

**PERCEIVED NEED OF DIRECTORS FOR FAMILY THERAPY-  
RELATED SERVICES IN A CHILD CARE OR PRESCHOOL SETTING**

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# **PERCEIVED NEED OF DIRECTORS FOR FAMILY THERAPY-RELATED SERVICES IN A CHILD CARE OR PRESCHOOL SETTING**

**Lisa C. Haines**

## **(ABSTRACT)**

The purpose of this study was to investigate preschool and child care center directors' perceptions about the potential for introducing family therapy-related services into a child care or preschool environment, and in particular, to explore their opinions about the extent to which children are affected by parental stress, to assess directors' awareness of the field of marriage and family therapy, to determine the extent of their current collaboration with family therapists or other mental health providers, and to gather their thoughts concerning the possibility of successfully bridging the professions of child care and family therapy in the future. Seventy-two of the 197 directors surveyed responded to the mailed questionnaire. Descriptive statistics were used for the quantitative data, while the qualitative data was evaluated using the method of content analysis.

Quantitative results revealed: 1) Most of the participants believed that children are at least somewhat affected by their parents' stress, 2) Over half of the participants were familiar with marriage and family therapists as trained professionals who focus on systemic treatment of the family as a whole unit, 3) Less than half of the participants currently offer on-site mental health services, 4) While it seems that participants routinely refer parents to and consult with mental health providers, they are least likely to consult with or refer to marriage and family therapists, and 5) Almost all of the participants identified at least one obstacle to providing family therapy-related services in their child care centers or preschools.

Limitations and implications for clinicians and future research are also discussed.

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## **CHAPTER I: INTRODUCTION**

### **The Problem and its Setting**

According to a survey conducted by the National Center for Education Statistics, more than fifty percent of children ages three to five in the U.S. whose parents participated in the survey were enrolled in some type of center-based early childhood care or education program in 2001 (Mulligan, Brimhall, & West, 2005). Furthermore, participants in the same survey indicated that their children (ages infant to five years) spent anywhere from twenty-one to thirty-two hours a week in center-based child care (Mulligan et al.). The effects of non-parental care on children has been and continues to be the topic of numerous studies. While research has widely acknowledged that attending regular day care may have both positive and negative effects on children as well as their families, depending in large part on the quality of care received, the fact remains that a large number of our nation's children are spending significant amounts of time with primary caregivers other than their parents, and that number is only growing.

As central figures in the lives of many of today's young children, it follows that day care providers and teachers may often be among the first adults to see indications of children's social, emotional, or behavioral issues, which may not be entirely obvious in a home environment. For example, the length of time children spend at home with their parents, versus the length of time they spend in school or day care may explain, in part, why parents might not be as likely to notice indications of these or other similar issues in their children. Teachers are, in fact, often considered to be reliable judges of signs of hyperactivity and attention problems in children (Puura et al., 1998), considering that these symptoms might be particularly observable in a child care or school environment. In addition, if the child's problems are related to social development, the reduction or absence of peer interaction(s) at home (as compared to school or

day care) might make it harder for parents to detect signs of trouble. Day care providers and teachers may also have a greater advantage over parents simply because of their job training and experience working with many different children who exhibit a wide range of behaviors, which might allow them to notice certain things that parents would perhaps ordinarily overlook or dismiss as insignificant. One study in particular showed that teachers tended to be more attuned to children's internalizing symptoms (i.e. anxiety, sadness, withdrawal, etc.) than were parents (Loeber, Green, & Lahey, 1990). Perhaps parents are less aware of their children's internal experiences and more conscious of exterior behavioral issues because they are forced to acknowledge and react to the behavior (Kazdin & Petti, 1983), whereas internal symptoms often do not demand an immediate reaction and, therefore, may go unnoticed. This may especially be the case if parents are distracted or under stress, and considering that most young children are unable to verbally express their emotions, it makes sense that parents may not always be in tune with how their children are feeling emotionally. Furthermore, teachers and day care providers have the benefit of being able to observe children more closely in day-to-day routines and interactions with peers, whereas parents' frames-of-reference may be more limited. In any case, day care providers and teachers may recognize the first signs of aggression; social isolation or difficulties with peer interactions; behavioral problems; or somatic symptoms such as stomachaches, trouble sleeping or excessive fatigue, bathroom accidents, and so forth. These "warning" signs may be indicative of depression, family-related stress, or other psychological issue(s). Studies have shown, in fact, that depression and anxiety in children are considerably under-diagnosed and under-treated (Cook, 2003). In a 1999 report, the U.S. Surgeon General indicated that approximately one in ten children and adolescents is affected by some type of mental health issue serious enough to impair his or her daily functioning (U.S. Public Health

Service, 2000), yet, only one in five of those children and adolescents in a given year will actually receive mental health services (Cook).

