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Therapeutic Nursery Program:
An Exploratory Study

ABSTRACT

The purpose of this qualitative exploratory study was to increase our understanding of caregiver experiences whose children use the services of early-intervention programs. The primary value of this study is a better understanding of caregiver perceptions of program aims (how they understand the program), program impact (what they feel or believe it has done/ is doing for them), and program relationships (how they view their family's relationships with staff). The goal was to add to the limited body of literature on the therapeutic nursery programs by seeking to better understand overall caregiver perceptions and experiences of one such program located in Rockville, Maryland. To that end, this qualitative study focused on the experiences of caregivers related to this particular TNP, an early-intervention program that serves children aged three to five with social, emotional, and behavioral struggles and that offers related services and support to their families. The most compelling finding of this study suggests that a family's personal history and past experiences with other childcare institutions are inextricably woven into their experiences of the Therapeutic Nursery Program, while also informing their beginning expectations of the program. Study implications suggest the need for funding for longitudinal research on this TNP, and comparison research between TNP's across the United States to understand the variables and mechanisms that make this program effective.

CAREGIVER EXPERIENCES OF A THERAPEUTIC NURSERY PROGRAM:

AN EXPLORATORY STUDY

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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I dedicate this thesis project to my husband and son because without them, this project wouldn't have been possible. They were my guiding light and my inspiration to press on. Their love and support gave me the motivation and desire to finish strong. To my father and my in-laws for loving on our family and caring for our son whenever I needed them to. And finally, to my friends who shouted encouraging words when I needed them the most.

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CHAPTER I

Introduction

The mental health needs of infants and young children in the United States are well documented, while early intervention techniques, evaluative research, and funding continues to be a struggle. The need for services among at-risk children and families have been identified by many types of health professionals including educators, healthcare professionals, child-welfare workers, mental health providers, and legislators; all of whom emphasize the importance of early childhood intervention programs (Shonkoff, 2010; Slade, 2001; Venza & Kaplan, 2011). However, despite the clear consensus that early childhood interventions positively impact children and families (Shonkoff, 2010; Ware, Novotny, & Coyne, 2001) there is still today a dearth of programs that provide such services or research on their comprehensive benefits.

There is agreement among experts in the field of early childhood development that early intervention programs should be structured to provide cognitive, social, emotional, and behavioral support while also integrating family involvement and familial support (Chin & Teti, 2013; Fraiberg, 1975; Kaplan & Venza, 2011; Novick & Novick, 2005; Shepard & Dickstein, 2009). For example, early childhood treatment models may choose to integrate caregiver involvement by way of parental education programs, workshops, coaching, or by inviting caregivers to participate in individual counseling. However, integrating parent services into early childhood treatment generally seems to promote positive treatment outcomes as opposed to

treatment models that focus primarily on the child's developmental deficits or behavior (Chin &

Teti, 2013; Fraiberg, 1975; Slade, 2001).

That said, the provision of such services can only be as effective as the caregiver's

motivation, participation, and compliance within the treatment model. The parent-child dyad

must work to accommodate the involvement of another relationship so as to include a

relationship with an early intervention professional, thus creating an important triadic

relationship, relationships referred to in the counseling world as a "therapeutic alliance." This

type of relationship -- the therapeutic alliance between child-therapist and the parent-therapist –

has been empirically explored and found to be effective as a positive change agent if relational

characteristics such as trust, safety (including safe boundary setting) effective communication,

and positive attachment are present (Novick & Novick, 2005).

One early intervention model for children (and families) who struggle with social,

emotional, or behavioral difficulties (including developmental delay such as autism) is called the

therapeutic nursery program (TNP). This type of program incorporates academic, cognitive,

social, emotional, and behavioral treatment interventions while integrating family involvement.

Research indicates that this type of treatment model has proven to be effective in decreasing

externalizing problem behaviors and increasing emotional vocabulary based on site-specific

administered tests, interviews, or surveys administered by therapeutic nursery programs across

the country (Ware, Novotny, & Coyne, 2001). An example of such a test is the Cognitive

Behavioral Check Lists (CBCL) administered prior to program involvement, again during

program participation, and once again upon program completion, with a goal of assessing

changes in problem behaviors. Overall results from these tests suggest that TNP's are successful

in decreasing problem behaviors and enhancing the child well-being in great measure due to the

program's structure, ongoing communication with the family, and consistent family involvement (Geltman, 2008; Marsh, 2000).

However, despite positive results from these assessment measures, TNP's are not widely implemented in the United States due in part to persistent funding issues. There is one such TNP in Rockville, Maryland, however, and it is that program that was the subject of study for purposes of conducting this thesis.

As a result of limited funding (and thus research), therapeutic nursery programs cannot yet be considered a fully theorized, conceptualized, and adequately researched intervention to be accepted as an evidence-based practice. Rather, they are mostly considered separate in their missions, often-using different theoretical orientations or models and generally varied in their structural mechanics, i.e. finances, physical space, organizational structure, etc. (Geltman, 2008; Marsh, 2000). Consequently, program goals, definitions of program outcomes, and outcome measures tend to differ between each therapeutic nursery program, and program outcomes cannot be generalized to other therapeutic nursery programs. It is important, therefore, that specific variables contributing to their effectiveness be empirically explored and further identified. Research for this particular program is essential for funding and for this program model to be organized and reproduced as an evidence-based practice.

A member of Adventist Health Care, the Reginald S. Lourie Center -- the TNP referenced above in Maryland, Northern Virginia, and Washington DC., was the site and subject of study for this thesis project. Generally speaking, parents of children served by this program have identified a positive improvement (thus, reduction) in their child's presenting problem, evidenced by data accumulated from end-of-year surveys and Cognitive Behavioral Checklists (CBLs), both administered since 2008. These checklists, which are subjective and context

dependent (parent or teacher, home or school) are reflections of caregiver experiences and of their children's overall functioning. In other words, data support empirical effectiveness of this specific program in meeting children's mental health needs. However, there is little direction regarding either precisely how the intervention is effective (in what ways, more specifically) and why it is effective.

The purpose of this qualitative exploratory study, therefore, was to better understand caregiver experiences and perceptions of the therapeutic nursery program in terms of program aims, program impact, and caregiver perceptions regarding the strength of the caregiver-teacher relationship and child-teacher relationship. The goal was to add to the limited body of literature on the therapeutic nursery programs by seeking to better understand overall caregiver perceptions and experiences of the program located in Rockville, Maryland. To that end, this qualitative study focused on the experiences of caregivers related to this particular TNP, an early-intervention program that serves children aged three to five with social, emotional, and behavioral struggles and that offers related services and support to their families.

The next chapter provides an overview of the related literature on early childhood development with an emphasis on early childhood education and early childhood mental health. Chapter II will also explore the therapeutic alliance as it exists in children's mental health settings, including early childhood mental health treatment.

CHAPTER II

Literature Review

The mental health needs of infants and young children in the United States are well documented, while early intervention techniques, evaluative research, and funding continues to be a struggle. The need for services among at-risk children and families have been identified by many professionals—educators, healthcare professionals, child welfare professionals, mental health professionals, and legislators—through supportive research, existing literature, and program/intervention advocacy (Shonkoff, 2010; Slade, 2001; Venza & Kaplan 2011). Despite the overarching consensus that early childhood interventions have a general positive impact on at-risk children and families (Shonkoff, 2010; Ware, Novotny, & Coyne, 2001), a great need for such programs and comprehensive research remains.

There is agreement among experts in the field of early-childhood development that early intervention programs should be structured to provide cognitive, social, emotional, and behavioral support while also integrating family involvement and familial support (Chin & Teti, 2013; Fraiberg, 1975; Kaplan & Venza, 2011; Novick & Novick, 2005; Shepard & Dickstein, 2009). Early childhood treatment models often choose to integrate caregiver involvement by way of parental education programs, workshops, coaching, and individual and family counseling. The integration of parent work into early childhood treatment has been shown to promote more positive treatment outcomes—i.e. decreased problem behavior, increased self-reflection, and

affect regulation—than treatment models that focus primarily on the pathology of the child (Chin & Teti, 2013; Fraiberg, 1975; Slade, 2001).

The provision of such services can only be as effective as the caregiver's motivation, participation, and compliance within the treatment model, however; and the parent-child dyad must accommodate the involvement of another relationship, one with an early intervention professional, and thus, form a triadic relationship. The relationships and the bonds that are created among the parent-child with the early intervention specialist through treatment are known among counseling professionals as a "therapeutic alliance." The therapeutic alliance between child-therapist and the parent-therapist have been empirically explored as effective change agents in the relationship if relational characteristics such as trust, safety—including safe boundary setting—effective communication, and positive attachment are present (Novick & Novick, 2005).

The therapeutic nursery program (TNP) is an early intervention model for children (and families) whose struggle with social, emotional, or behavioral difficulties has begun to impinge upon their overall quality life. This program incorporates academic, cognitive, social, emotional, and behavioral treatment interventions, while also integrating family involvement. This treatment model has proven effective in decreasing externalizing problem behaviors and increasing emotional vocabulary based on site-specific administered tests, interviews, and/or surveys administered by therapeutic nursery programs across the country (Ware, Novotny, & Coyne, 2001). An example of one such test is the Cognitive Behavioral Check Lists (CBCL) administered prior to program involvement, again during program participation, and once again upon program completion to assess changes in problem behaviors. Overall results from such tests have suggested that the therapeutic nursery program approach to early intervention is successful

in decreasing problem behaviors and enhancing the child well-being as a result of program structure, communication with the family, and family involvement (Geltman, 2008; Marsh, 2000). Regardless of positive results from these assessment measures, however, this type of program is not widely implemented in the United States due, in part, to the persistent struggle to obtain funding on behalf of early intervention research. As a result, therapeutic nursery programs cannot yet be considered a fully theorized, conceptualized, and adequately researched intervention to be accepted as an evidence-based practice.

Because of a lack of research either within such programs or across them, existing programs are mostly considered separate in their missions, often differing in theoretical orientations and varied in structural mechanics (Geltman, 2008; Marsh, 2000). Consequently, program goals, definitions of program outcomes, and outcome measures differ between each therapeutic nursery program, and program outcomes cannot be generalized to other therapeutic nursery programs. Specific variables that contribute to the effectiveness of TNP's must be further isolated and empirically explored. Research for this particular program is essential for funding, and for this program model to be organized and reproduced as an evidence-based practice.

The Reginald S. Lourie Center, a member of Adventist HealthCare, houses the only therapeutic nursery program (TNP), the program that was the subject of study for this thesis project, in Maryland, Northern Virginia, and Washington DC. Generally speaking, parents of children served by this program have identified improvement in their child's presenting problem, evidenced by data accumulated from end-of-year surveys and Cognitive Behavioral Checklists (CBLs), both types of measures administered in the program since 2008. These checklists, which are subjective and context dependent (parent or teacher, home or school) are, reflections of caregiver experiences and of their children's overall functioning. In other words, data supports

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the effectiveness of this specific program in meeting children's mental health needs, but there is little direction regarding how the intervention is effective (in what ways, more specifically) and why it is effective as reported by children and families in the program. The research that was the subject of this thesis, therefore, explored caregiver experiences in the TNP so as to uncover a beginning understanding of how and why this program is believed to be effective.

Children's Mental Health

The mental health needs of infants and young children are well documented (Osofsky & Lieberman, 2011; Sroufe, Egeland, Carlson, & Collins, 2005). For example, according to a recent epidemiological study, five to six percent of children in the United States between the ages of four and seventeen are experiencing mental health struggles in terms of managing emotions, impulsivity, and behavior regulation and modulation (America's Children: Key indicators of well-being, 2014). According to Lavigne and colleagues (1996), 14-26% of children under the age of five have identified with clinically significant socioemotional behavioral problems. In addition, Lavigne and colleagues (2009) conducted an epidemiological study with a sample of 796 four-year-old preschool children to assess rates of oppositional defiant disorder (ODD), attention deficit hyperactive disorder (ADHD), generalized anxiety disorder (GAD), and major depressive disorder (MDD) affecting preschool aged children. A prevalence rate of 12.8% for preschool-aged children with ADHD, 13.4% for preschool-aged children with ODD, and less than 1% for disorders GAD and MDD were reported in this study.

"Infant mental health" is defined as the period between pregnancy and five years of age during a time of social and emotional development. During this time, professionals work to relieve disruptions in a child's psychological development caused by various internal or external variables (Lieberman & Van Horn, 2008). Young children can and do experience both

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internalized mental health problems, such as anxiety and depression, and externalizing problems, such as aggression (Lavign et. al., 1996). Without intervention these struggles become impingements on a child's development; and studies have shown that problem behaviors in preschool are stable and carry forward in development (Sroufe, Egeland, Carlson, & Collins, 2005). Children who experience early problem behaviors, therefore, are also at an increased risk for expulsion and other academic struggles (Hoover, Kubicek, Rosenberg, Zundel, & Rosenberg, 2012) and other related mental health issues in later development (Forness, Cluett, Ramey, Ramey, Zima, Hsu, Kavale, & MacMillan, 1998; Hoover et. al., 2012; Reid & Eddy, 2002). Clearly, therefore, early childhood intervention programs are crucial to children's development within the greater context of lifelong development.

