you could put some space between your feet. **You might** add more space between your feet or **if you want** bring your feet closer together.

Next, **if you want**, reach out through your arms and fingers. **You choose how much** you want to reach and if you want to reach your arms up high towards the sky or lower at your shoulder's height. (younger kids may need help/ demonstration with this part.)

Finally **if you like**, **maybe** you take one of your palms to the top of your head, and imagine you are growing a little taller.

You may notice if you are holding your breath. If you are, maybe you will feel even stronger if you take a few slow breaths.

YOU CHOSE FEET AND TOES!

You might choose to use your eyes to see your feet on the ground.

Or you might decide to take your shoes off to see to feel the ground beneath your bare feet. **Maybe** you leave your socks on and feel the socks that keep your toes warm.

Do you want to wiggle your toes? Do you feel your feet making contact with the ground?

You could rock from side to side on the corners of your feet, or stand on your toes and rock backwards slowly to your heels.

Maybe you want to jump up and down three times?

If you want, you could try to balance on one foot by bringing your knees towards your body for a few rounds of in-breath and exhale breath

Clinician can use this opportunity to model choice, and individual authentic experience. That being said, it is okay if the child mirrors you. You might say: "I think I will keep my right shoe on, and take my left shoe off to try to see if I feel a difference."



**YOU CHOSE TO STAND TALL LIKE
A MOUNTAIN!**

If you like you can imagine what it feels like to be proud of climbing all the way up a mountain.

Or you could start by connecting your feet to the ground, notice how strong your legs are as they support you standing up tall.

Maybe you would like to reach your arms up like the boy in this picture, or **maybe you can do something else with your arms.** Stretch them out to the side, or open your palms and reach through your fingers.

If you like, you might bend your knees. You may feel how strong your legs are as you bend then straighten your legs.

Finally, maybe you could notice if you are holding your breath. **If you are, maybe you will feel even stronger** if you take a few slow breaths.

Appendix F

Questions on the Qualtrics Quantitative Survey

Given to both clinicians in the experimental group as well as the comparison group clinicians.

In the context of (for the experimental group clinicians), including the body based intervention; and (for the comparison group clinicians), the results of your normal play therapy session, please take a moment to thoughtfully answer the following questions about your client:

- 1) The child was able to express herself/himself with appropriate language of feeling
- 2) I noticed a productive difference in the affect regulation of the child during session.
- 3) I noticed a productive difference in the content or tone of the play therapy during session with client.
- 4) I did not notice any difference in the affect regulation of the child during session.
- 5) I did not notice a difference in the content or tone of the play therapy during session with client.
- 6) This session seemed productive to me.
- 7) This session did not seem productive to me.
- 8) This session did not seem to be importantly different than other sessions.
- 9) The child appeared genuinely willing to try out the body based intervention.
- 10) The child was not willing to try the body-based intervention.

At the bottom of the Qualtrics survey, as well as the Microsoft Word questionnaire, the following statement will be included, “All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.” Also included will be the statements, “The data collected from this study will be used to complete *our Master’s in Social Work (MSW) Thesis*. The results of the study may also be used in publications and presentations” and “I have completed the Collaborative Institutional Training Initiative (CITI) online training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.”

Appendix G

The Qualitative Post-Study Questionnaire

*Please take a few minutes to thoughtfully answer the following questions regarding your involvement in the trauma-informed body-based intervention. It is important for you to know that your responses will generate an important qualitative component of our final thesis, both in our reflections and in a final assessment of effectiveness. All responses may remain anonymous unless you choose to identify yourself. Please do not hesitate to add anything that these questions may have missed about your experience in participating in this study. **Thank you for all your time and for your part in gaining evidence based knowledge on this emerging area of therapeutic work.***

1. Is there anything you would suggest changing about the intervention itself, or the way it was implemented?
2. How did you feel about conducting interventions with your clients?
3. At this point in time, do you see yourself continuing to integrate any of the components (or cards) of the trauma-informed, body-based intervention? **Yes** **No**
- a. **If you responded no**, do you think you will integrate any general interoceptive work within a play therapy model?
 4. Are there any barriers you experienced or foresee experiencing in using interoceptive components in therapeutic work, particularly within a play therapy model?
 5. Would you be willing to develop your own practice related to this intervention?
 6. Would you say that you already have a body-based practice that includes interoception?
 7. Do you have concerns about integrating this intervention as was presented to you during the 4-week study?
 8. Do you think this intervention has the potential to be harmful to young clients?