What might be contributing to depression, distress, psychological problems, etc., in young children today? In our society, more than ever it seems, families are being faced with a myriad of stressful social issues, including divorce, blended families, single parenting, violence in the media, and the increased exposure to alcohol/drugs and sexual activity at earlier ages than ever before. Additionally, there are the “typical” or “expected” life stressors such as financial concerns, dual-working parents, unemployment, illness of aging parents or other family members, the struggle of balancing career and family, and so on. Research has repeatedly indicated that exposure to stressful life events such as these can increase a child’s risk of experiencing difficulties in psychological adjustment (Compas, 1987). Moreover, studies indicate that stressful events specifically involving the family may play a particularly crucial role in a child’s social development, considering that the family serves as the primary agent for socializing children (Gaylord, Kitzmann, & Lockwood, 2003). Overall, it has been shown that the greater the amount of family stress, the greater the risk of negatively impacting children (Shaw & Emery, 1988). In addition, children learn ways of coping by following the examples set by their parents. Therefore, if parents have difficulty demonstrating positive methods of coping with their own problems, it would make sense that their children would have trouble coping as well.

In a society where more children are spending much of their time in day care and, some might argue, are exposed to more stressful situations than in the past, it seems that preschools and child care centers would benefit from recognizing the enormous potential for addressing the psychosocial problems of the children in their care by taking steps to employ an on-staff family

therapist, or, at the very least, working more collaboratively with family therapists. Furthermore, a professional partnership between preschool teachers/day care providers and family therapists would be ideal because of their shared goals of helping children and families to be as well-adjusted and successful as possible. Despite this logic, I found no evidence in the literature of any child care centers or preschools offering therapy and other mental health services to their families via an on-staff family therapist in particular. Are teachers and day care providers noticing a need for the children and families in their schools and centers to take part in family therapy? Do child care providers and teachers observe links between parents' stress and children's behavior? My study addresses these and other similar questions by exploring the attitudes of day care center directors and preschool teachers regarding stress in children, current awareness of marriage and family therapy, and thoughts about the possibility of integrating family therapy into a child care or preschool environment.

#### Rationale for Study

The reality of our society today is that many children spend the bulk of their days in child care or preschool settings, so we can surmise, therefore, that day care providers and teachers are intimately familiar with the children entrusted to their care, and may be important witnesses to any psychological issues these children may present during their time in school or child care. If caregivers have the resources in place to be able to refer parents to a family therapist, either off-site or on-site, as soon as those symptoms appear, parents and children can address the issue(s) in the early stages, before the problem has a chance to become even more serious.

#### Infant/Family Mental Health: An Example of Success in Ohio

First, it is necessary to examine what is already being practiced in terms of mental health and child care professionals working together. The early 1990s saw an initiative to integrate

infant mental health into early intervention programs and to encourage collaborative efforts across many disciplines serving young children and their families. Backing this proposal in particular was a committee of the Ohio Interagency Early Intervention Council called the Infant/Family Mental Health Subcommittee, a group in Ohio created specifically for the purpose of promoting multi-discipline collaboration. The committee had three main goals: to incorporate an infant/family mental health perspective into early intervention, to increase public awareness of the magnitude of mental health in infants/families, and to promote collaborative teaching, service, and research among various organizations and disciplines providing services to infants and families (Thomasgard, 1998). Features of the initiative included development of a comprehensive resource database of mental health providers, specifying their demographic information along with area(s) of expertise, as well as the formation of Collaborative Office Rounds (COR), a case-based continuing education/discussion group for providers, emphasizing children's psychosocial development in a peer supervision format. Although the clinical value of COR has been shown to be significant, this model has failed to "catch on," with the exception of a few federally-funded programs in the state of Ohio (Thomasgard).

### Counseling in Schools

My search for literature on the topic of family therapy in child care/preschool also yielded numerous articles focused on various aspects of school counseling. Considering the perspective of my research, this information is pertinent because many features of school counseling may also be relevant in a child care setting, and the extensive research consistently indicates the effectiveness of school counseling in terms of dealing with children's problems and issues. One article in particular on the subject of social skills education points out that school counselors are usually among the first to get involved when children have behavioral or

emotional issues that are exhibited in school, primarily due to the fact that counselors are whom teachers and parents typically approach with concerns about their students or children (Cook, 2003). In addition, school counselors are frequently responsible for screening for and assessing children's emotional problems in order to refer parents to mental health specialists (Cook).

Another article explains that one of the school counselors' primary functions is to meet with parents in order to help them create a positive environment at home and buffer the negative impacts of stressful situations in the home on the child's chances of being successful at school, both academically and socially (McFadden, 2003). In turn, parents also seek consultation with and feedback from school counselors, often for one or more of the following three reasons: as a basis for forming and maintaining a relationship with their child's teacher(s), to improve various parenting skills, and to address family discipline issues (McFadden).

Despite the substantial evidence of the effectiveness of counseling school-age children, what does appear to be missing from the literature, however, are studies that focus on the aspects of offering family therapy for younger children and families by means of their schools or day care centers.

### Objectives and Research Questions

The purpose of this study is to investigate preschool and day care center directors' general perceptions about the possibility of introducing family therapy-related services into a child care setting, and in particular, to explore their opinions about stress in children, assess directors' existing knowledge of the field of marriage and family therapy, and to gather their thoughts concerning any potential obstacles which might hinder or prevent integration of family therapy and child care.