The development of a child is transactional and occurs among three levels: within the child, within the primary caregiving relationship, and within his or her relationship to the community (Greenspan, 1992). There are characteristics within each level that are either risk promoting or protective factors that continuously interact with the child's current developmental level. Transactions between the individual and the external environment promote or hinder development depending on the presence of both risk and protective factors. Risk factors are defined as aspects of the child's biological composition, behavioral patterns, and relationships that negatively affect their physical, social, or emotional development. Protective factors refer to aspects of the child, parent, or community that mitigate risk factors and therefore promote physical, social, and emotional development (Davies, 2010; Greenspan, 1992).

Risk factors.

Due to the interactive nature of a child's development, biological predisposition continuously interacts with the surrounding environment, which includes caregivers, family, community, and culture (Greenspan, 1992; Sroufe, Egeland, Carlson, & Collins, 2005). Risk factors include such things as poor health status (Chin & Teti, 2013) difficult temperament (Davies, 2010), low socioeconomic status (Brody et. al., 2002), minority status (Carlson & Cocoran, 2004; Rhoades, Greenberg, Lanza, & Blair, 2011), marital status of caregivers (Carlson & Cocoran, 2004), and mental health status of caregivers (Chin & Teti, 2013). As these risk factors interact with the child and his/her surrounding environment, the child is at an increased risk for developing maladaptive coping strategies. We can see how such risk-factors interact in the following hypothetical example:

> Jane is constitutionally sensitive to stimuli such as touch and who generally responds adversely to physical touch may have an anxious caregiver who aggravates this sensitivity by regularly touching, checking, and/or worrying about this child's well-being. In this example, a risk-factor exists within the caregiver-child relationship as a result of mismatch, or an inherent difference in affectional need. This naturally creates a barrier of attunement that this dyad will need to address in order to achieve an optimal holding environment. In addition to this attunement barrier, if the child is then low-income then they may have limited access to quality resources. Consequently, this dyad has limited access to a quality educational system, limited access to healthcare, difficulty obtaining welfare services, and faced with limited job opportunities. This caregiver (one or both) are faced with external stressors that then requires more time, more attention, and more

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effort which then takes away from their ability to focus on, or improve, this

developmentally important relationship.

In this example we can clearly see how constitutional factors, adverse life experiences, and

quality of environment can exacerbate and/or add to the cumulative risk factors that a caregiver-

child relationship may experience (Davies, 2010; Greenspan, 1992).

Risk factors become increasingly dangerous as the number of risk factors facing a child

increases (Davies, 2010). Studies exploring adverse childhood experiences have found that the

presence of multiple risk factors increases the child's risk for psychological disorders later

(Evans, Dongping, & Whipple, 2013). Dube and colleagues (2003) explored the interrelatedness

of adverse childhood experiences assessing for 10 risk factors such as emotional and physical

abuse, emotional and physical neglect, and domestic violence, mental illness in the household,

substance abuse, parental separation and divorce. This study found that participants who reported

exposure to one risk factor were two times more likely to be exposed to two or more risk factors

than those who reported no exposure. Participants who reported having four or more out of 10

risk factors were more likely to have experienced childhood maltreatment and household

dysfunction than those who had three or fewer (Dube, Felitti, Dong, Chapman, Giles, & Anda,

2003). Thus, individuals who report childhood exposure to any one risk factor are more likely to

be at risk for addictions and are more susceptible to physical and psychological problems in their

adult life (Dong, Anda, Felitti, Dube, Williamson, Thompson, & Giles, 2004; Dube et. al., 2003).

Finally, children with risk exposure are more likely to develop anxiety disorders (Reiser,

McMillan, Wright, Asmundson, 2014) among other psychological and physical issues, such as

depression and obesity (Flaherty, 2009; Gilbert et. al., 2009). Clearly, the current research

indicates that the presence of multiple risk factors adversely affects quality of life (Dong et. al.,

2004; Dube et. al., 2003; Ghosh et. al., 2004; Reynolds, Temple, Robertson, & Mann, 2001),

suggesting the need for accessible resources and early intervention, such as a therapeutic nursery

program, to protect against the impact of adverse experiences and multiple risk-factors.

Protective factors.

Protective factors mitigate risk by reducing stress and promoting growth and

development (Davies, 2010; Lieberman & Van Horn 2008). External influences such as

employment and socioeconomic status, caregiver capacities, biological conditions (e.g., good

health, temperament, self-regulation, and above average intelligence) serve as innate protective

factors for a developing child (Davies, 2010). A child develops skills such as self-regulation,

coping, and perspective taking under the caregiver's protective and nurturing ability (Greenspan,

1992). The safety and security provided becomes internalized and learned. Thus, when a risk

factor is present, a child is able to access coping strategies and to overcome a stressful event and

acquires the capacity for self-regulation, empathy, and mutuality through the use of a caregiver

(Davies, 2010; Lieberman & Van Horn, 2008). As Lieberman and Van Horn (2008) phrase it,

"Loving parental care has unmatched transformational powers in restoring the child's

developmental momentum in risk situations" (p. 5).

Primary and secondary relationships.

The momentum toward a child's healthy development is built upon the foundations of

caregiver availability, attunement, and protection, as theorized by the pioneers of attachment

theory such as Bowlby (1988), Mahler (1947), and Winnicott (1956). Further, current literature

on attachment theory and child development emphasizes the quality of early primary

relationships characterized by availability, attunement, and engagement of the caregiver as

central for successful child development, the lack of which serves as a basis of therapeutic early

childhood intervention programs (Mendez, 2010; Brody, Dorsey, Forehand, & Armistead, 2002; Lieberman & Van Horn, 2008; Sroufe, Egeland, Carlson, & Collins, 2005).

Feinstein, Fielding, Udvari-Solner, and Joshi (2009) suggest that there are two types of relationships that exist in a child's life: primary and secondary relationships. Primary relationships are those that directly influence a child's development, suggesting that caregivers are one of a few primary relationships that may include helping professionals like social workers, psychologists, psychiatrists, and teachers. Further, to be conceptualized as a primary relationship, each such relationship must in some way impact the other. For example, the dyadic relationship between the caregiver and the child will ultimately impact the treatment relationship between the helping professional and the child based on caregiver attitudes and beliefs about treatment. In fact, many early childhood intervention experts expect that their work will either directly (through treatment goals addressing the relationship) or indirectly (to the simple implementation of the program) cause positive change in primary relationships (Sroufe, Egeland, & Carlson, 2005).

According to object relations by theorists such as Winnicott (1956), by attachment theorists such as John Bowlby (1988), and by developmental theorists such as Stanley Greenspan (1992), the primary relationship (caregiver-child relationship) is integral to the successful acquisition of language, motor skills, autonomy, identity, and social skills. The primary relationship between the child and helping professional also has a considerable amount of empirical evidence supporting and validating its importance to therapeutic outcomes (Greenspan, 1992). However, the secondary relationship of the caregiver-helping professional relationship has been less empirically studied, and the quality of this type of relationship remains relatively

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unstudied despite findings that indicate the essentiality of caregiver involvement in early childhood treatment (Mendez, 2010).

The importance of secondary relationships: caregivers and helping Professionals.

Out of all the direct relationships in a child's life, there are relationships that are secondary to primary relationships, thus the term "secondary relationship." The relationships have influence over primary relationships, such as the relationship between caregivers. One may automatically comprehend the significance of this relationship and the strength of its influence on a child's development. Contextually, the next secondary relationship outside of the family unit will be between caregivers and helping-professionals, which also holds significant influence over the life of the child and impacts the child's development and according to the limited research available, the caregiver-helping professional relationship has been found to be integral for increasing program involvement, decreasing treatment drop-out rates, and enhances overall positive outcomes of the program or treatment (Kazdin, Holland, & Crowley, 1997).

Importance of caregiver relationships.

Relationships are the mechanisms through which a child's interpersonal and intrapersonal experiences are organized, made sense of, integrated, and learned. Beginning in infancy, children use emotional experiences of others in concert with their own to better understand the function of interpersonal relationships and to explore the environment surrounding them (Lieberman & Van Horn, 2008). Healthy caregiver-child relationships are foundational for healthy growth, development, and psychological well-being—positive and nurturing caregivers support overall development (Degotardia, Sweller, & Pearson, 2012; Lieberman & Van Horn, 2011). Self-regulatory skills have been linked to increased academic achievement and school

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preparedness, skills that are acquired within the context of early caregiving relationships (Lukie, Skwarchuk, LeFevre, & Sowinski, 2013; Masten & Coatsworth, 1998;).

In attachment research, (e.g., Bowlby, 1969; Main, Kaplan, & Cassidy, 1985) caregivers are active participants in the construction of the child's emotional and social development. Just as development is an ongoing process, attachment relationships continue to influence the child throughout their lifespan. Apart from the clinical psychology and social work, neuroscience has also found that early attachment figures (caregivers) significantly influence brain structures that mediate social and emotional functioning (Siegel, 2001). Negative early relationships (e.g. unavailable or frightening caregiver, chronic "misattunement" and/or neglect) have been found to have adverse effects on a child's development. According to attachment research, anxiety and depression in adulthood have been closely linked to caregivers who were perceived as unavailable, inconsistent, and/or frightening (Slade, 2001). Thus, when children perceive caregivers as frightening and/or unavailable, they cannot use their primary caregivers to integrate strong affective states, adversely affecting their regulatory skills (Powell et. al., 2013; Greenspan, 1992; Slade, 2001). As a result, early-childhood experts emphasize the importance of early-intervention programs designed to help correct early childhood experiences while also addressing factors that impede caregiver-child relationships, such as limited education, unemployment, and caregiver mental health problems (Osofsky & Lieberman, 2011).

Caregiver role in education and mental health treatment.

In fields of special and general education, child therapy, and early childhood intervention, caregiver involvement and engagement practices are considered necessary and foundational. In fact, studies indicate that caregiver involvement and engagement in the program is important not only for outcomes but also for the child's psychological, physical, cognitive, and social

development (Korfamacher et. al., 2008). Further, research indicates that caregiver engagement in childhood programs increases caregiving confidence and effectiveness effectiveness (Green, Walker, Hoover-Dempsey, & Sandler, 2007). It is important to note that terminology used to describe the process in which families and helping professionals work together varies in much of the existing literature; for example, terms such as collaboration, caregiver involvement, cooperation, and participation (Feinstein, Fielding, Udvari-Solner, & Joshi, 2009) generally refer to the same dynamic, i.e., caregiver involvement in the program. Therefore, for the purposes of this literature review, "caregiver involvement" is broadly defined as the process in which caregivers participate (quantity) and engage (quality) in program services (Korfamacher et. al., 2008).

Empirical data suggest that caregiver involvement with children's early-intervention programs boosts social competence, cognitive development, communication skills, literacy, and numeracy development, vocabulary growth, expressive language, comprehensive skills, pro-social skills, and ultimately, in decreasing behavioral problems (see, e.g. Brody et. al., 2002; Englund, Luckner, Whaley, & Egeland, 2004; Fan & Chen, 2001; Kazdin, Holland, & Marciano, 2006; Knopf & Swick, 2007; Lukie, Skwarchuk, LeFevre, & Sowinski, 2013; Masten & Coatsworth, 1998; Sroufe, Egeland, Carlson, & Collins, 2005). Further, within the context of child therapy, studies suggest that the quality of caregiver participation aids in overall therapeutic outcomes in that it facilitates a carryover effect at home, reinforcing intervention goals and therefore improving treatment outcomes (Kazdin, Whitely, & Marciano, 2005).

Therapeutic Alliance

In psychoanalytic theory, the therapeutic alliance encompasses the quality and nature of the relationship between the therapist and the client, including the collaborative nature of identifying tasks and goals for therapy and the subsequent trust and bond that forms during therapy (Kazdin, Whitely, & Marciano, 2006). A therapeutic alliance forms at the beginning of therapy often beginning during the client's first interactions with the agency or therapist. For example, clients often interact with an agency's intake line, waitlist staff, or directly with their potential therapist, and such interactions may create the blueprint from which the therapeutic alliance is built. In psychoanalytic theory, the therapeutic alliance is viewed as central to the therapeutic process and transcends across most therapeutic modalities (Bordin, 1979) and, although research is limited, it stands to reason that the therapeutic alliance exists among clients and professionals in early childhood intervention programs as well.