Yes No

- a. **If you answered yes**, please explain in as much detail as you can, giving examples if helpful.

Appendix H

SSMH Bayview Associates Approval Letter



500 Victory Rd * Quincy, MA 02171
(617) 847-1950 * (800) 852-2844
Fax (617) 786-9894

www.ssmh.org

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MEMO

To: Alexandra Leiter
From: Dean Tsapatsaris, LICSW, Research Review Committee Chair
Re: Research Proposal
Date: November 4, 2015

On November 3, 2015, the Research Review Committee reviewed your proposal to conduct a study on the effects of a trauma-informed body-based intervention for at-risk preschool aged youth. The Committee has given your proposal a conditional approval, subject to the following restrictions:

- You must obtain the prior approval of the program manager and Vice President of any SSMH program that is involved in or is affected by your study. Your study cannot interrupt or impede the clinical or business operations of South Shore Mental Health. SSMH reserves the right to unilaterally halt your study should the Research Review Committee believe that the clinical or business needs of the organization or its clients are not being met.
- You agree that at the conclusion of your study, you will provide a written copy of the results to the Research Review Committee.

Thank you for your cooperation with our research review policy. Please contact me if you have any questions.

Appendix I

The Home for Little Wanderers Approval Letter

Kara Sabalauskas <ksabalaukas@thehome.org>	Jan 21 (1 day ago)	
to me, Erica, Paul, Heidi		

Hi Erica,

The Home's research review committee has approved your request to conduct your project at the Preschool Outreach Program pending the following:

- Your project is approved by Smith's HSR and you send us a copy of your approval letter.
- You provide us with a copy of your completed thesis and any published papers/presentations of the findings.
- You change the following sentence in the consent form from "Your/your child's decision to refuse will not result in any loss of benefits (including access to services) to which you/your child are otherwise entitled" to "Your/your child's refusal to participate will not result in any loss of services from The Home."

Let me know if you have any questions.

Best,

Kara

Kara Sabalauskas, MSW

Director of Evaluation & Research

The Home for Little Wanderers

10 Guest Street

Boston, MA 02135

(617) 585-7577

ksabalaukas@thehome.org

www.thehome.org

Strong families. Strong life.

Disclaimer: The information in this transmittal (including attachments, if any) is privileged and confidential and is intended only for the recipient (s) listed above. Any review, use, disclosure, distribution or copying of this transmittal is prohibited except by or on behalf of the intended recipient (s). If you have received this transmittal in error, please notify me immediately by reply email and destroy all copies of the transmittal. Thank you.

Appendix J

Additional Notes for Clinicians in the Experimental Group

Additional Notes for Clinicians participating in Experimental Group:

Dear Participating Clinicians,

We want to express our gratitude for the opportunity to do a thesis like this with the participation of thoughtful, open minded, and dedicated clinicians. We have done all we can to minimize paperwork related to the study.

Option I: Experimental Group

Your role is the following: for the course of four-weeks, or four sessions, please *offer* the client a choice of one of five cards from the deck provided to you. The client should choose one card at the beginning of the session (approx. 2-5 min) and one at the end of session (approx. 2-5 min) for a total of no more than 10 minutes. Written on the back of the card are options for you to offer the client. You can use some of the phrases or all. You will also be engaging in your own experience of mind-body exercise, either the same card as the child or you may choose your own card.

Please fill out this simple survey at

https://smithcollege.qualtrics.com/SE/?SID=SV_cXP0d27EJ1ILgQB

The link will also be in your email. You will fill out a total of four of these surveys, one for each session.

Below are some notes that I hope may be helpful to you over the course of the next 4 weeks.