The following research questions guided my study:

- To what extent do directors consider children's psychological issues to be associated with parental and/or family stress?
- To what extent are directors familiar with the field of family therapy and the family systems approach to psychotherapy?
- To what extent are child care and preschool directors currently utilizing some type of mental health services in their work with children?
- What do child care and preschool directors perceive to be potential limitations, if any, to implementing and utilizing family therapy-related services in a child care or preschool environment?

### Theoretical Framework

The theoretical framework I used to guide this study was systems theory. Picture this: while at day care, a five year-old complains of an upset stomach every day immediately before his class is due to go outside to the playground. In another classroom, caregivers struggle with how to handle the aggressive and impulsive behavior of a three year-old who lashes out at peers and teachers and demonstrates an inability to connect at all with his peers. Another preschooler displays serious lack of respect for authority as well as significant anger management issues, even starting fistfights with peers, in spite of extensive efforts by his teachers and parents to help him change his behavior. In all three of these true-story scenarios, as a family therapist with training in systems-oriented thinking, I find myself wondering, *What's going on at home?...What don't we know about this child's family?* These questions summarize the basic concepts of systems theory, which was one of the most significant theoretical influences on the early pioneers of family therapy. According to this framework, each part of the system (or in this case, the family) affects all other parts of the system, therefore, exploring and understanding the

family as its own entity and the interactions between family members is more revealing than simply examining each individual part (Nichols & Schwartz, 2001). In other words, systems theory maintains that “the whole is greater than the sum of its parts” (p. 105), a statement which has come to be closely associated with a systems way of thinking about family therapy.

Additionally, systems-oriented family therapists believe that systems (families) are extremely influenced by change; thus, changes in one part of the system can have unanticipated effects on the whole, and that the environment (i.e. neighborhood, culture, school, church, etc.) can also introduce changes in the family as well (Nichols & Schwartz). Taking into account these concepts in relation to the scenarios mentioned above, it would likely prove to be quite helpful to consider each child’s situation in relation to his or her family, instead of looking at their problems in isolation. Likewise, in terms of this study, systems theory proved to be a useful framework because the underlying hypothesis is that directors believe children in preschool and day care could potentially benefit from participating in therapy with their families because children are just as much, if not more, affected by stress in the family as the parents themselves.

## CHAPTER II: LITERATURE REVIEW

### Introduction

#### Review of Research Questions

This study attempts to answer the following research questions:

- (1.) Are preschool and day care center directors currently using some type of mental health services to help the families and children for whom they provide care? What types of services do they typically use, and from which professionals do they obtain these services? What, if any, are the perceived limitations to being able to provide family therapy for children and families in their schools and/or centers?
- (2.) How much do directors think parents' stress plays a part in their children's problems? How many of the children in their preschools or day care centers have parents whose stress levels negatively impact their parenting?
- (3.) Are child care and preschool directors familiar with the systems approach of marriage and family therapy to treating problems within the context of the family?

This chapter will review the existing research on this topic and highlight the gaps that still remain.

In order to understand the perceived need of preschool and day care center directors for family therapy-related services in their own environments, it is important to consider their experience with children's problems as related to family/parental stress, their awareness of marriage and family therapy as a specific mental healthcare field which focuses on helping the family **as a whole**, and how they are currently managing the mental health needs of the children in their care. To place this study within the context of previous research, this chapter reviews literature related to children's experience of their parents' stress, and looks at the state of child

care in our society, as well as the existence of comprehensive mental health services being provided to today's young children and their families.

## Stress and Children

### Models of Parental Stress

In order to better understand how parental stress affects children and families, it is useful to come up with a working definition of stress. For questionnaire purposes, I described parental stress as a 'variety of problems parents and families may face, such as work pressures, financial strain, marital difficulties, etc.' (see Appendix A). Although many other versions have made their way into existing literature, there appears to be a general agreement that parenting stress is characterized by a disparity between the perceived resources and the actual parenting demands (Deater-Deckard & Scarr, 1996). Deater-Deckard (1998) explains that parenting stress can be characterized as a process involving: 1) the demands of parenting; 2) parents' emotional adjustment and behavior; 3) qualities of the parents' relationship with the child; and 4) the child's psychological well-being. This parenting stress is experienced by the parent as negative feelings towards the self as well as towards the child(ren) (Deater-Deckard).

Another leading model of parenting stress was proposed by Abidin (1976, unpublished manuscript; as cited in Morgan et al., 2002). This model suggests that the level of stress experienced by a parent is a function of relevant situational characteristics of that parent (e.g. marital relationship, self-efficacy, depression, parent-child relationship, etc.) and characteristics of the child (e.g. mood, flexibility, level of hyperactivity, etc.); these characteristics, when combined with external situational stresses, such as unemployment, illness of a family member, and so forth, can increase the risk of engaging in dysfunctional parenting behaviors. Abidin (1995) reasons that this is because life stress negatively impacts parents' perceived ability to

cope with their parenting role and exhausts their emotional resources, which, in turn has implications for their parenting behavior. Abidin's parenting stress model eventually led to the creation of the Parenting Stress Index (PSI), a self-report instrument encompassing three parts: parent domain, child domain, and life stress, which has been used clinically as a valuable screening tool to identify family systems under extreme distress.

