A Different Lens: Engaging Parents in Virtual Play Therapy Through Video Feedback

Lilly Jay, M.S.

The Help Group

Correspondence concerning this presentation should be addressed to ljay@thehelpgroup.org.

Introduction

The Help Group, a non-profit community mental health service provider based in California, includes an intensive day treatment program for preschool-aged children with extensive histories of trauma and abuse. This program is one of many mental health services that was forced to change its model of care due to the coronavirus pandemic. Instead of milieu-based treatment, the program shifted to providing telehealth sessions to children in their homes. Though it has been challenging to recreate the intimacy and interaction of play therapy virtually, telehealth has created opportunities—and not just limitations.

First, telehealth necessarily requires a higher level of parent involvement and there are more opportunities for clinicians to observe the parent-child relationship. Second, because computers and phones are commonplace in telehealth sessions, recording for either training or therapeutic purposes, is less disruptive to the therapeutic frame. Due to increased involvement with parents and the integration of an audio/visual recording devices into treatment, this is an ideal time to explore video-assisted feedback for parents. Showing parents videos of their interactions may aid clinicians in inviting parents to play in a way that helps their child process trauma and feel secure in the parent/child relationship.

In other words, an intervention that allows parents to observe themselves interacting with their children may be an effective, and timely, way of improving the parent/child relationship for young clients with trauma exposure. In order to assess the viability and potential impact of showing parents filmed dyadic interactions, one family from a therapeutic preschool program was selected to participate in a four-week video-based intervention.

Literature Review

There are a multitude of video feedback interventions for parents. Though these treatments have distinct features, they have shared characteristics. Reviewing the key ingredients, so to speak, of interventions that use video-feedback to engage parents was instructive in creating the video feedback intervention. Ruben G. Fukkink (2008) does much of this comparative work in his meta-analysis of 29 studies of video feedback interventions. Beginning in the 1970s, psychologists began using videos of their clients to elicit self-reflection (Fukkink, 2008). This insight—about the way in which watching oneself facilitates reflection—was later applied to family therapy. In particular, videos were thought to be an effective way of helping a parent (as opposed to a child) more clearly see and understand their parenting behaviors. Effective video interventions involve a recorded interaction between the parent and child, clinician selection of a video clip and conversation about the selected clip between clinician and parent (Fukkink, 2008). Lastly, the vast majority of these interventions share a strength-based approach and seek to inspire change through positive reinforcement of attuned parenting (Fukkink, 2008).

Interventions build upon these three components (video recording, clip selection and clip review/discussion) and, consequently, vary in their focus, protocol and impact. Behavior-oriented interventions, as the name suggests, use video feedback to increase parental sensitivity and behavioral change in the parent by allowing the parent an opportunity to watch themselves

engage in a behavior they are meant to increase or decrease (Fukkink, 2008). Psychotherapeutic interventions take a more indirect approach to positively impacting the dyad's dynamic and assert that videos will help parents articulate their own childhood memories and beliefs about parenting and, through this reflection, they will create new, healthier understanding of their child and role as a parent (Fukkink, 2008). All video feedback interventions seem united by the theoretical understanding that children's behavior and attachment is influenced by their parents' behaviors with sensitive parents raising healthier children (Klein Velderman et al., 2006). Meta-analysis of different studies does not reveal notable differences in efficacy across interventions. Instead, video feedback interventions categorically appear to have a statistically significant impact on parenting behavior and attitudes (Fukkink, 2008).

One particularly salient model, for reasons that will become clear, is Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline in Foster Care (VIPP-FC). This intervention consists of six visits with a focus on increasing caregiver responsiveness and sensitivity (Schoemaker et al, 2018). VIPP-FC is considered an evidence-based intervention that was adapted from VIPP with the intention of addressing the trauma and insecure attachment that often accompanies a child's placement in foster care (Schoemaker et al, 2018). While VIPP-FC incorporates periods of play in the intervention, play is regarded as an opportunity to observe the dyad's interaction rather than an important process in and of itself. This intervention seeks to center attuned play as a key ingredient in secure attachment and incorporation of a foster care child into a new family. Combining the delivery model of telehealth, the precedent for using video-feedback with foster care children *and* the ethos of play therapy may yield a powerful intervention.