Three pieces of paperwork to return to Alexandra before you begin:

1. parent consent form
2. professional confidentiality form to be signed by you, the clinician
3. assent form for children 6 years old and over

If a client does not come one week, please let us know ASAP, and we will most likely ask you to simply do one more week of the intervention so that you have four results.

Our Theory/Methodology:

Modeled off of the Trauma Center's TC-TSY, there are a few principles that are helpful to keep in mind. First, that the choice to choose a card is the child's alone, if a power struggle does emerge resulting from this exercise; please do not feel that you need to push the child to engage in the activity. Instead, please call Alexandra, and we can try to find a time to chat about what you noticed. *Any information is valuable to our study.* We may have you choose another child if it is possible, or to write a brief statement about what you noticed in session in response to the introduction of the exercise. Anything that you choose to share, can also be written up by Erica or myself, after taking thorough notes over a phone interview or office interview. Ultimately, you are the clinician and we believe that you know best what is going on with your client at any given point in time.

As clinicians, it can be difficult to stay "out of the head" as we think of it, however, if possible, try to keep any language or discussion as "body based" as possible. Although it might be perfectly useful to invite a client to "imagine that you are a star", this type of imagery immediately makes the exercise mind based, and the connection within the body is lost.

Instead, we suggest something along the lines of this, obviously this is NOT a script, but it offers ideas about how to use invitational language that guides the child into their own body instead of imagination that exists apart from their physical body and regulating capacities.

Clinician: *If you like, you might begin to notice how much space you can take up by reaching your arms up to the sky, or out shoulder height? How much more space could you take up using your feet and legs? You could try putting space between your feet, so that your feet are maybe under your hips, or wider. The choice is up to you. Whatever you choose, you might bring your focus to your breath, are you breathing? What does your breath feel like? If your arms or legs get tired, notice how the different muscles are feeling, which ones are the most tired?*

If the child gives feedback, the clinician should be as non-directive as possible, avoiding any type of language that may take away from the child's experience inside of their body, which may be seen as primarily nonverbal.

Further, utilizing core techniques of non-directive play therapy, you might decide to use (when appropriate) body-based or "feeling" reflections. important to interoceptive

bodywork is authentically modeling curiosity for self-exploration on a very basic level: being curious about how much space you can take up with your arms, are you holding your breath? do you notice your breath moving along your rib cage or in your abdomen as you take on new forms?

For Example: **Child says:** I can feel my left toes more than my right toes even though I took both shoes off. **Clinician may say:** You feel your left toes more right now than your right toes. That is something you noticed.

Finally, it is important that you, the clinician are authentically engaging in the mind-body exercises. Try to avoid copying the child or guiding the child, you can do the same card and have your own experience. *The clinician pays attention to their internal sensory feeling of the body, or “interoceptive awareness” in order to model attunement for the child.*

II.

Option 2: Comparison Group (Control-ish Group)

If you find yourself with a child who won't engage in the practice or whose parents are ambivalent about signing for the study, you have the option to engage in the “comparison group.” This will just take you to continue your therapy with that child as usual, and fill out the weekly survey as best you can for each of the four sessions. (You will also have a total of four surveys for “comparison” group kids.) Keep in mind that we designed the weekly survey for both comparison and experimental clinicians. The last two questions for example, you will answer that you are in the comparison/control group and therefore do not have an answer to those questions.

Thank you again for taking the time and energy to engage in this exciting study. We look forward to hearing from you and will be available to answer any questions.

Thank you again!

Alexandra and Erica

Appendix K

Basic Sociocultural /Economic Demographic Comparison of Bayview and HFLW Using 2010 and 2014 Census Data.

	Zip Code Of agenc y	City	Total pop- elation	Median age	% population under age 10	% of households with yearly income less than \$10,000	Largest % racial makeup
HFLW	02131	Roslindale	29,826	39.5 years	13 %	8.30%	60% white; 26% black/African American; 13.3% other
Bayview	02169	Quincy	55,055	40.2 years	10%	3.90%	72% white; 19% Asian; 7% black/African American