### Extrafamilial and Interpersonal Stressors

Webster-Stratton (1990) asserts that the degree to which parenting behavior is disrupted as a result of stress is determined by the manner in which the parent assesses the stressful situation, and the parent's assessment determines the degree of likelihood that the child(ren) will exhibit subsequent behavior problems. In addition, Webster-Stratton explains that, even though extrafamilial sources of stress (e.g. daily hassles, financial hardship, etc.), and interpersonal stressors (e.g. divorce, depression, marital conflict, etc.) can also directly influence children's behavior, the impact of parental stress on children can be moderated by the overall quality of the parent-child interactions.

How do these various extrafamilial and interpersonal factors surface in terms of parenting behavior? Situational stressors occurring outside the family system, such as unemployment or economic adversity, may cause parents to be less likely to be supportive, to foster their children's independence, or to use logic in their interactions with their kids (Webster-Stratton, 1990). In her own research, Webster-Stratton (1988) noticed associations between mothers' high levels of reported major life stressors and negative perceptions of their children's behavior, as well as associations between more stressful life events and the presence of controlling and punitive parenting behaviors, and greater deviance in children's behavior. Major life stressors, however, need not be present in order to experience parenting stress. In fact, while the occurrence of

major stressful life events is relatively low for most families (Crnic & Greenberg, 1987), it is reasonably safe to assume that all parents are routinely faced with the daily challenges that accompany the job of being a parent. Crnic and Greenberg (1990) later studied the effects of the accumulation of these common parenting hassles on aspects of parental, child, and family functioning. Their findings indicated that minor stressors were not only more predictive of maternal, child, and family status than was major life stress, but that reported daily hassles was associated with decreased parenting satisfaction as well as less functional family status overall.

Divorce and/or separation are perhaps the most typical examples of interpersonal stressors which undoubtedly have cumulative effects on parenting. Research shows, however, that even couples' marital problems (as opposed to divorce or separation) can profoundly influence parents' interactions with their children as well (Stoneman et al., 1989). In her own clinical observations of families with conduct-problem children, Webster-Stratton (1990) found that low reported levels of marital satisfaction were significantly associated with increased reports of parenting stress, more acting-out behaviors from the child, and increased negative maternal perceptions of child adjustment. Other research indicates that distress in the parents' marital relationship has been correlated with increases in children's internalizing and externalizing behaviors and troubles with peers (Vandewater & Lansford, 1998).

### General Stress

Parenting stress in general may be linked to coercive parent-child interactions (Wahler, 1980) inconsistent or ineffective discipline practices (Suárez & Baker, 1997), rejection-type behaviors (Rodgers, 1991, unpublished doctoral dissertation; as cited in Rodgers, 1998), and even child abuse and/or neglect (Howze & Kotch, 1984). Research also indicates that parenting stress has been associated with measures of insecure attachment in infants (Jarvis & Creasey,

1991), which is considered a risk factor for children's psychological adjustment later in life. In fact, Creasey and Jarvis (1994) found that parenting stress was more predictive of attachment security in eighteen month-olds than child care-related factors, such as receiving in-home or center-based care. Additionally, other studies show that as parental stress increases, parents' perceptions of the child's current behavior decrease in accuracy, and parents are more likely to focus on the negative aspects of the child's behavior while attributing that behavior to the child instead of the circumstances (Morgan et al., 2002). This is especially significant because parents' perceptions of their children's behavior play a key part in ultimately determining the behavior.

Furthermore, lack of social support (or a social network perceived as unsupportive) and job dissatisfaction have negative implications for parenting behavior as well (Rodgers, 1998). Crnic and Greenberg (1990) found that friendship and community support appear to buffer the adverse effects of daily parenting hassles for mothers in terms of their interactions with their children, even more so than spousal support. They suggest that friendships with other parents may be a source of emotional support for many mothers because they are more likely to share the common day-to-day challenges and experiences of parenting, whereas fathers typically miss out on these experiences by virtue of being at work during the day.

#### Child Characteristics as Related to Parental Stress Levels

It goes without saying that the job of being a parent can be very stressful at times. Even "normal" child characteristics, such as age, number of children in the family, and age differences between siblings, can all be related to levels of parenting stress. But what about parents of children who are especially demanding or those with behavior problems, hyperactivity, attention-deficit disorder, and so forth? It makes sense that parents of children with special needs or

significant behavior problems might be more prone to experiencing parenting stress, however, there is also a wealth of literature supporting the notion that “temperamentally difficult” children not only cause parents more stress, but can also reduce parents’ abilities to function effectively in a parental capacity (Bates, 1980). Child abuse studies have, in fact, found that abused children are more likely to be characterized as stubborn, aggressive, demanding, negative, and more difficult to manage compared to non-abused children (Kadushin & Martin, 1981). Moreover, in an earlier study based on observations by Webster-Stratton and Eyberg (1982), mothers of preschoolers who reported that their children had difficult temperaments were more likely to react negatively toward their children, and, in turn, their children were more likely to display behavior problems as a result, thus maintaining a dysfunctional cycle in the parent-child system.