The therapeutic alliance is one of the most well-studied areas of the therapeutic relationship (Kazdin, Whitley, & Marciano, 2006). Further, therapeutic alliance research has indicated that a client's positive views or beliefs about the therapeutic alliance is very closely tied to positive treatment outcomes (Hawley & Weisz, 2005; Kazdin, Whitley, & Marciano, 2006; Shirk & Karver, 2003; Nock & Ferriter, 2005; Hatcher & Barends, 1993). Hatcher and Barends (1993) conducted an exploratory factor analysis of working alliance among 231 patients to better understand the significance of clients' perceptions of the working alliance. Clients who perceived the alliance as collaborative and purposeful were more confident in and committed to the therapeutic process than those who felt that the alliance was neither collaborative nor purposeful. Furthermore, when clients believed that having the space to acknowledge and/or express negative concerns and/or disagreements was part and parcel of the positive working

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alliance, this was also a signifier of treatment progress. Ultimately, therefore, it seems that a client's perception of the working alliance will enhance the effectiveness of treatment and may transcend into the realm of other professional relationships.

Caregivers as partners.

The most studied working alliance exits within the realm of adult psychotherapy, with less on children's mental health (Baldwin, 2010; Hawley & Weisz, 2005; Shirk & Karver, 2003), and even less with regard to the alliance between caregivers and mental health professionals. Without a doubt, however, research does indicate that the therapeutic relationship is essential to the effectiveness of children's psychotherapy and equally as important for therapeutic outcomes (Shirk & Karver, 2003). Children's mental health has been mostly characterized by a systems oriented and relationally focused approach due to the absolute necessity of having the caregiver involved in the treatment of their child (Altman et al., 2002; Novick & Novick, 2005). Caregivers not only provide consent for a child to be in treatment but are the lynchpin for the success of their child's therapy/treatment. As Altman and colleagues (2002) state, "parents are partners to the therapy, adversary to the therapy, part of the system, sources of guidance as well as resistance for the therapist to respond to…" (p. 287).

Feinstein, Fielding, Udvari-Solner, and Joshi (2009) propose a collaborative model regarding the role of caregivers, one in which they use the term "supporting alliance… an alliance encompassing the network of relationships that link clinical, educational, and family settings" (p.21). They posit that the primary alliance (caregiver-child relationship) is most successful within the context of a supporting alliance with the relationship between caregiver and therapist an essential piece toward success (Baldwin, 2011; Kazdin, Holland, & Crowley, 1997). Further, Shirk, Karver, and Brown (2011), who conducted a recent meta-analysis of associations

between the therapeutic alliance and therapeutic outcomes, found significant outcomes resulting from both child-therapist alliances and caregiver-parent alliances. Finally, Nevas and Farber (2001) found that parents who experience primarily positive and feelings about therapist felt hopeful, understood, and grateful. It seems clear that parents (or other primary caregivers) who feel these ways would be positively attuned to the program's aims and positively involved in achieving those aims, benefiting both the children and overall family.

Baldwin (2011) conducted a longitudinal qualitative study that examined caregiver experiences of the therapeutic alliance. Participants were grouped into two main groups: 1) successful therapeutic alliances and 2) unsuccessful therapeutic alliances. This study found that caregivers in the successful therapeutic alliances group tended to identify their personal growth as a positive influence for their child and their family dynamics. Caregivers in the unsuccessful alliance group spoke of their child's struggles to connect with their therapist, possibly viewing the therapy as unsuccessful or lacking. Baldwin (2011) also noted that a therapist's theoretical orientation could impact caregiver involvement by excluding their opinions and values in the treatment of their child. Furthermore, Baldwin (2011) further hypothesized that the perception of being excluded from their child's treatment negatively impacted caregivers' perception of their relationship with the mental health professional. Thus, their view of the therapy changed as a result of their feelings around their participation and/or involvement in the therapy. In short, the quality of the relationship between the caregiver and helping professional impacts treatment outcomes (Baldwin, 2011; Hovarth & Symonds, 1991).

Early Childhood Intervention

Despite documented success many early intervention programs lack comprehensive research to obtain additional funding for further research and/or programming (Osofsky & Lieberman, 2011; Shonkoff, 2010;). Nonetheless, as noted throughout this review, early childhood interventions offer significant opportunities to positively impact the developmental trajectory of young children and families experiencing mental health problems (Breitenstein, Gross, Ordaz, Julion, Garvey, & Ridge, 2007; Fischer, Anthony, Lalich, & Blue, 2014), particularly early interventions that are family focused (Martin et al., 2013), such as Head Start and therapeutic nursery programs. As this review also indicates, unaddressed social-emotional-behavioral issues among young children increases risk factors for delinquency, substance abuse, unemployment, and criminal behavior, further substantiating the need for early intervention (Patterson, Reid & Eddy, 2002). Furthermore, as Selma Fraiberg (1975) notes, parental engagement and motivation to participate in their child's development is central to his/her wellbeing. Finally, as children grow and reach developmental milestones, parents are concurrently growing and, possibly, re-experiencing parts of their own childhood, so that if there is an impingement to either the child or parent development during this growing period, the other individual may be affected, as might be the relationship between the two (Fraiberg, 1975).

Early childhood interventions are designed to counter risk factors that children may face at home or in the community, hopefully providing a protective influence for children considered at risk of mental-health problems (Koroly, Kilbum, & Cannon, 2006). At-risk children are considered children who face multiple risk factors that may impact their social, emotional, and physical health in later development. Children experiencing positive "competence-promoting processes" in one context such as school or therapy may then serve as protective influence in a

"noncompetence-promoting process" context (Brody, Dorsey, Forehand, & Armistead, 2002, p 275). A recent study that assessed the efficacy of early child hood mental health services found that externalizing behavioral problems decreased significantly due to early childhood mental health interventions (Fischer et. al., 2014). Also, at-risk infants and young children who receive early intervention services are more likely to experience improvements in their overall development (Osofsky & Lieberman, 2011). Similarly, literature on caregiver engagement identifies a similar process for caregivers: caregivers who experience empathy, attunement, and consistency in a professional encounter (e.g. therapist or teacher) are more likely to internalize and metabolize these experiences than those who experience who felt that they (or their child) were misunderstood, unheard, and/or unseen. These experiences then transcend into the caregiving relationship and serve as a protective influence for the child (Venza & Kaplan, 2011).

Caregiver relationships in academic settings.

Similar to outcome research for children's outpatient therapy and early intervention, parental engagement research also suggests a positive correlation between positive caregiver participation/engagement and positive outcomes (Hoover-Dempsey & Sandler, 1997). Positive outcomes include improved academic success, improved motivation, and increased pro-social behaviors (Fan & Chen, 2001; Hoover-Dempsey & Sandler, 1997). Mesosystems created by school, home, and interacting community and interactions within these contexts shapes a caregiver's willingness to participate in a child's education and/or therapy (Hoover-Dempsey and Sandler, 1997; 2005). Also, caregiver perceptions and beliefs about the academic program and/or of their invitation to be involved has been found to affect their actual involvement (e.g. Hoover-Dempsey & Sandler, 1997; 2005). Additionally, cognitions may influence the amount and form of behaviors, or practices, that parents choose to engage in, while low socioeconomic

status has been found to correlate with lower participation (due to low education, adverse past experiences, and negative perceptions of the institutional programs). Thus, negative experiences discourage program participation and/or adversely affect perceptions of their child's involvement in the program, while not surprisingly, the opposite is also true. Interestingly, a study on caregiver motivations for involvement in home-based or school-based academic programs found that the largest predictor of caregiver involvement in home-based or school-based programs was their perception of the invitation to be included. Caregiver involvement was primarily motivated by their perception and understanding of the interpersonal relationships between themselves and helping professionals (Green, Walker, Hoover-Dempsey, & Sandler, 2007) In short, it is clear that relationships between caregivers and helping professionals contribute to positive overall program perceptions and are indicative of caregiver involvement, both of which have been found to be essential for positive early-intervention outcomes (Hoover-Dempsey et al., 2005).

Conclusion

As noted above and elsewhere, the therapeutic nursery program is a type of early intervention program for children ages three to five years old. The model is individualized according to a child's presenting needs and incorporates identified social, emotional, behavioral, or physical needs into an individual curriculum. Children who participate receive approximately four hours of intervention a day, five days a week. While studies that have attempted to evaluate the effectiveness of this program have varied in their results (Geltman, 2008; Marsh, 2000), there is a general conclusion that this early intervention method provides a protective influence, although we do not yet know precisely how (Geltman, 2008). Unfortunately, this type of intervention is not widely funded and is therefore not widely utilized, limiting the research that is able to directly link practice techniques to outcomes (Marsh, 2000) and by doing so, provide

evidence for practice. In its attempt to do just that, however, the therapeutic nursery program housed within the Reginald S. Lourie Center, a member of Adventist HealthCare in Maryland, consistently administers a survey and a Cognitive Behavior Checklist evaluation both before and after participation in the program. Over the past eight years their evaluations show significant parental satisfaction and a decrease in identified presenting problems and/or concerns, although the methods or techniques contributing directly to such outcomes are currently unclear, making further research necessary

Generally, children rely on their closest relationships (which includes educational relationships) to help guide them, teach them, protect them, and love them into adulthood; and it is understood that those at risk of not developing in a normal trajectory will benefit from programs that provide structure in the form of clear rules and expectations, predictability, and love, fostering a sense of safety. "At-risk" children interact with multiple risk factors that can be internal (e.g. physical or emotional health) or contextual (e.g. social and environmental), both type of which statistically increase the likelihood for low academic achievement and externalizing behaviors (Davies, 2010). From an attachment theory perspective, parental availability and involvement is essential for the growth and development of children (Davies, 2010) and even more importantly, once a child begins attending school. Brody, Dorsey, Forehand, and Armistead (2002), who conducted a study using a multi-informant research design to better understand the protective contributions of both parenting and classroom processes for African American students, found that children of parents who were highly involved in support and behavior monitoring were more successful in developing and maintaining self-regulatory skills than those whose parents were relatively unavailable.

From this review, it is apparent that additional research is needed to better understand the quality of secondary relationships in the therapeutic nursery program, specifically the caregiver-helping professional relationships. The goal of this study, therefore, was to identify areas for further study regarding parental engagement and parental satisfaction of the TNP as an early childhood intervention. The findings of this study contribute to social work knowledge in that it focuses on parent-professional interactions, hopefully identifying effective techniques to encourage caregiver participation and to ensure carry-over and reinforcement into the home.

While early childhood interventions are increasingly recognized as opportune ways to engage at-risk families and to foster relationships among and between the families that are served, there is limited research as to what function the caregiver-staff relationship serves in promoting positive outcomes. Research notes the critical importance of caregiver involvement in terms of intervention outcomes (Kazdin, Whitely, & Marciano, 2006), but there is still a need to understand the predictors of parental engagement so that intervention strategies can be better tailored to meet the needs of families and ultimately of the children involved in early childhood interventions (Chin & Teti, 2013) such as those offered by the therapeutic nursery program in Rockville Maryland, which was the venue and subject of the study described in the following chapter on methods.

CHAPTER III

Methods

Purpose of Study

The purpose of this study was to explore caregiver experiences of their involvement in a particular therapeutic nursery program (TNP) in Rockville, Maryland. To that end this study explored the perceptions of 12 caregivers of children between two and one half and five years old who were participating in the program. Semi-structured interviews were utilized to interview caregivers participating in the TNP. More specifically, the purpose of this study was to explore themes that may contribute to caregiver experiences and whether it is reasonable to attribute to those experiences a successful therapeutic alliance between caregiver and TNP staff. The major research questions and sub-questions were as follows:

Research question:

> How do caregivers whose children attend the therapeutic nursery program (TNP) at the Reginald S. Lourie Center in Rockville, Maryland, experience this particular early childhood intervention?

Sub-questions:

- How do caregivers understand the aims of the TNP?

- How do caregivers describe the impact of the TNP (1) on their child and (2) on their family?

- How do caregivers experience their relationship with TNP staff, and how does that experience affect their perceptions of the program?

As noted above semi-structured interviews (see appendix G) were used to explore these questions and were administered to 12 caregivers who had children involved in the TNP during the year 2014-2015 or had been involved in the TNP during years 2011-2014. Caregiver responses focused on their individual understanding of the TNP; their perceptions of the impact of the TNP on the lives of their children and families; and their views regarding the relationships among themselves, their children, and TNP staff. Specifically, the study explored whether or not aspects of the therapeutic alliance are relevant to overall caregiver experiences with this program. Participants were recruited through a nonrandomized convenience sampling method. Program description, sample population, sample size, data collection, and data analysis are described below.

Program description and intervention.

The therapeutic nursery program (TNP) that was the study of this research is located in the Reginald S. Lourie Center, an outpatient behavioral health clinic for infants and young children serving clients in Montgomery County, Maryland. It is a nursery half-day program that addresses the needs of young children with emotional and behavioral problems, combining early childhood mental health practices and early childhood education practices, with a special focus on the healing nature of primary early childhood relationships (Brinamen & Page, 2012). This TNP functions within the necessity of building trusting relationships among all involved in the program including the child, parent, teacher, social workers, and psychologists. This program offers individual child psychotherapy and family-focused therapy as part of a treatment plan after a referral is made by a TNP social worker. The program also includes an early childhood

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academic component. The work is team based, with TNP mental health professionals and teachers working collaboratively to construct programming, curriculum, and child-specific goals.