Case Information

The client and caregivers who participated in this project provided informed consent and were told how this intervention might help them reach treatment goals. The client in question is a four-year-old, White female who was placed in foster care with caregivers who were previously unknown to her. Due to the child's exposure to trauma and the death of her mother, which precipitated her placement in foster care, the caregivers were referred to The Help Group program. Presenting problems at the time of admission included hoarding food, overeating and defiance. Their treatment goals at the time of admission were to reduce these behaviors. According to the case conceptualization, treatment would address these symptoms, in part, by the caregivers cultivating a healthy attachment with the client and learning how to appropriately support the client in understanding her past experiences. The client's externalizing behaviors were also ameliorated with psychoeducation and behavioral interventions outside of session. In an environment with clear expectations/consequences and consistently available food, these symptoms diminished. Consequently, the video-feedback intervention was most heavily influenced by relational, as opposed to behavioral, video-feedback protocols.

At the outset of treatment, the client presented as a bright and playful child. Slowly, her virtual play therapy with the clinician began to include salient themes such as loss, separation and seeking safety. Concurrently, the caregivers expressed discomfort in responding to the client when she discussed the many Adverse Childhood Experiences she had encountered before entering their care. Each caregiver reported slightly different concerns. One shared a fear that they would further traumatize the client by saying or doing the wrong thing in response to the

client sharing memories. The other caregiver was worried that the client did not feel comfortable or close to him. Both shared doubts about their competency as foster care parents and their ability to play with the client.

Treatment/Intervention

For four weeks, the clinician alternated between facilitating dyadic play between the client and one of the caregivers. Each week the play was filmed and shared with the caregivers in follow up joint collateral sessions. The following procedure borrows elements of several different video feedback interventions including VIPP-FC, Filming Interactions to Nurture Development (FIND) and Video Intervention Therapy (VIT) (Barone et al, 2018; Fisher et al, 2017; Facchini, Martin & Downing, 2016). Some consideration that determined this specific protocol were the limitations of telehealth, ease of use for clinicians and relevance to treatment goals of The Help Group clients.

At the beginning of each dyadic session, the clinician explained to both the child and caregiver that during the first ten to fifteen minutes of session, she would not participate in play, as to not distract from the dyadic interaction. The therapist prompted the caregiver to play with their child as they normally would. Using the 'Record' feature associated with a HIPPA-Compliant Zoom account, the therapist recorded play between child and parent. At the end of recording, the clinician indicated the end of recorded play and for the rest of the session engaged with parent and child as indicated by the client treatment plan. Between sessions, the therapist reviewed recorded tape and found approximately 30 seconds of positive interaction. Positive interactions may include serve and return, sharing emotions, attunement or an interaction that positively relates to treatment goals. During caregiver collateral session, the clinician presented the video clip to the caregivers.

The clinician elicited reflection from the caregivers using the following prompts: What do you see in this clip? What do you find interesting? How did you know to do that (in reference to a specific positive skill used by parent)? Does the outer "movie" look or feel different from what you internally were feeling at the time or expected to see? After discussion about the caregivers' observations of themselves, the child and the play, the therapist discussed why she had selected the video. While reflecting on the clip selection process, the therapist offered ample praise of caregivers' willingness to be playful and responsiveness to the child. The clinician then offered psychoeducation about play therapy and introduced relevant concepts such as following a child's lead in play and reflecting the child's affect.

Results

As is always the case in dyadic work, treatment progress can be conceptualized in three distinct ways. The clinician must consider the impact on the child, on each caregiver and, importantly, on the caregiver-child relationship. There are, in a sense, four clients. Careful tracking of progress towards treatment goals, clinical observation and conversation with the caregivers about the intervention indicate the utility of the intervention.