Children’s behavior problems such as aggression, hyperactivity, defiance, conduct disorder, or other externalizing behaviors are often also connected to issues such as problems at school, social and public embarrassment for the family, isolation and rejection from other parents, fewer child care options, complaints from frustrated teachers, and sibling and marital conflict, among others (Suárez & Baker, 1997). These factors are likely to contribute to even greater levels of parental stress, which, as previously described, maintains a cycle whereby stress influences parents’ behavior, which in turn influences the child’s behavior, and so on.

### Effects of Parental Stress on Children

Thus far, I have highlighted several aspects of parental stress: potential causes, effects on parenting behavior, as well as effects on parents’ perceptions of their children’s behavior. The studies to which I referred earlier clearly indicate that children’s behavior is subsequently affected by their parents’ behavior under the influence of parental stress, but what about the effect of parents’ stress on children’s overall psychological well-being?

Crnic and Acevedo (1995) point out that stress itself does not affect children, but because it can dramatically affect functioning of the family system and quality of parenting, ultimately stress has implications for children's developmental functioning. Taking that into consideration, exposure to parental stress can be responsible for a myriad of detrimental effects on children, and exposure to multiple stressors has been connected to increases in children's externalizing and internalizing problems (Shaw & Emery, 1988), which has been found to be true across diverse ethnic, age, and gender groups (Gaylord et al., 2003).

One developmental area in particular that has been shown to suffer as a result of children's exposure to parental stress is the ability to maintain positive relationships with peers (Patterson et al., 1991). The internalizing and externalizing behaviors that often surface in response to significant family stress are perhaps a factor in troubled peer relations, often leading to rejection from peers (Gaylord et al., 2003). Patterson et al. (1991) conducted a study exploring children's status with peers as related to family background and recent life events. They found that exposure to multiple chronic stressors had a cumulative effect on children's peer relations, whereby greater life adversity increased the likelihood that children would be rejected by their peers.

Another study by Cummings et al. (1985) investigated the scope of young children's responses to 'background anger,' which is described as aggressive verbal conflict witnessed by children, but does not include physical aggression. When Cummings et al. explored the emotional repercussions of background anger on two year-olds, they discovered that, following a one-time exposure to hostile adult interaction, the girls presented as more distressed (e.g. crying, hiding, etc.), whereas boys engaged in more aggressive, physical behaviors (e.g. kicking, hitting, etc.). Other research involving children witnessing parental conflict has indicated that their

immediate response to verbally aggressive conflict, especially conflict pertaining to the child and ending with poor resolution, was to feel threatened and experience emotional distress (Davies et al., 1996).

Creasey et al. (1997) conducted a study to explore how six and seven year-old children responded to negative parent affect versus how they responded to negative affect in peers. Subjects were presented with vignettes depicting parents and peers as being happy, sad, or angry, and were then interviewed to gauge their emotional reactions to each vignette. They found that, as predicted, subjects not only had a more negative affective response to parent affect as compared to peer affect, but they also reported experiencing feelings of hopelessness when confronted with parental distress, as well as being more inclined to use avoidant coping skills to self-soothe in the face of parents' sadness. Creasey et al. suggest that, even if parenting behavior is unaffected by stress, young children are still susceptible to parents' negative affect because they are especially aware of caregivers' emotions, often modeling their coping responses to stressful or uncertain situations based on caregivers' displays of affect. It may also be that, if parents are indeed emotionally unavailable during stressful times as one could imagine, children might subsequently acquire avoidant coping styles, or the inclination to direct anger towards parents, caregivers, or other attachment figure(s) when in distress (Main, 1996). In terms of coping, some suggest that when children experience their parents' stress first-hand, they feel helpless in their ability to use coping skills effectively to ease their negative emotional response to the stress, which may eventually prevent children from developing healthy coping strategies to deal with distress in the future (Grych et al., 1992).

## Comprehensive Mental Health Services

It seems that it is typical for teachers or parents to seek the assistance of mental health professionals only *after* recognizing concerns about a child, but Johnston and Brinamen (2005, italics added) make a convincing case for making therapeutic services available in child care and pre-school settings *before* problems surface:

“...the mental health professional almost exclusively enters child care when there are worries about a child’s mental health. But this need not be our point of entry... After all, we do not become concerned about the nutritional needs of children only [after] we identify signs of malnutrition. Similarly, mental health should not become an issue only in its absence for it is an issue for all children in child care” (p. 270).