At the time of this study, the TNP was housed in one location with a single classroom containing 12 children and five staff for a one-adult-to-three-children service ratio. A daily schedule was strictly followed for reliability, consistency, and predictability. All children attend "morning circle" in which the teacher guided them through a morning routine consisting of a greeting song, identification of the calendar, days of the week, seasons, a feelings-share time, job assignments, and story time. Children are encouraged to sit in their chair and follow directions; a quiet sensory toy is allowed if the child plays with it independently and quietly. Other activities throughout the day include two periods of unstructured playtime either indoors or out, one curriculum-focused lesson, and a good-bye circle. Children are offered breakfast in the morning and eat a lunch packed from home in the afternoon (children and staff eat together). In addition to these activities, children whose treatment plan indicates the need for individual psychotherapy will attend sessions once a week with an assigned clinician. The TNP social worker, social work interns, teacher, and teacher's assistant all work collaboratively to provide families with ongoing case management through case documentation. Furthermore, the TNP director, social worker, lead teacher, and assistant teacher provide families with ongoing opportunities for communication through individual meetings, telephone calls, and emails. In addition, the TNP social worker holds a monthly "Parent Coffee" session so that caregivers have time to discuss their struggles, feelings, and concerns while building supportive relationships with other caregivers.

Therapeutic Nursery Program staff.

At the time of study this TNP had eight helping professionals on staff: one director, one social worker, one lead teacher, one assistant teacher, and four interns. The director (a licensed psychologist) and the lead teacher (a licensed preschool teacher) were both longtime program veterans, each with over 15 years of experience in early childhood services. The program social worker was a licensed general social worker in the state of Maryland and had been at the TNP for two years. The teacher assistant also had two years of experience in the TNP. Program interns were in graduate school for either a masters or a doctoral degree in social work. Length of time for interns in the program varied from eight to nine months depending on the academic program. Each intern received weekly one-hour supervision and monthly one-hour group supervision.

Sample Population

Families who access TNP services must live in Montgomery County, Maryland, and are either self-referred or referred by community services such as a healthcare provider or through Child Find, a program of the county. There are 12 children enrolled per year; six spaces are reserved for children with Medicaid and six spaces are reserved for self-paying families. Transportation is available to families located in certain areas of Montgomery County. If transportation is a concern, the TNP staff works to provide an alternate method of transportation (for example, transportation through Medicaid). Enrolled children must have a social, emotional, or behavioral diagnosis. Finally, families must participate in family observation and evaluation to establish need for the program.

Study Sample

For this exploratory qualitative study subjects were selected utilizing a nonrandomized convenience sampling method from the TNP at the Reginald S. Lourie Center. Twelve caregivers were each invited to participate in approximately one-hour interviews. The following criteria were used for inclusion: (1) primary caregiver of a child between three and five years of age (2) who were (at the time of study) or had been enrolled in the Rockville TNP between the years of 2011 and 2014 (3) with an Axis I diagnosis (DSM-IV) and (4) an individual treatment plan (ITP) with specific goals addressing child-specific social, emotional, or behavioral difficulties.

Recruitment was conducted after receiving study approval by the Human Subjects Review committee at Smith College School for Social Work (appendix D) and through Adventist Healthcare (appendix B). Participating caregivers gave consent through a Human Subjects Review committee approved Informed Consent form (appendix E). Further, the TNP director granted permission to interact with TNP families (appendix A) and identified caregivers who met the inclusion criteria.

Active recruitment occurred in person during drop off or pick up from the TNP for families participating at the time of study and by telephone for those who had received TNP services within the prior three years. Prospective participants were provided a brief overview of this study in an informal way and told that a Smith College School of Social Work intern was carrying out the study and that it was approved by Smith College, by the director of the TNP, and by the review board for Adventist HealthCare. The Informed Consent form (appendix E) was then given in person to each potential participant or through email depending on caregiver preference.

Data Collection

Participants were involved in a one-time, semi-structured face-to-face interview lasting approximately 45 to 60 minutes held at the Reginald S. Lourie Center in the privacy of a consultation room. The interview began after reviewing informed consent information regarding confidentiality and rights of the participant. Respondents were reminded that participation was voluntary and that they could withdraw from the study at any time without repercussions. Upon their agreement respondents then responded to 11 open-ended questions about their experiences with the TNP. Some questions had additional prompts to encourage participants to expand on their responses. Participants were asked to explore both their initial involvement and their current involvement in the program and to describe relational perceptions over time. Questions asked in the interview included, "How do you feel about your involvement in the therapeutic nursery program? "Can you think of and describe a time you felt very involved in the program?" and "Can you describe your relationship with the staff at the Therapeutic Nursery Program?" An interview guide can be found in Appendix E.

Interviews were recorded on a hand-held device, with permission indicated on the Informed Consent form prior to the interview and further verbal confirmation at the time of interview. Personal identity was safeguarded in a variety of ways: I transcribed audio-recorded data and stored confidential data on a flash drive in a password protected file. Participants were notified that the recordings and transcription will be destroyed after three years of storage per the federal guidelines for human-subjects research. Signed Informed Consent forms are maintained in a secure location and will also be destroyed after three years. Further, I asked each participant to omit identifiable information such as child's name, gender, and diagnosis. If such information was disclosed during the interview, I disguised this information during the transcription phase

using a pseudonym. Each transcript was coded with a number based on numerical order of the interview. Finally, all email exchanges were stored in a password protected email account until deletion at the study's completion.

Data Analysis

I used grounded theory to explore interview results (Engel & Schutt, 2013). After data transcription I began coding for patterns and trends among participant narratives, also including narrative similarities and differences. Throughout the coding process, I continuously reviewed the data in search of patterns and trends between narratives. From this process, themes and categories emerged. Finally, I triangulated my findings with similar research studies and discuss my findings in Chapter V in light of this other research, including need for further research on this topic.

The next chapter of this thesis presents the findings of the study, beginning with a section on the characteristics of the sample followed by substantive findings as they responded to the overall research question about experience.

CHAPTER IV

Findings

This chapter presents the findings of an exploratory study of caregivers' experiences of a Therapeutic Nursery Program (TNP) located in the Reginald Lourie Center at Rockville, Maryland. More specifically, this qualitative study sought explore caregiver perceptions of program aims, impacts, and relationships, and if it is in fact realistic to attribute aspects of the therapeutic alliance (Bordin, 1979) to those experiences and perceptions. Caregivers asked to participate in this research study were identified as legal primary caregivers of children enrolled in the TNP at the time of interview during the 2014-2015 school year or between the years of 2011-2014; findings were derived from audio-recorded semi-structured interviews with those who were eligible (see appendix G).

The purpose of this study was to explore caregiver experiences of their involvement in a particular therapeutic nursery program (TNP) in Rockville, Maryland. To that end, this study explored the perceptions of 12 caregivers of children between two and one half and five years old who were participating in the program. The study explored themes that may contribute to caregiver experiences and whether it is reasonable to attribute aspects of the therapeutic alliance (Bordin, 1979) to the relationship between caregiver and TNP staff.

Analysis of 12 caregiver responses uncovered trends and themes, providing a beginning understanding of a caregiver's experiences in this particular TNP. During reading and re-reading of interview transcripts, significant statements emerged. Themes and subthemes were developed

based on the groupings of significant statements (Engel & Schutt, 2013). Findings of this study are presented in the following three categories: (1) understanding and expectations of the TNP; (2) impact of the TNP on children served and their families; (3) caregiver experiences regarding the various relationships among all participants in the program.

Table 1 (see p. 35) provides an overview of the following data analysis, detailing categories, relevant themes, and evidence of themes. Analysis of the data revealed themes relevant to three primary analysis categories. Category One encompasses caregiver understanding of the aims of the TNP, and there are three themes in this category as follows: (1) family history; (1) program quality; and (3) help. Category Two consists of caregiver perception of the impact of the TNP on the children and their families, and the following two themes are detailed: (1) belonging and acceptance and (2) acquired skills. Category Three consists of caregiver experiences regarding the various relationships in and of the TNP with three themes: (1) staff characteristics, (2) value of caregiver involvement, and (3) communication and engagement. The final category, Category Four, encompasses additional findings related to (1) utilization of staff and (2) changes to the program.

A salient point in these findings is that in most categories, positive and negative examples were given by respondents. Differentiating the positive experience from the negative experience was notated in the initial coding process but was not coded for directly later in the process. Thus, each category remained supported by both the positive and negative examples. In addition, subsequent findings do not stand alone as discrete findings but should be considered as interrelated and bidirectional concepts. For example, in the following case scenario, all three primary categories are present—understanding of aims (coded as program expectation), perceived impacts of the program, and overall perception of existing TNP relationships.

As one participant explained:

> I was a teacher so I wanted it to be up to my standards, and he had already been kicked out of a pre-school, and the director (referring to the director of the TNP) was amazing. He was like "Yeah, he can start tomorrow" and I was like "no, I don't think he's ready for tomorrow, but just as long as I have something set in place." So coming into this we already kind of knew some of the people and some of the area and were just so grateful, relieved, hopeful, we had hope. We toured it, the first time we toured it and we saw other kids who were acting like him and we were like "okay, I can see my son here."

Categories and themes in the above example can be separated and categorized, but they cannot be isolated as a separate thought; that is, each thought is supported by the other. Therefore, each category and theme is considered interrelated and bidirectional. For instance, the following were all relevant to this caregiver's perception of the TNP: (1) individual expectations for a quality program, i.e. "up to my standards," (2) adverse history with another preschool, i.e. "kicked out of a preschool," (3) relief at having a sense of belonging and acceptance to a program, i.e. "we saw other kids acting like him and we were like okay; I can see my son here," (4) caregiver's perception and experience of TNP, i.e. "the director was amazing." Therefore, the following findings should be regarded as interconnected concepts flowing from caregiver narratives regarding experiences of this particular TNP rather than discrete dynamics with no particular context.

Table 1.

Categories of caregiver experiences in the Therapeutic Nursery Program with related themes and evidence of each theme

Experience Related Category	Experience Related Themes	Evidence of Themes
Aims of the Therapeutic Nursery Program (expectations) -10 out of 12 caregivers acknowledged knowing nothing about the program upon referral and were referred through community referrals (i.e. pediatrician/doctor or PEP). Other 2 caregivers found the Nursery Program through individualized research.	History of negative experiences	*Ostracized, isolated, rejection* *Misunderstood* *Nowhere to turn* *anxiety around not-knowing*
	Expectations for a quality program	*Professional program, structured specifically for children with social/emotional/behavioral problems. To receive the help and support that they need for their family and their child.*
Impact of the Therapeutic Nursery Program	Belonging and Acceptance for both parent and child	*Finding community* *Mutual support/reciprocity with provider and between parents (resource sharing, someone to talk to and who understands what they are going through)* *Unconditional positive regard (not feeling judgement)*
	Increased skills and support	*Increased knowledge and education* *Increased self-efficacy* *Increased emotional regulation (child)* *Increased confidence and an /improved relationship (parent and child)* *Reduced anxiety* *Less isolated*
Relationships in the Therapeutic Nursery Program	Value	*Unconditional positive regard (no judgment)* *Love* *Desire to help* *Individualized care/ to be known*
	Trust	*Safe and secure, confidential* *Reliable and consistent* *Ability and expertise*
	Communication *A perception of the invitation to be in the know and to become a part of the treatment.	*Positive and/or predictable communication (accessible, receptive, open, honest, flexible)* *Respectful Boundaries* *Collaboration, teamwork, partnership partnership (among staff and between staff, parents, and providers.)* *Coordination of treatment* *Resource Sharing (trainings, articles, community activities, interventions)*

Characteristics of the Sample

To participate in this study, 12 caregivers participated in individual, face-to-face interviews that lasted approximately one hour each in an office located at the Lourie Center. Of the 12 participants, one chose not to have the interview audio-recorded. All participating caregivers were female, and all their children at the time of the study were between three and five years of age. Due to the small sample size and for the sake of confidentiality, more specific sociodemographic data was not obtained such as data regarding either the caregiver or the child's name, the child's specific age (other 3-5 years of age), their child's gender, caregiver's or child's ethnicity, or caregiver's payment-method for services (either self-pay or Medicaid).

Aims of the Therapeutic Nursery Program

Caregivers answered a set of questions about their feelings, understanding, and expectations upon entering the TNP program to explore whether such variables impacted the nature and quality of their overall experience and participation in the TNP. More specifically, these variables explore caregiver-specific understanding of the program aims: how they perceived that the program aims related to the assistance and support that their child and family needed. All study participants indicated that they expected that the TNP would provide assistance, resources, and direction regarding their presenting concerns or situations. Two themes appear to contribute to their understanding of program aims: (1) history of experience with other programs and services, and (2) their expectations upon coming into the program. As noted in table 1 (see above), caregivers had general expectations about the program's ability to be a first-rate professional program fully capable of meeting their family's needs. All caregivers expressed both themes in their narratives. The first theme, "history of their experience" was often found in support of the second theme, "program expectations," which further supports the

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interrelated nature of variables that affect caregiver experiences in this program. Participant six gives us an example of the interrelated nature of caregiver-specific history and program expectations:

> (The TNP gave us) that assurance that we can take care of this "problem" right, that we can help you, that we can be this sort of, this safe constant place. Where before it was, you know, I never knew (when) I would get a call. He could be at school for 30 minutes and I would get a call or I would get a call 30 minutes before regular pick up time. That, in and of itself, was very stressful on top of the behavioral issues and worrying about him. (I had) that feeling of never being able to know what is going to happen that day (before the TNP).