Over the course of the video intervention, the child met her treatment goal to be less reliant on food as a means of self-soothing and seeking a sense of security in her relationship with the caregivers. Additionally, the child expressed a desire to engage in "special play time"

with each caretaker. Week to week, the client explored a new kind of play that she first introduced to the therapist which she would then bring to her dyadic session with her preferred caregiver and, lastly, to the session with the caretaker with whom she is less attached to currently. Play is frequently conceptualized as a laboratory in which children can play out and make sense of their world. In this case, individual therapy was a laboratory in which the client could experiment with play related to her past experience before letting her caregivers in on her most vulnerable internal processes. As an example, the child initiated a game with the therapist in which she played the role of a kitten who is thrown into a dumpster and then rescued by the clinician. This painful tableau of her sense of being discarded by her mother and retrieved through foster care was perhaps too overwhelming to play out with her real-life rescuers (her foster care parents) at first. Showing the caregivers film of how they were, in different sessions, invited into this play and both, in their own ways, responded appropriately elicited important discussions about how the child is processing her trauma, within different relational contexts.

When asked to reflect on the experience of watching and discussing dyadic sessions, the caregivers reported appreciation for the chance to see themselves playing. They consistently expressed doubts about how they had responded to the client in play and then relief when they saw that their external actions did not reflect the anxiety and sadness that often arose internally when the child played out scenes from her past. One unanticipated benefit of the intervention was that the caregivers were able to see their partner play; they often expressed admiration and appreciation for how the other caregiver had engaged in play. Lastly, when considering the impact of this intervention on the dyadic relationship, the child began to more openly discuss her past and ask questions about foster care with the caregivers. The caregivers in turn reported greater confidence in answering difficult questions.

Conclusion

This was a very small-scale exploration into the feasibility and clinical utility of video-feedback via telehealth. One client from an intensive treatment program for children under the age of five was selected to participate with her foster care parents. Over the course of the four-week intervention, the caregivers expressed greater comfort engaging in play with client and increased confidence in their ability to respond to content related to her trauma. As the caregivers became more available to witness the client's play, she became increasingly willing to share the full breadth of her experiences, preoccupations and resilience with them. The caregivers and client co-created a stronger attachment through play and, in doing so, set the stage for a reduction in client's symptoms and a newfound sense of connection.

There are unique features to this case that may have impacted the success of the intervention. First, the caregivers are somewhat removed from the trauma that the child experienced and played out in session. The caregivers processed the sadness, anger and disgust that they experienced when confronted with the child's ACEs but did not have the additional burdens of guilt and regret that a caregiver might experience when a child is maltreated while in their care. This is to say, caregivers might be more resistant to playing out themes related to their child's trauma and watching that play later if they too lived that trauma. Second, the caregivers in question were motivated participants in treatment and open to self-reflection. They are perhaps better equipped than the average caregiver in observing themselves playing. At the heart of this project there were two questions: is this intervention useful and is this intervention feasible? The

former has been discussed and it can be said that it was useful in strengthening attachment, increasing the child's openness with the caregivers and enhancing caregiver confidence in play. As for the feasibility, the process of reviewing videos and selecting a video clip created an additional 10 to 15 minutes of work for the clinician. This process, of watching the tape and picking one clip to show, is not prohibitively time-consuming, even in the context of a busy community mental health care setting. It is recommended that clinicians use this intervention in order to engage caregivers in play therapy and invite them to participate in the child's process of unraveling trauma through play.

Future Directions

Future research can build upon this preliminary exploration of video-feedback in play therapy. Additional research might compare this intervention (four weeks of video-facilitated feedback to caregivers) to treatment as usual (play therapy and collateral caregiver sessions). Researchers might use measures to assess the efficacy of the intervention. Two measures worth consideration are The Parenting Sense of Competence Scale (PSOC) (Gilmore & Cuskelly, 2008) and The Parenting Scale: A Measure of Dysfunctional Parenting in Discipline Situations (Arnold et al., 1993). Future clinicians might also assess the way in which this intervention has an impact on the entire family system as it offers co-parents a unique opportunity to see their partner's one-on-one interactions with their child.

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