### Bridging the Areas of Child Care and Mental Health

Considering that the number of young children being referred to mental health professionals for behavior problems (e.g. severe aggression) has been on the rise in recent years (Mark-Wilson et al., 2002), mental health practitioners have widely recognized the need for establishing better connections with professionals in the child care field in order to help children where they spend the majority of their day, to provide more support to teachers working with difficult children, and to promote more referrals to mental health professionals for children and families. While acknowledging this need for increased alignment between the mental health and child care professions, Collins et al. (2003) also point out that the objective of building these partnerships at the community and state levels, although worthwhile, has so far proven to be an elusive one. The reason: barriers such as lack of provider expertise, limited access to services, and inconsistency in coordination of services (U.S. Public Health Service, 2000). Nevertheless, the potential joining of the two fields, if achieved, would offer undeniable benefits to everyone

involved: children, parents, child care teachers, and mental health providers alike would reap the rewards of successful integration of services. Although the overall question of how to remedy this situation continues, Collins et al. (2003) outline a series of steps that can be taken by both mental health professionals and day care providers at the local level to make a difference in the mental health needs of young children. Some of the key pieces to providing comprehensive services within most child care environments include such elements as family-centered services, training and professional development opportunities for day care staff as well as for mental health professionals, and access to a mental health consultant. The utilization of mental health consultation can make it possible, as I will discuss, to successfully bridge the existing gap between the child care and mental health communities.

#### Mental Health Consultants to Child Care

Child care consultants aim to promote early prevention by providing a variety of mental health and consultative services within the day care environment. The consultant, for instance, may engage in such activities as meeting with parents and teachers when there are concerns about a particular child, working closely with the director(s) to address certain structural aspects of the program, or holding all-inclusive staff meetings to educate or provide a forum for group discussion. The benefit: consultation to child care centers strives to incorporate a mental health perspective into the child care environment by helping staff, families, and child care programs identify, treat, prevent if possible, and at least reduce the harmful effects of emotional and behavioral problems in the lives of young children (Alkon et al., 2005). Families who benefit from collaborative alliances between the mental health and day care professions have opportunities to access a wider array of services in a more convenient fashion, and to participate

in a more communicative and open relationship with their child care provider(s), hopefully resulting in a sense of security about the overall wellness of their children's mental health.

### Types of Consultation

Child care consultants may work within a solely child-centered framework, a strictly programmatic framework, or a combination of both. As the name implies, child-centered consultation focuses on the individual child's problems by providing the child, and sometimes his or her family, with direct clinical services. Programmatic consultation, on the other hand, places emphasis on improving the child care program's overall quality, such as dealing with any systemic issues that might be preventing teachers from developing positive, stable relationships with the children. In addition, mental health consultants can help in reducing high staff turnover rates, which contributes to the quality of the program, by facilitating better staff communication, improving self-efficacy among teachers, and boosting staff morale (Alkon et al., 2005).

### Effectiveness of Mental Health Consultation

One outcome study that evaluated various aspects of mental health consultation to child care assessed teachers' sense of self-efficacy, child care quality, and teachers' reactions to working with the consultant over the time period of two years. Data was collected twice; once at the beginning of the study, and again one year later ('Time 1' and 'Time 2'). Focus groups for teachers were held at both times. The feedback was extremely positive; at Time 2, seventy percent of teachers reported that, compared to one year earlier, they would be much more "likely to try to understand the meaning of children's behavior" (Alkon et al., 2005, p. 96). Fifty-five percent said that they were much more "likely to respond appropriately and effectively to children in distress", while fifty-nine percent indicated that they had a much better attitude about "working together with parents" (p. 96). Data collected during the focus groups conveyed a

significant shift from Time 1 to Time 2 in teachers' perspectives regarding children's behavior. At Time 1, teachers described being greatly taxed by their challenging behavior, viewing it as intentionally spiteful, but by Time 2, they expressed a new sense of curiosity and empathic understanding that the behavior had deeper meaning related to the child's life experiences:

“...I don't just see them as bad kids. She [the mental health consultant] was able to let me know it was not just a behavior problem, it was something from when he was a little kid” (p. 97).

During the second round of focus groups, teachers also reported feeling heard and supported by the consultant, which ultimately enabled them to enhance their interactions with the children by being more supportive, available, and compassionate in the classroom:

“...I guess I learned not to be so hard because at first I was very hard. I learned how to be softer. I learned how to feel and put myself in the child's place, and I could feel the same thing that I think he can feel...it came from the consultants—from their visits...and what they're talking about...” (p. 97).

Another consistent theme that emerged from the focus group discussions at Time 2 was teachers' appreciation for having the consultant(s) available to help them communicate more effectively with parents, and to act as a point of contact between staff, parents, and other service providers or agencies (i.e. schools, social services, etc.).

#### Daycare Consultants: A Focus on Caregiver Relationships

Sixteen years ago, the Infant-Parent Program at the University of California, San Francisco, developed Daycare Consultants, a component which emerged from the program's philosophy of addressing infant mental health needs in the context of the primary relationships that ultimately mold the child's sense of self (Johnston & Brinamen, 2005). With the steady

increase in the number of children in child care, the provider-child relationship is an important one to take into consideration. Daycare Consultants was developed to enhance this relationship by strengthening emotional and social connections between caregiver and child, and also between caregivers (e.g. teacher-parent, and teacher-teacher), through providing comprehensive services such as consultation, individual therapy, and play therapy groups. A hallmark of the Infant-Parent Program and the Daycare Consultants component is a concept they call “inclusive interaction,” implemented through the consultant’s commitment to working within a framework of inclusion (Johnston, 2000, p. 15). This model places emphasis on including all involved parties in the consultation process and by treating each participant as possessing a uniquely valuable perspective, as well as by working cooperatively to develop shared meaning about their own and the child’s behavior (Johnston). This pursuit of developing shared meaning is considered one important facet of inclusive interaction. Another feature, Johnston explains, is seeking to become immersed in the center’s environment (e.g. program philosophy, daily schedules, relationships among staff, etc.), which allows the consultant to better understand the complex relationship between provider and child. The relationship between the consultant and those whom he or she is consulting, which grows over time much like the therapeutic relationship between therapist and client, is another central piece to the success of inclusive interaction. While the consultant’s relationship with the caregiver/consultee plays a large part in the caregiver’s experiences with the children, it is this relationship that should ultimately provide the support and understanding that the teacher needs in order to support, understand, and empathize with the children for whom he or she cares (Johnston).