History of Negative Family Experiences

When caregivers were asked to describe their involvement in the TNP, all caregivers independently spoke about their child's social/emotional/behavioral/ developmental struggles as the impetus for seeking services. Furthermore, all caregivers emphasized a history of adverse experiences prior to their involvement in the TNP. Many caregivers reported a sense of "not knowing" and/or a sense of isolation or feeling disappointed as a result of their treatment at other nursery/academic programs. Two caregivers experienced a sense of "not knowing" due to their involvement in multiple social systems, notably Child Protective Services, the foster care system, and early childhood intervention for development, academics, and counseling. They expressed an anxious uncertainty of how to obtain required but difficult-to-access resources, such as those provided by a TNP. Nine of the 12 reported that their child was asked to leave preschool programs, leading them to this TNP while one reported that their child was not "ready" for mainstream preschool and kindergarten. In addition, most caregivers narrated prior experiences

when answering questions regarding feelings about the program and how they understood their involvement in the program, further indicating that such experiences are important for treatment seeking behaviors. Ten of the 12 caregivers acknowledged knowing nothing about the program upon referral and were referred through community referrals (i.e. pediatrician/doctor or PEP). The other two found the TNP through individual research. Examples of participant's negative experiences in other programs are as follows:

As Participant 1 described:

> Even though my child was school age, he was acting a year behind. So when you are three and you are acting like a two-year-old, that's huge. So same thing, he was four and ready for another program, but in his mind he was still acting three. He still needed me; he wasn't potty trained… When he was three and a half he was so hard. There were many days that I would just cry, like, 'I don't know how I'm going to do this… Even his primary care physician had no experience or knowledge of how these kids work and so they just thought our kid was a bad kid. My child couldn't sleep at night, ever. So we took him to a sleep expert and they told us flat out "kids can't get PTSD," and I'm like "Are you kidding me? Come live my child for a week and you'll see that he has PTSD." So even from experts, they were having a hard time knowing how to deal with him.

As Participant 6 put it:

> I don't think anyone likes to find out that their child, who is only three, already has sort of, for their age, big problems and that you don't know. You don't know what to do with them. That's what I think was the most difficult part, coming to terms with the fact that there was something going on here. Did we do something wrong? Is this just the way he is? Is this a phase or is this not a phase?

Examples of participants' history of isolation are as follows:

Participant 1 recounted:

> Every day we went to the park somebody was calling us "the crazy kid" or telling the
> children not to play with us, or umm, leaving the park because they didn't want our child
> being around their child, umm. I mean, it seemed like every single day I was, I felt so
> isolated

As Participant 9 stated:

> My child had been kicked out of school, and we were scrambling and felt like we really
> wanted a good place for him that would be accepting even, even though our other school
> said that it would be accepting.

Expectations

Not surprisingly, each caregiver expressed having expectations for a quality program upon entering the TNP. In fact, many expectations were built upon their past experiences and their child's presenting difficulties. Their expectations appeared to be a key theme that contributed to their overall experience and understanding of the program, which included their understanding of expectations for caregiver involvement, professionalism, and acquisition of skills and support.

Caregiver involvement.

All caregivers expressed having an expectation for their individual involvement in the therapeutic nursery program to varying degrees. There was a consensus that it was important that their involvement be suitable to their social context and lifestyle. Most caregivers reported involvement that was professionalized in the TNP -- that is, the expectation to be involved ranging from little emphasis on physical involvement in the classroom (e.g. no regular in-class

volunteer expectations) but very specific and planned involvement opportunities, such as family holidays and class field trips. These caregivers focused on feeling involved through structured opportunities such as planned observations, parent meetings, planned family activities, and other opportunities for contact and communication. The degree to which caregivers felt satisfied with this type of involvement varied. Some felt a sense of relief and security, while others yearned for more interaction and connection. However, they all spoke of their involvement as professional warmth -- kind and loving but also professional with boundaries. A subset of these caregivers then emphasized a physical involvement in the TNP with a focus on in-class opportunities, such as field trips, family activities, and the desire for more volunteer opportunities in the classroom. These caregivers desired both a professional and physical involvement in the classroom, focusing on in-class opportunities, such as field trips, family activities, and volunteer opportunities as well as outside meetings and communication.

As Participant 4 stated:

> I think that as someone who works full time I actually like that there isn't an expectation that the parents are also working in the classroom, which I found at (his) previous experience -- that there was an expectation of parent involvement at a pretty high level… For example, you were required to come and have lunch um with the students once or twice a month, and there were sort of other obligations in the classroom. So I think, for me personally, and sort of what I do for when I'm not here with my child that I like… is… that they give you opportunities to participate but there is not an expectation that you are available all the time to help with things.

And as Participant 7 voiced:

> (Things have changed) … I thought there would be an opportunity to sort of be a little bit
> more oriented toward the class -- to be able to know her companions a little bit… so that
> it wasn't just mommy nanny dropping her off, that I was entrusting her into a relationship
> with others and peers which I was also a part of and felt comfortable with.

Participant 8 put it this way:

> I feel like that at that time there is a lot going on where we are actually in the
> classroom… but it is also something that I would be willing to volunteer to do more
> things like in the classroom. That is one thing I would say… I guess that's the point
> where I don't feel terribly involved, but that could be the dynamic of the classroom
> works.

Three types of involvement were presented by caregiver narratives. The first type of involvement was feeling involved based on communication (knowing what is going on in the classroom through in-person conversation, email, or monthly updates). The second type of involvement appeared to be active participation (field trips, family holiday celebrations, caregiver observations, and being physically involved in the classroom with predictability and/or regularity). The third type of involvement was accessibility to resources (access to an individual therapist or access to meetings and support groups).

As Participant 4 explained:

> So, in terms of interacting with the students, I participated in the family share for the
> holidays, and that was a really nice experience, although my child managed to whack his
> head on the furniture when I got there so that was hard (laugh)… But it was nice to watch
> the teachers respond to him.

And Participant 5 said the following:

> I think I never been involved in any of my kids' programs, as I am in my child's (TNP),
> because… this program really gives you that incentive to get involved -- because if you
> are not involved they call you to be involved which is great. It gives you that incentive…
> How can I say it? It's like an island… You want to be involved. You want to be a part
> of it. The more you are involved the more you learn, which is great. You don't feel
> rejected… It's like a family.

Six caregivers felt contented with their level of physical involvement in the program, while six
expected more opportunities for physical involvement in the classroom through in-class
volunteer opportunities. Two spoke of observation opportunities as educational but desired more
opportunity to interact with their child in the classroom. Further, quality of involvement was
often noted as positive when caregivers experienced relationships in the classroom as positive,
and vice versa (see "Relationships in the Therapeutic Nursery Program" for further explanation,
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Knowledge, ability, and professionalism.

Caregivers emphasized the importance of engaging with staff who are knowledgeable,
professional, and able and willing to help the child and family. Most often, caregivers spoke of
TNP staff as knowledgeable teachers who were experts in their field. Experience, education,
professionalism, and communication styles were also indicated as valued staff characteristics.
(Communication is discussed in detail below but is also relevant to caregiver understanding of
the TNP program.) Also, caregivers desired staff to be capable of educating them, the caregiver,
about specific strategies and techniques to individually help their child and capable of teaching
them strategies that could be used at home.

As Participant 4 explained:

> To be able to have him work with people who understand what he needs and also to help
> us learn what he needs… that sort of rethinking -- what, who he is, what he needs, how
> do we interact with him, how can we change our expectations to make life more
> manageable -- all those things were important.

And Participant 5 recounted:

> (It's) amazing to have somebody you can come to and say, you know, "I see this in my
> child" and have somebody turn around and say "Really. I haven't seen that, but we will
> check on it and we will talk about it. We will look for it," and I get some information.

Summary of Caregiver Perceptions of Program Aims

Caregivers' understanding, feelings, and expectations of program aims appear to
contribute to their experiences of this TNP, as evidenced by supporting themes: adverse histories
and program expectations. They described adverse histories and program expectations when
answering questions aimed at eliciting information about their understanding of program aims
prior to entering the program. Therefore, adverse histories appear to contribute to treatment-
seeking behavior, and program expectations appear to contribute to how they understand their
involvement in the program.

<div align="center">

Impact of the Therapeutic Nursery Program

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Caregivers also answered a set of questions regarding their perception of the TNP's
impact on them and their families. These questions were intended to elicit narratives that explore
TNP characteristics that they found helpful and valuable to their cumulative experiences. Two
themes appear to contribute to their understanding of program impact: (1) a sense of belonging
and acceptance and (2) increased skill. All caregivers expressed both themes in their narratives.

A Sense of Belonging and Acceptance

All 12 caregivers expressed the concepts of belonging and acceptance as important to how they experienced the impact of TNP, which was as a place where caregivers and their children could receive physical and emotional support. Six of the 12 noted a desire for an increased level of engagement, acceptance, or belonging with a focus on feeling known, understood, and validated without judgment or ridicule. Others felt adequately involved in the program and happy with their child's involvement with a focus on their child's acceptance and belonging – that is, relationships with peers, relationships with teachers, and overall comfort in the program. When asked to describe a particular instance when they felt involved, all caregivers cited their involvement in field trips and in-class activities. Many also described engagement opportunities as a learning opportunity and a chance to foster relationships in the classroom, particularly the chance to feel mutually supported by other caregivers. In fact, half of the respondents described the TNP as their community and/or an extension of their family where they received tangible and emotional support. When caregivers felt that they were accepted or as if they belonged, they also experienced empowerment and hope along with mutually-supportive relationships among other TNP caregivers.

As Participant 1 said:

> When we had the TNP family days—the carnivals and the field trips and whatever—
> when the families got together, I remember feeling like "finally I found a community"
> and feeling like "my kids not the weird kid" and "we're all in this together… and being
> able to step back and know that if my kid bites your kid you're not gonna get upset at me.
> And your kid is gonna do weird things and I'm going to accept that, because here we are.

And as Participant 6 explained:

> I think the social workers did a great job during the parent meetings. Those were very
> helpful and I think more of that would have been great. They're here primarily for the
> children, (but) parents need the support too… a place where you can talk freely about
> what is going on with your kids and what is happening at school and what is happening at
> home and not feel embarrassed and constrained… Everybody has different feelings
> about these things about how our kids act. These bonds loosened and you could laugh.
> There was someone else who could see the humor in whatever crazy thing that your kid
> had done in the park or whatever.

Participant 7 also voiced an opinion on this:

> It was Hanukah, and I've done it three times now, and the actual joy of seeing the kids
> really gather around, listen to the story, learning to spin the dreidel, participate with the
> "gelt," share in the holiday treats, stay the whole time and watch the delight in their faces.
> And then actually, that was followed up by parents… We would meet in the classroom
> the next day, and "oh that's all they talked about, spinning the dreidel with you." So the
> parents very much would be able to gather in the classroom and watch the teachers, and
> we would be by the window "yap, yap, yap, then oh we better go" but I think there is a
> chance for the parents (to get to know each other), and I know I have to get really
> involved where they participate in an activity in the classroom.

Increased Skills

Regarding skill building for caregiving, all 12 caregivers hoped to gain skills and support from the TNP. Narratives indicated an expectation for skills acquisition for caregiving strategies and knowledge on how to navigate next steps in the educational system, along with an expectation for symptom reduction. Caregivers who indicated an overall positive program experience described the benefits of acquired skills and support. In fact, most often, caregivers attributed their child's symptom reduction as a byproduct of these acquired skills and support. Behavior improvement, increased coping strategies, and caregiver tools were identified as important variables for positive experiences in the program.

Felt, observed, or reported increased skills either on behalf of the caregiver or of the child included skills such as improved stress management, emotional literacy, behavior modulation, emotional regulation, peer relationships, and attachment relationships. Caregivers who reported increased skills indicated increased confidence in their ability to parent and greater confidence in knowing where to go to find a solution or to advocate for their child's needs. Some caregivers reported an increased ability to manage anxiety and stress, allowing themselves to emotionally and physically separate from their child in order to receive the help that they need and/or to regroup so they can have a more successful interaction with their child. Caregivers also reported improvements in their child's behavior and/or their child's social skills and reported that their child had increased self-confidence. When asked about their hope for their child in the future, all caregivers reported continued growth for their child—that their child would continue to grow and acquire adaptive skills so that they may one day be seen as a typically developing child. In fact, 10 out of 12 caregivers said that they wanted the TNP (at least in some form) to extend beyond preschool age and into grade school age.