## Summary

From the research examined in this literature review, it is clear that children are at risk for experiencing a host of behavioral, social, and/or emotional issues as a result of exposure to parental and family stress. It is also clear that a dysfunctional cycle may emerge from the effects of stress on parenting behavior, which then influences children's behavior, therefore adding to parents' stress levels. Much of the research has focused on how life stress is exhibited in parents' behavior around their children. It is also clear that undiagnosed or unresolved mental health problems in early childhood can contribute to a range of more serious psychological problems and difficulty adjusting later in life. Furthermore, studies indicate that untreated behavior problems originating during the preschool years are more resistant to later psychiatric treatment (Kazdin, 1995), a phenomenon that may be caused, in part, by children's entrenched behavioral habits and continually low self-esteem, as well as others' habitual responses to those behaviors (Gross & Grady, 2002).

### Child Care in Today's Society

We have seen that the number of children in child care is higher than ever before, as is the number of hours they spend in day care each week. According to the U.S. Census Bureau, in 2002, 4.2 million of our nation's children under age five were enrolled in an 'organized care facility,' which includes day care centers; preschools and nursery schools; and Head Start programs, which makes up about twenty-three percent of the population (Johnson, 2005). More recent statistics indicate a rise in these figures during 2005; with a reported thirty-six percent of children from birth through age six (not yet in kindergarten) attending center-based care (Federal Interagency Forum on Child and Family Statistics, 2006), and experts predict that the number of children will continue to grow as more and more mothers enter the work force. Additionally, we

know that many children spend the bulk of their days in child care. Studies show that, in 2002, preschoolers of employed mothers spent an average of thirty-four hours a week in a center-based day care environment, which was a higher number of hours than children spent in any other child care arrangement, including care from grandparents or family day care arrangements (Johnson, 2005).

### Quality of Care

Fortunately, research indicates that high-quality child care via a secure environment with healthy attachments to primary caregivers can help to moderate the potentially negative effects of long hours in day care centers and exposure to parental distress. Thus, the issue of quality of care becomes an important one when considering children's mental health needs and the topic of bridging the fields of child care and mental health. In general, high quality day care is typically characterized by practices that foster children's cognitive and socioemotional development, as well as their ability to learn successfully (Lamb, 2000), which might be virtually impossible if a close relationship between child and caregiver is not established. Some outcome studies have examined quality of care more specifically in terms of structural aspects, such as age range, class size, and ratio of teachers to children (Lamb). Other research has looked at indicators of quality as related to staffing characteristics, including wages; caregiver education and training; and teacher turnover (Johnston & Brinamen, 2005). As mentioned previously, staffing inconsistency as reflected by high turnover rates may affect children's socioemotional development (Alkon, Ramler, & MacLennan, 2003) through its impact on the caregiver-child relationship. Factors such as lower wages, bigger class sizes, and higher ratios of children to teachers can play a part in increased turnover rates, therefore contributing to lower quality of care.

It is clear, then, that the quality of child care is one of the integral pieces in the puzzle of addressing young children's mental health needs. But are today's children receiving high-quality day care? According to the Cost, Quality, and Outcomes Study (1999), on a scale from '1' to '7', with '1' meaning 'inadequate level of care,' and '7' meaning 'excellent care,' the majority of the randomly-selected full-day child care centers in four states (N=401) earned only mediocre scores, falling between '3' and '5' on the scale (Peisner-Feinberg et al., 1999). While almost sixty-five percent of the centers scored in the 'medium' range (i.e. 3<5), only twenty-four percent were rated as providing good quality care, scoring a '5' or higher on the scale (Peisner-Feinberg et al.). Another study conducted by the National Institute of Child Health and Human Development's (NICHD) Early Childhood Research Network (2000) gathered data on various attributes of positive caregiving, collected from observations at child care centers when the children were fifteen months old, twenty-four months old, and again at thirty-six months. Across all three phases of data collection, the vast majority of child care centers in the study scored in the 'somewhat uncharacteristic' range (15 mos.=62%; 24 mos.=66%; 36 mos.=62%), meaning that positive caregiving activities were 'somewhat uncharacteristic' of caregivers at those centers. Roughly about a quarter of the centers at fifteen months (23%), twenty-four months (19%), and thirty-six months (30%) were rated as exhibiting 'somewhat characteristic' positive caregiving. Only a small percentage of the participants, however, scored in the highest range of 'highly characteristic,' and the scores also decreased as the children grew older. While 5% reached the highest rating at fifteen months, the score had dropped down to a mere 3% when the children were thirty-six months old (NICHD Early Childhood Research Network). From this and other sources of data, we may draw the logical but tentative conclusion that the overall quality of child care in today's society is neither excellent nor exceptionally poor, with definite

room for improvement. Ideally, the future will present opportunities for implementing positive changes in the system so that more families will have access to higher-quality child care.