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As Participant 1 put it:

> The teacher was able to share some of that stuff at home too; and that was key for me --
> that help that you guys brought from here to home, because in the past I was figuring it
> all out on my own.

And as Participant 5 recounted:

> I love they give us that opportunity to be involved in our kid's life. All the activities give
> you a chance to be involved with them, which is great, because we learn and we grow
> with them, we understand them and we know how to deal with them… He is able to
> express himself, how he feels… which was something (of) a struggle before we came
> here… It's a lot of resources.

As Participant 6 explored:

> I feel like we got a lot of support and a lot of empathy, but what I really would have
> loved was… more opportunity to learn myself what works with these other kids and just
> day to day nuts and bolts kind of stuff, because that's the stuff that gets us in trouble with
> these type of kids.

Participant 9:

> I had no space for myself. So over time, again, one of the things TNP does is help parents
> realize that it's not just about the child and the child getting support and what the child
> needs, but it's also about the parents. There was a sense that my son's challenges were
> related to me when I came in as a parent. And I think over time, I have learned more
> about what some of the difficult things for my child are and what the triggers for his big
> feelings. And so, I've been able to separate it so it's not a personal issue for me anymore.

Finally, as Participant 11 put it:

> I feel more connection with my daughter…She follows the rules, she helps me much, and she helps me also to watch the other kids. Teachers told me that. She participates and everything. When the teacher asks she responds... Before she came here she was quiet and she wouldn't say nothing. Now she's participating a lot. It's a really big change.

Summary of Impact of the TNP

In sum, caregivers who reflected on the program's impact (on their child, them, or the family) reported two themes regarding themselves and their children: a sense of belonging and acceptance and acquiring or improving caregiving skills. Narratives reflected belonging and acceptance based on the following characteristics: feeling known without judgment, feeling that their participation was important, and having a sense of community in the program. Increased skills centered on skills acquired by the caregiver and by the child. Caregivers focused on increasing their knowledge regarding the child's progress and abilities, learning different parenting skills appropriate for the child, understanding next steps for the child's academic journey, and improved relationships with their child. Increased skills for their child centered on achievement, coping strategies, social skills, emotional regulation and healthy coping strategies, knowledge of parenting skills and next steps, and improved relationships.

Relationships in the Therapeutic Nursery Program

Caregivers were then asked to describe relationships with TNP staff and between their children and staff. Responses revealed relational perceptions of the TNP that both contribute to and are affected by their perceptions, understanding, and experiences of this early intervention program. The following three themes were evident in their perceptions of relationships: (1) value to the program, (2) trust, and (3) communication.

Value

  Caregiver narratives indicate that feeling valued was critical to their relationship with the

TNP staff. Those who felt valued then felt respected and believed that TNP staff had a heart fort

their family and their family's success. Staff who were perceived to hold relationships in high

regard tended to exhibit a deep understanding of their child and family as evidenced by

individualized care, intentional connection, and unconditional positive regard. Caregivers who

observed positive interactions that appeared specific and unique to their child reported a sense of

feeling valued and important. Two caregivers used the term "love" when describing the

relationship between staff and child. Specialized care appeared multiple times in caregiver

narratives, which included specialized intervention techniques for their child, specialized

meeting times according to caregiver schedule, and implementing caregiver ideas specific to

their child. Caregivers also felt valued when staff strategically offered them additional resources,

coaching, meetings, or opportunities for observation.

Participant 1 explained it this way:

  When the teacher fell in love with my son I was so happy and pleased… You can pay the

  teacher to teach; you can't pay them to love your kid. And so I knew that she was always

  going to be there and treat him like her own son… She (lead teacher) was able to come

  up with some of these great ideas. It wasn't just "nope, these are the rules; this is the way

  it is." She thought outside of the box with him and really found what worked for him.

Participant 4 said the following:

  I can't remember when or why, but we did a sit-down meeting with all of them relatively

  recently, and it was maybe even outside of the normal scheduled conferences because my

child had started later in the program but they certainly made time to do that for us, which

was very helpful.

And Participant 6 put it this way:

You never felt like there was any judgment on you at school no matter what your kid did

at school (laughter), and some of these other children too, I know. I have done some

pretty wild things. And there was never any sense of "Well, this is going to be your

fault," which you get in other school systems.

Trust

Caregivers also emphasized an element of trust in their relationships with the TNP staff.

Most often, trust was characterized by consistency, reliability, dependability, and acceptance.

Caregivers indicated trust when they believed that TNP staff would follow through with their

word, an action, or a consequence. Caregivers trusted that staff would consistently and reliably

implement agreed-upon behavioral interventions and would regularly follow through with

specific caregiver requests if agreed to do so. Trust was used to indicate safety and security in a

variety of instances and contexts. For example, caregivers trusted that their child would remain

physically safe in the TNP environment, which meant that the building was physically safe and

that TNP staff had the knowledge, ability, and forethought to keep their children safe. Caregivers

mentioned that it was not only important that they trusted TNP staff but to see that TNP staff was

able to trust each other in all contexts—e.g. to handle a situation together or to ask each other for

help, and to provide each other with verbal or physical support to keep children safe and secure.

Caregivers also trusted that staff would unconditionally accept their child, as noted above in the

section "Impact of the TNP" under the "belonging and acceptance" theme.

As Participant 5 expressed:

> To know that he is safe… That is the best thing. The best thing is that it has made the
> kids feel safe, that they have an environment because nothing will happen to them, if
> something happens to them, or if something is going on with them, then they know that
> somebody will help to understand and overcome that.

And as Participant 6 said:

> I think there comes a level of absolute trust. I was never worried that anything would
> happen to them (the child). There was absolute trust of the staff here, which I think is the
> most important thing, especially for kids like this where they can be *so* aggravating and to
> know that there is a staff of teachers.

Finally, as Participant 9 explained:

> It's almost like a sign of "I trust that you are not going to write me off because I'm a bad
> kid and so I'm going to let you see this part of me, or I'm going to unload my negative
> feelings or all of the anxiety that I have with you because you can handle it." I think the
> proof of that is when he comes out of the other side he is then very loving with the lead
> teacher or other teachers in the room. I'm sure you've seen them, so, so yeah, I'd say
> overall he's developed a better… more trust in adults who are not his parents.

To end this section, it is important to note that two caregivers who appeared to be skeptical and

critical about their child's participation in the TNP had apparently experienced mistrust in their

relationship with TNP staff, reporting that staff did not follow through with their requests or that

they felt behavioral interventions were not appropriate.

Communication

Caregivers emphasized communication as both an expectation (noted above) and as necessary component of successful relationships in the TNP. Mode of communication and quality of communication were identified as important contributing factors. Communications included various meetings, brief in-person updates, phone calls, e-mails, take-home calendars, and informational flyers. The quality of communication was described most often and was reported to be open, honest, and predictable. Caregivers also expected staff to be understanding and respectful of their time (schedules at work and at home), and emphasized the importance of positive comments (child's achievements). Communication was also used to describe the ability of staff to share resources in an easily accessible manner, and respondents indicated that the ability to allocate, coordinate, and assist with resources was important. Coordination of treatment, particularly next steps after TNP, was a common thread among caregivers. Many who were facing transition out of TNP expressed the feeling of being "thrown to the wind," with a renewed anxiety about navigating a new educational system. They also identified staff ability to communicate efficiently, clearly, openly, and honestly about treatment and next steps as central to the relationship. Caregivers expected staff to be receptive and responsive to communication such as when implementing a new intervention, with many describing their relationship as being a part of a "team," with an emphasis on collaborative teamwork. In addition, the invitation for involvement must fall under the "communication" theme, because clear invitations that communicated a worth, value, and importance affected their overall perceptions of their relationship with TNP staff and the overall impact of the TNP. Such invitations created feelings of belonging and acceptance while also clarifying program boundaries, both of which were considered as important by the respondents.

As Participant 1 said:

> And that's another thing that I really like about the program is that you guys have meetings and you discuss our children and discuss "This isn't working; what else can we do?" and you'll involve us in some of those discussions…. (and) She was just giving positive feedback about him all the time, so that was nice to hear that he was so inquisitive and he had appropriate questions and was thoughtful in his responses…(and) the staff were open, honest, and straight forward, um… But they also had, clearly a knowledge of how to deal with my son, and that was such a refreshing feeling.

And as Participant 4 stated:

> (An important thing was) open communication between the lead teacher and my husband and I. Particularly when we started we did weekly emails for a while. We set up some times to talk on the phone, so that transition involved a lot more interaction between myself and the lead teacher…I know that there is some coordination with my child's occupational therapist; there have been a number of points that they have been working very hard to make this a team effort to get him everything that he needs.

Participant 6 explained it this way:

> (The TNP team can be seen) supporting each other…and I think that's where a lot of the trust comes in. because they are just so professional and so well coordinated in the classroom that you know that no matter how aggravating your child is, that there is multiple layers of people within that classroom and at least one of them is going to have the patience for that behavior on that day

And Participant 7 stated the following:

> I feel discouraged (where there is a) lack of implementation of ideas or resources that are given to the staff (by me, the caregiver) to help my child." (and) It would be just great if that monthly newsletter or whatever had something about "by the way we are going to try this in the classroom," or " you might hear your child talk about this" or I would just like to have…the lead teacher come in (to the parent meeting) every once in a while to say "Gee, I was just at a conference and we were learning all this great information about early childhood intervention, and we came away feeling so enthused and exhilarated, and we have some new ideas we are going to try in the classroom, and you might be hearing about them over the next month.

Participant 10:

> Whenever we dropped him off if there was any problem the day before they (the TNP staff) always took time to talk to us…They communicated very well, very well. So you know, anything that kind of went out of the ordinary or if the child got up on the wrong side of the bed that day and just wasn't right… they kind of let you know.

Summary of Relationships in the TNP

Caregiver responses revealed relational perceptions of the TNP that both contributed to and were affected by their perceptions, understanding, and experiences of the TNP. For example, TNP program structure (e.g. opportunities and invitations for involvement) contributes to a caregiver's understanding of the program and their relational perceptions. Caregiver narratives indicated that feeling valued by staff was critical to their relationship development. Caregivers also emphasized an element of trust in their relationships with TNP staff. Most often, trust was characterized by consistency, reliability, dependability, and acceptance. Caregivers indicated

trust when they believed that TNP staff would follow through with their word, an action, or a consequence. Additionally, caregivers emphasized communication as an expectation (aforementioned in the section "Impact of the TNP") and as a necessary component of successful relationships. Value, trust, and communication were salient themes in caregiver relational perceptions in the TNP.

Conclusion

The professional literature on caregiver participation in early childhood programming and child psychotherapy has emphasized the importance of caregiver participation and collaboration in a child's early mental-health treatment (see, e.g., Barnes, Guin, Allen, & Jolly, 2016; Blue-Banning et. al, 2004; Novick & Novick, 2005; Swick, 2003). In the exploratory study described here, 12 caregiver narratives were examined to garner a beginning understanding of how caregiver perception affects their experience of a TNP and whether it is realistic to attribute aspects of the therapeutic alliance (also known as a working relationship) (Bordin, 1979; Novick & Novick, 2005) to caregiver experiences and perceptions of the TNP.

Three categories identified were as follows: (1) aim of the therapeutic nursery program, (2) impact of the therapeutic nursery program, and (3) relationships in the therapeutic nursery program. Each category encompassed themes relevant to its category. Aims of the TNP were categorized by adverse histories and program expectations prior to active program involvement. Impact of the TNP included feeling as though they belonged in the program (a sense of community) and whether or not the family received resources, skills, and support that they believed they needed. Perceptions of relationships in TNP were categorized by value, trust, and communication. A salient point in these findings is that each theme was interrelated and bidirectional with only one exception; history of adverse experiences, which appeared to inform

perceptions and experience in other themes rather than other themes informing adverse history.

All themes are discussed further in the next chapter, which compares these findings to those already contained in the related literature, which then presents implications for practice (direct service and program planning), and offers recommendations for future research.

CHAPTER V

Discussion

The research problem addressed by this study was the lack of research surrounding caregiver experiences of an early-childhood-intervention program, namely the Therapeutic Nursery Program (TNP) of Rockville, Maryland. The major research question was how do caregivers whose children attend this TNP experience this early childhood intervention program? Secondary research questions were as follows: How do caregivers understand the aims of the TNP? How do they describe the impact of the TNP on their child and family? How do caregivers experience their relationship with TNP staff? Finally, how does their view of the relationship impact their perceptions of the program?

The purpose of this qualitative exploratory study was to increase our understanding of caregiver experiences. The primary value of this study is a better understanding of caregiver perceptions of program aims (how they understand the program), program impact (what they feel or believe it has done/ is doing for them), and program relationships (how they view their family's relationships with staff). As this was a qualitative exploratory research study, interviews were the primary source of data collection (Yin, 2016). Twelve caregivers who either were participating at the time of study or had participated in the previous three years were interviewed for approximately one hour each in a private room of the Lourie Center housing the TNP. One participant declined to be audio-recorded; thus, manually-recorded field notes were used to record this interview instead of an audio tape.

This chapter opens with the study's strengths and limitations. It then compares and contrasts the findings of this study in light of the professional literature on the subject, discusses the implications of the findings for social work practice, and ends with recommendations for further study.

Strengths and Limitations of this Study

This study had several strengths and some limitations as well. First, there is a limited availability of research and other literary resources (e.g. books and articles) on the TNP as an early intervention program and much less clinical research on caregiver experiences of the TNP—including their perceptions and beliefs of the program and of barriers to involvement. This may be due, in part, because the therapeutic-nursery approach to early intervention is not a fully theorized or conceptualized area of practice, which separates each therapeutic nursery program into discrete entities rather than conceptualizing them as one singular approach and thus, limits the effective triangulation with other TNP research (e.g. contrasting one TNP with another that shares the same psychodynamic orientation or methods relating to the value of caregiver involvement). As a result, an exploratory research design was appropriate for this study. However, the limitation of literary resources broadened the scope of the study significantly such that the study ended up being quite complex and the data obtained also rather vast and complex to analyze. The instrument used for this study (semi-structured interviews, see Appendix ##) was able to yield a great deal of data, as noted, but may have been improved, or could be still be improved, with the use of pre and posttest measures in a multidisciplinary study which is discussed further later in this chapter.

The study also had limitations regarding the sample. The number of study participants for this qualitative research (N=12) was appropriate for this thesis project, and convenience

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sampling was also appropriate as well as practical. However, in order to reach the adequate number of study participants and to uphold confidentiality, the inclusion criteria were broadened over time. That is, this TNP has an annual enrollment of 12 child participants per year, which yields a pool of 12 caregiving dyads. Of these 12 caregivers, however, some were not legal guardians at the time of study (and thus, at the time of recruitment) or were actively involved in child protective services. These caregivers were not, therefore, eligible to participate in this study. Consequently, to obtain 12 participants I broadened the inclusion criteria to include caregivers enrolled in the three years previous to the study. This broadening of the sample pool created two weaknesses in the data collected. First, the procurement of sociodemographic data was limited. The Human Subjects Review board at Smith College asked that I refrain from gathering sociodemographic data (aside from the requirement that caregivers meet basic inclusion criteria) due to concern that caregivers could be identified based on program enrollment (12 students per year) and the sample size (12 caregivers over a three-year period) regardless of protectionary measures. For this reason, I could not discern whether a family interviewed was a family who was self-pay or Medicaid, which might, for example, have affected their expectations of the program in some way. Also, it was not possible to discern whether the individual interviewed was the child's biological caregiver or an adoptive caregiver, which may also affect expectations and experiences. Second, caregivers who were not actively involved in the TNP at the time of study were susceptible to reporter bias, which includes telescoping, exaggeration, or selective memory (Yin, 2015). Finally, demographic data for those not actively involved in the program at the time of study could not be identified because such data was not collected at the time of the study, for reasons noted previously. Such data would

have allowed for the categorization of caregivers who were in the program at the time of study compared to those who were recalling past experiences.

Finally, a set of study limitations centered on time. I had less than two months from the time the study was approved by both Smith College and Adventist Healthcare to recruit and conduct interviews. Thus, while 12 participants were effectively recruited and interviewed, transcription and initial coding occurred after multiple interviews, which might have hindered both the effectiveness of the instrument (normally/routinely altered slightly between interviews for better clarity or depth potential with enough time to do so) and analysis, which normally occurs on an ongoing basis rather than at the end of data collection. Nonetheless, the findings of this study do offer significant implications for social work and add to a body of knowledge on the subject of early intervention for children with mental health problems.

Findings and Implications

The above-noted limitations notwithstanding, this exploratory study provided insightful first-hand accounts of caregiver experiences and perceptions of an early childhood intervention program known generically as a therapeutic nursery program (TNP). In particular, the study focused on one such program in Rockville, Maryland. Findings of this study, as described in Chapter IV, are consistent with existing literature on the significant impact of caregiver engagement in both early intervention programs and early childhood educational programs and with the research on the significance of positive relationships between caregivers and helping professionals (e.g.; Blue-Banning et. al,. 2004; Englund, Luckner, Whaley, & Egeland, 2004; Feinstein, Fielding, Udvari-Solner, & Joshi, 2009; Green, Walker, Hoover-Dempsey, & Sandler, 2007; Korfmacher et. al., 2008; Zill et. al., 2001).

Three analysis categories were central to this research study: (1) understanding and expectations of program aims; (2) impact of the TNP; and (3) caregiver experiences of program-based relationships including their relationship with staff. Upon analysis of these categories, it was found that each category contained major themes. For example, the first category (understanding of aims) revealed three major themes: family history, program quality, and help. The second (perception of impact) contained two major themes: belonging/acceptance and acquired skills. Finally, the third category (experiences of relationships) contained three major themes as follows: staff characteristics, value (if the caregiver feels important and valuable in the TNP), and communication and engagement. Categories and major themes will be discussed in more detail below and will include potential implications for further research.

Aims

Interview questions in support of the question "How do caregivers understand the aims of the therapeutic nursery program?" provoked narratives that spoke of negative past experiences (adverse histories) and caregiver expectations of the program. Negative past experiences were characterized by feelings of isolation— or feeling alone in their struggles, experiencing rejection by peers, by family members, and by other professional institutions—feeling misunderstood, unimportant, or ignored by professionals and other parents, and feeling anxious and fearful that their child was never going to receive the help that they needed. Thus, the findings of this study suggests that a family's personal history and past experiences with other childcare institutions are inextricably woven into their experiences of the TNP, while also informing their beginning expectations of the program.

Program expectations centered on two subthemes: involvement and staff knowledge, ability, and expertise. For example, there was a consensus among caregivers that it was

important that their involvement be suitable to their social context and lifestyle. Most caregivers reported involvement that was professional -- that is, involvement but with little emphasis on their physical involvement in the classroom—e.g. no regular in-class volunteer expectations but very specific and planned involvement opportunities such as family holidays and class field trips. Most caregivers focused on feeling through structured opportunities, such as planned observations, parent meetings, planned family activities, and other opportunities for communication. The degree to which caregivers felt satisfied with this type of involvement varied. Four felt satisfied with structured involvement, while eight caregivers felt involved but indicated a desire or hope for more in-class involvement opportunities. In addition, caregivers noted the importance of three types of involvement in the TNP. First, there was an involvement in terms of communication with staff—knowing what is going on in the classroom through in-person conversation, email, or monthly updates. Most often, these caregivers had narratives that appeared to be satisfied with this involvement. Second, there was a type of involvement in terms of active participation -- field trips, family holiday celebrations, caregiver observations, and being physically involved in the classroom with predictability and/or regularity. These caregivers generally indicated a desire to be more involved in the classroom. The third type of involvement was the child's accessibility to resources—access to an individual therapist or access to meetings and support groups.

Most caregivers referred to prior experiences when answering questions regarding their feelings about the program and how they understood their involvement, potentially indicating that such experiences could contribute to treatment-seeking behaviors. Caregiver understanding, feelings, and expectations of program aims do appear to contribute to their experiences of the program, which is evidenced by supporting themes: adverse histories and program expectations.

Further, program expectations appear to vary between caregivers of the TNP. The general conclusion, however, is that caregivers feel valued in and by their involvement, while some desired even more involvement. The weight that these findings carry in overall program experience cannot be accounted for based on the parameters of this research; clearly, more research is necessary. For example, adjusting the methodology to include sociodemographic data would indicate whether a caregiver's perception of involvement is due in part to such status or perhaps employment status. Additionally, the study of adverse histories as they may or may not affect perceptions would be useful in understanding the impact of family history.

Impact

The "impact of the TNP" on the children and their families centered on feelings of belonging and community and on obtaining resources, skills, and support that they believed was important for their journey toward healing. Generally, caregivers wanted to belong to a community free from judgment and fueled by understanding. They wanted to experience a community where they could share resources and develop mutual support. Many parents valued the monthly parent coffee session but also desired more interaction with other caregivers and staff as well. This finding may be linked to the isolation that caregivers described under "adverse histories" and may indicate a greater need for peer support.

Caregivers indicated skills and support as an important characteristic of program impact, noting an increase or desire for an increase in their child's academic performance, increased confidence, reduced anxiety/increased emotional regulation or adaptive coping strategies, and feeling less isolated or alone. This indicates that caregivers want their child to succeed and that they want to be able to help their children to do so. Caregivers also indicated a desire to be equipped to work with their child, which may identify an area for program development in the

form of workshops on caregiving skills and how to transition out of such a program. In fact, a salient point in this category is the juxtaposition of isolation in the "aims" and "community" sub-categories, further substantiates the need for additional research to isolate and study adverse histories and their impact on caregiver experiences and even more specifically, on their expectations of a TNP.

Relationships

Relational perceptions of the therapeutic nursery program focused on value, trust, and communication, a finding that is consistent with literature on parent-helping professional collaboration and partnership (Blue-Banning et. al., 2004; Swick, 2003). This study also found that relationships contribute to the overall experience of the program; the weight of this contribution, however, remains unknown.

Caregivers indicated that feeling valued was important to their relationship development with TNP staff. Staff who were perceived to hold relationships in high regard tended to exhibit a deep understanding of their child and family as evidenced by individualized care, intentional connection, and unconditional positive regard. Caregivers who observed positive interactions that appeared specific and unique to their child reported a sense of also feeling valued. In fact, two caregivers used the term "love" when describing the relationship between staff and child.

Caregivers also emphasized an element of trust in their relationships with the TNP staff. Most often, trust was characterized by consistency, reliability, dependability, safety, and acceptance, and caregivers indicated that it was not only important that they trusted TNP staff but that TNP staff were able to trust each other in all contexts as well, such as handling a special situation together or asking for help and providing each other with verbal or physical support to keep children safe and secure.

Further, caregivers emphasized communication as both an expectation (noted above) and as necessary to successful relationships in the TNP, both in terms of mode of communication and quality of communication. Communication included various meetings, brief in-person updates, phone calls, e-mails, take-home calendars, and informational flyers; and quality of communication was described most often as open, honest, and predictable. Caregivers also expected staff to be understanding and respectful of their time (schedules at work and home), and emphasized the value of positive comments (child's achievements). Communication was also used to describe staff's ability to share resources in an easily accessible manner and indicated that staff's ability to allocate, coordinate, and assist with resources was also important. Finally, coordination of treatment, particularly next steps after TNP, was a common thread for half the sample, with two caregivers noting transition out of TNP as feeling "thrown to the wind" with renewed anxiety about navigating a new educational system.

According to Knopf and Swick (2007), parental involvement is directly influenced by parental perceptions of their relationship with the teachers and staff of early childhood programs. Parents desire for their child to belong, to feel connected, and to be healed in the same way that they also desire to feel connected and for their child to be healed. These experiences are subjective and often depend on the ways in which the caregiver is actively engaged with the program and centering on quality of service (involvement, skills and support, and effective communication) along with quality of relationship through which services were provided (communication, value and trust).

Therapeutic Alliance: Applicable or Not?

Ultimately, this research study has some evidence to support the use of terms such as a "therapeutic relationship" or "therapeutic alliance" when referencing professional caregiver-staff relationships. The therapeutic alliance (Bordin, 1975; Novick & Novick, 2005) is a trans-therapeutic concept that describes the relationship between helping professionals and clients in a manner that promotes mastery and growth. Bordin (1979) describes three core concepts of the therapeutic alliance (therapeutic relationship): (1) positive bond between professional and client, (2) collaboration and agreement on the tasks of treatment, and (3) collaboration and agreement on goals of treatment. Child psychoanalysts Kerry and Jack Novick (2005), describe the working relationship with caregivers in treatment phases beginning in the evaluation phase, moving to pretreatment, then to the beginning of treatment, then to the middle of treatment, and lastly to treatment termination. They suggest that each phase presents new tasks that, when accomplished, give caregivers new skills in functioning and fostering mutual respect, support, love, and continued growth. Inherent in all relationships, and within each phase of this framework, is the inevitability of ruptures and attempts at repair. An example might be disagreement over treatment goals that results in a meeting, which then restores faith and trust in the relationship. Pieces of this research study fit both Bordin's (1979) core concepts and Novick and Novick's (2005) description of the therapeutic alliance for parent work. First, caregivers in this study indicated a desire to be part of a community and to see that their children are uniquely cared for and "loved." Second, they reported an expectation in skill acquisition and a decrease in problem behaviors, trusting that staff would have the knowledge and skills to keep their children safe and to implement agreed-upon interventions. Third, they indicated that their relationship with TNP staff grew over time through value, trust, and communication. More research designed

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specifically to better understand the therapeutic alliance in a TNP such as the one in Rockville, Maryland is needed to understand how the theory of the therapeutic alliance operates within the TNP.

Conclusion

In conclusion, this study provides a beginning understanding of caregiver experiences of parents of children served by a therapeutic nursery program in Rockville, Maryland. Albeit its limitations, one can still see the complexity of caregiver experiences and how both positive and negative experiences may contribute and effect experiences in such a program. Caregivers want their child to receive specialized care and to progress on their healing journey while they, themselves, desire to feel also connected, valued, and important to the program. They want to be active participants in their child's treatment, and their level of comfort in participation varies, suggesting that staff might consider an ongoing-inquiry approach, i.e., regularly engaging in conversations about how to best engage caregivers. To both broaden and deepen this understanding, future research should be multidisciplinary, longitudinal, and span to other TNP's and include a full assessment of sociodemographic data and its potential impact and also possibly include a pre/post-test design to better ascertain changes in perspectives of caregivers over the lifespan of their participation in such a program.

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Appendix A:

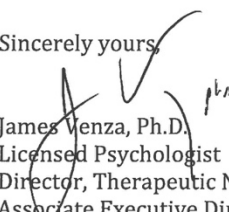# Agency Approval Letter

November 25, 2014

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

The Reginald S. Lourie Center for Infants and Young Children gives permission for Jaimie Tyler to locate her research in this agency's Therapeutic Nursery Program. We request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by Jaimie Tyler. The Lourie Center's IRB will review the SSW HSR approved research and will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee. If needed, the Lourie Center's IRB will contact the SSW HSR committee for clarification of any issue.

We are pleased to support Jaimie's research and to contribute to the field of early childhood intervention.

Sincerely yours,

James Venza, Ph.D.
Licensed Psychologist
Director, Therapeutic Nursery Program
Associate Executive Director

Appendix B:

Adventist Healthcare Approval Letter

Adventist HealthCare

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

INSTITUTIONAL REVIEW BOARD DETERMINATION LETTER

March 9, 2015

Jaimie Tyler
Reginald S. Lourie Center
12301 Academy Way
Rockville, MD 20852

TITLE OF STUDY:	Caregivers' experiences of the Therapeutic Nursery Program in Maryland: An exploratory study
PRINCIPAL INVESTIGATOR:	Jaimie Tyler

Dear Jaimie:

This letter is to notify you that your project "Caregivers' experiences of the Therapeutic Nursery Program in Maryland: An exploratory study" as described in the attached protocol has been reviewed for applicability of human subjects protection regulations.

This project involves a one-time, semi-structured interview of primary caregivers of children ages 3-5 years old who are enrolled in the Therapeutic Nursery Program about their feelings about and experiences with the program. Each interview will be recorded and the audiotape will be given an interview number based on numerical order of the interview. The interview will be transcribed onto an encrypted flash drive that is password protected and the audiotape will be destroyed. This transcription will not be linked to identifiable information and any verbal identifiable information given by the participant during the audio recording will be omitted during transcription.

In accordance with 45 CFR 46.101(b)(2), the IRB has determined that the research is exempt from IRB review as it is research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior. The information obtained is not recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects, and any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

No further review by the Adventist HealthCare Institutional Review Board – Shady Grove Adventist is required. In the event that there is a change to the project that may effect this determination, a description of the change must be submitted for review.

Should you have any questions, please contact the Adventist HealthCare Institutional Review Board Administrative Office directly at (301) 315-3281 or (301) 891-6624.

Sincerely,

A. Kimberly Iafolla, M.D.
Chair, Adventist HealthCare IRB – Shady Grove Adventist

cc: AHC IRB - SGA File

Appendix C:

HSR Request for Revision

SMITH COLLEGE

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

February 6, 2015

Jaimie Tyler

Dear Jaimie,

Thank you for the effort you have put into your Human Subjects Review (HSR) application. Our job as a federally mandated human subjects review committee is to make sure that all research projects which we approve follow federal guidelines for research with humans, including informed consent, protection of vulnerable participants, the ability to withdraw from projects, appropriate storage and collection of data, and other items discussed in the HSR manual.

Part of our job is to ensure that the research results are worth the risks and costs to the participants. The actual benefits to the researcher, participants, and the field of social work, must be worth the time and energy participants will put into being a part of the study. Projects that are unclear in their questions and methods may lead to results that are not beneficial to the participants or to the field.

Attached you will find your proposal with our required changes in **MS Word** *Track Changes* and our requests for revisions marked as *New Comments* in the margins. These comments will provide guidance to make substantive changes in accord with HSR federal guidelines for research.

Please make all changes to your research proposal with **MS Word** *track changes* or indicate changes in another way (e.g. bold type or highlighted type) so they are easily read in order to speed the return of your revision. If you feel we have misunderstood your study and there are changes you do not wish to make, please explain in the margins with a *Comment/s*. Sometimes we ask for changes that do not make sense to applicants because something was unclear to us and your explanation can clarify these issues.

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Please understand that we function with a collaborative model- we want to help all applicants learn from their research while protecting all human subjects. Should you have any concerns about committee comments, please review with your thesis advisor, who may follow up with a contact to the Chair, HSR Committee.

Please return your application to Laura Wyman at lwyman@smith.edu. Please label each document you send with **your name, the term "HSR," the term "Revision", and the number of the revision.** As an example, if your name is Sara Jones, we should receive an application revision document like this: "SaraJones HSR Revision1.docx".

Please label the subject line of your email as HSR Revision.

Please note that most of your correspondence will come from me through Laura. It may also come from Marsha Pruett, PhD, Co-Chair of the Human Subjects Review Committee. She will respond when I am not able.

Sincerely,

Elaine Kersten, EdD
Co-Chair, Human Subjects Review Committee

CC: Dominique Steinberg, Research Advisor

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Appendix D:

HSR Approval Letter

SMITH COLLEGE

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

February 12, 2015

Jaimie Tyler

Dear Jaimie,

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,

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

CC: Dominique Steinberg, Research Advisor

Appendix E:

Informed Consent Form

SMITH COLLEGE

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

....

Title of Study: Caregiver's experiences of the Therapeutic Nursery Program: An Exploratory Study

Investigator(s):

Jaimie Tyler
MSW Candidate at the Smith School of Social Work
MSW Intern at Reginald S. Lourie Center in Rockville, MD.
jtyler@smith.edu

....

Introduction
* You are being asked to be in a research study that explores caregiver experiences of involvement with the Therapeutic Nursery Program at the Reginald S. Lourie Center in Rockville, MD.
* You were selected as a possible participant because you are the primary caregiver of a child affiliated with a program that has been identified as a Therapeutic Nursery Program. The "Therapeutic Nursery Program" is defined by this study as a nursery program designed as early an early intervention program to address children's social, emotional, and behavioral health and well-being.
* It is asked that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
* This study seeks to explore caregivers' experiences of the Therapeutic Nursery Program as an early intervention program. More specifically, this study aims to understand caregivers' perspectives and their experiences of relationships with teachers and staff in Therapeutic Nursery Program. This study hopes to enhance current knowledge of early childhood intervention programs by exploring caregiver experiences of relationships within the Therapeutic Nursery Program as an early intervention program.
* This study is being conducted as a research requirement for my master of social work degree.
* Ultimately, this research may be published or presented at professional conferences. Information gathered may also be used to help therapeutic nursery programs improve their intervention techniques.

Description of the Study Procedures
If you agree to be in this study, you will be asked to do the following things:
- Complete and sign this informed consent form which will allow the researcher to contact you
- Schedule a convenient day and time to complete a 45 minute to one hour interview at the Reginald S. Lourie Center in the clinic wing
- Meet with this researcher, Jaimie Tyler, to complete a 45 minute to one hour interview
- Contact the researcher should you have any questions, comments, or concerns

Risks/Discomforts of Being in this Study

- This study has the following risks: This study may cause some emotional discomfort due to the vulnerable nature of discussing relationships, particularly the relationship between caregiver and Therapeutic Nursery Program staff. Should this occur and if you need to discuss your concerns further, you may contact Jimmy Venza, the Therapeutic Nursery Program Director at the Reginald S. Lourie Center, at (301) 984-4444 to discuss your concerns more fully. A comprehensive list of mental health services in Montgomery County has been attached to this letter for your convenience.
- The director of the Therapeutic Nursery Program will receive a final report once this research has been completed. All identifiable information will be disguised in the final report; however, it may be possible to identify participants of this study due to the small enrollment size of the program.

Benefits of Being in the Study
- The benefits of participating in this study are having an opportunity to talk about your experiences as a caregiver involved in the Therapeutic Nursery Program, gaining insight into your own experience as a TNP caregiver, and providing information that could be helpful for future research.
- The benefits to social work/society are an enhanced knowledge of caregivers' experiences of Therapeutic Nursery Program as an early intervention program and a bettered understanding of relationships between Therapeutic Nursery Program staff and caregivers. Thus illuminating further areas of potential research for the Therapeutic Nursery Program.

Confidentiality
- This research will be submitted in partial fulfillment of a Masters in Social work and will be disseminated. A final report will be given to the director of the Therapeutic Nursery Program to give insight into caregiver experiences of the TNP, while also assisting in the development of potential research. Subsequently, this report may be shared with TNP staff. All identifiable information will be disguised; however, there is a small chance that it may be possible for TNP staff to identify participants of this study due to the small enrollment size of Therapeutic Nursery Program. No identifiable information will be included in the final report to ensure privacy and confidentiality. Participation- or non-participation- of this study will not have any effect on the services provided to you or to your family by the Reginald S. Lourie Center.
- No information will be shared between myself, the researcher, and the TNP teachers/staff regarding this research. More specifically, I will not share information about participation or non-participation, scheduled interviews, and interview content. This information is private and confidential and only I- the researcher- will have access to this information.
- Individuals assisting in this research will be asked to sign a confidentiality agreement.
- 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/gift
- You will receive the following payment/gift: $5

Right to Refuse or Withdraw
- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up until May 15th, 2015) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by May 15th, 2015. After that date, your information 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 me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Jaimie Tyler at jtyler@smith.edu or by telephone at (301) 984-4444 ext. 116. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your 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 volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

…………………………………………………………………………………….

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

…………………………………………………………………………………….

1. I agree to be audio taped for this interview:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix F:

Mental Health Resources

Mental Health Services in Montgomery County, MD			
Agency	Contact Information	Services	Payment Information
Child Center and Adult Services, Inc.	Shady Grove Professional Building 162220 S. Frederick Avenue., Suite 502 Gaithersburg, MD. 20877 Phone: 301-978-9750	Outpatient Services	Medicaid Most Private Insurances Sliding Fee Scale
Jewish Social Service Agency	Phone: 301-838-4200	Outpatient Services	Medicaid Medicare Private Insurance: Aetna, BlueCrossBlueShield, Cigna, MAMSI/MDIPA/Optimum Choice, Tricare, United Behavioral Health, United HealthCare Sliding Fee scale
George Washington University Center Clinic	1922 F. Street, NW, Suite 103 Washington, DC. 20052 Phone: 202-994-4937	Outpatient Services	Sliding Fee Scale
Vesta, Inc. Germantown Horizon Outpatient Clinic	20410 Observation Drive, Suite 108 Germantown, MD. 20876 Phone:240-296-5862	Outpatient Services In-home Therapy Services	Medicaid Medicare Uninsured accepted under certain criteria
Child Center and Adult Services: Community Cares	17 E North Summit Ave Gaithersburg, MD 20877 Phone: 301- 978-9750	Outpatient Services	Medicaid
Adventist Behavioral Health and Wellness Services	R14901 Broschart Rd Rockville MD 20850 Phone: 301-251-4500	Outpatient Services Inpatient Services	Medicaid Private Insurance

***If you have other questions about services or would like additional assistance, please contact the Access Team of Montgomery County Mental Health Services for Children and Adults. The Access Team provides consultation and referral services for individuals looking for mental health services. Phone calls and walk-in's are welcome// Address: 255 Rockville Pike, Suite 145, Rockville, Md. 20850// Phone: 240-777-4710

Appendix G:

Interview Guide

1. How do you feel about the Therapeutic Nursery Program?

2. When first approached about the therapeutic nursery program, what did you know about the program?

> (Probes: What did you expect your involvement to be like, such as participating in outings, activities, parent- teacher meetings? Did your expectations match your current experiences of the TNP?)

3. How do you feel about being involved in this program (ex. judged, compared, misunderstood, relieved)?

4. Can you describe your relationships with the TNP teachers?

> (Probe: Can you give me three words to describe this relationship?)

5. How has your relationship with the TNP teachers changed since beginning the TNP?

> (Probe: Can you give an example or two?)

6. Can you describe your child's relationships with the TNP teachers?

> (Probe: Can you give me three words to describe this relationship?)

7. How has your child's relationship with the TNP teachers changed since beginning the TNP?

> (Probe: Can you give an example or two?)

8. Can you think of and describe a time when you felt very involved with the therapeutic nursery program?

9. Have you ever felt discouraged in the Therapeutic Nursery Program?

> (Probe: If yes, can you describe a time when you've felt discouraged?)

10. What do you hope will happen for you as you move ahead with the Therapeutic Nursery Program?

11. Is there anything you would change about the Therapeutic Nursery Program?

12. Is there anything else you would like to say about your experience with the Therapeutic Nursery Program?