#### What is Missing?: Addressing Gaps in the Literature

In this section, I have highlighted research from studies about the potentially detrimental effects of parents' stress on young children; about acknowledging the importance of dealing with children's mental health issues; and about the state of child care today, including emphasis on the value of receiving high-quality care. Considering the wealth of literature on these topics, which seems to support a logical progression to integrating family therapy with day care, why then, was I only able to locate a relatively few number of articles specifically devoted to the topic of combining mental health and child care? While the current literature regarding mental health consultation to child care centers indicates a philosophy of including parents in the consultative process, it is not clear if marriage and family therapy in particular is a consistent part of the services being provided by the consultant. Additionally, if integration of child care and family therapy is indeed being practiced elsewhere, why does the subject appear to be all but missing from the current literature? Research must shift its focus in order to bridge the gap between the two fields of marriage and family therapy and child care/preschool to make collaboration a possibility for other programs in the future as well.

### **CHAPTER III: METHODS AND RATIONALE**

For this study, I utilized a questionnaire (see Appendix A) designed to explore the potential for integration of child care and family therapy, from the perspectives of day care center and preschool directors. The questionnaire addresses awareness of children's problems as related to parental stress, current awareness of the role of marriage and family therapists, and perceived factors contributing or acting as obstacles to the integration of family therapy in a child care environment. Although the majority of the questions are closed-ended, two short-answer (or open-ended) questions are also included to provide additional information.

#### **Participants and Selection Process**

For this study, I surveyed directors of all NAEYC (National Association for the Education of Young Children)-accredited child care centers in the state of Virginia. This sample was chosen for several reasons; the first being that directors in particular would likely be the more influential figures (as opposed to parents or teachers) in having the authority to implement steps to bring family therapy into a child care environment. Secondly, directors may have a more realistic perception of the potential obstacles to successfully integrating child care and family therapy. In addition, the sample was limited to accredited centers because the common accreditation process brings a certain amount of similarity to the centers; given that they have all gone through the same evaluative process, we can be relatively certain that they have comparable credentials and have been recognized as demonstrating what NAEYC has determined to be quality child care, according to ten standards of excellence. These standards include, but are not limited to: fostering positive relationships between children and adults, working from a comprehensive curriculum covering all areas of child development, conducting ongoing assessments of children's learning, employing an excellent and qualified teaching staff, and

working collaboratively with children's families. The actual process of becoming accredited begins with a period of self-study, followed by application for accreditation, after which specific requirements must be successfully met in order to qualify for an on-site visit from an NAEYC validator, who then evaluates the center based on the ten aforementioned standards of excellence and determines the center's scores and accreditation status. Ultimately, surveying all accredited child care centers in the state serves the purpose of gathering initial data from a large number of subjects. Rather than limiting the study to child care centers in one geographical area, in surveying all centers in the state, the study increases its generalizability by taking into account socioeconomic differences, variations in lifestyles, and so forth, as well as providing a larger sample size, thereby strengthening the value of the results.

#### Procedures

Upon discussing this topic with fellow family therapists and day care staff members, I developed the questionnaire, targeted to preschool and child care center directors. The goal of the questionnaire was to gather demographic information; as well as to assess participants' perceptions about children's experience of their parents' stress level(s), participants' current awareness of marriage and family therapy, and their attitudes regarding various aspects of collaboration, either currently or future potential for, between day care providers and family therapists.

The questionnaire was initially reviewed by the members of the research committee in order to gather feedback and suggestions about the survey questions. Before the questionnaires were distributed to all participants and data was collected, the researcher received prior approval from the Institutional Review Board (IRB) to conduct the study. After being granted official

approval from the IRB, the researcher subsequently distributed the questionnaires to accredited centers in Virginia.

The surveys were sent to the participants via traditional postal mail, according to a list obtained via the NAEYC website ([www.naeyc.org](http://www.naeyc.org)) by initiating a search for all accredited child care centers located in the state of Virginia. The website list is comprised of center names along with corresponding addresses and phone numbers. Each mailing consisted of a self-addressed stamped envelope, the questionnaire, and a signed cover letter (see Appendix B), which served several purposes: first, it introduced the researcher, explained the nature and goals of the study, and indicated the approximate length of time required to answer the survey questions. Secondly, it assured the participants of total confidentiality, and verified that there were no anticipated risks to those who chose to participate. Finally, the letter explained that, by completing and returning the survey, the participants thereby granted their consent to take part in the study. A Post-It® note was affixed to each cover letter, containing a personal message written by the researcher to thank the recipients in advance for their participation.

Each survey packet was individually coded in order to track responses and conduct follow-up mailings. The list of child care centers was numbered consecutively, and each number was written discreetly at the top of each corresponding questionnaire. The researcher was the only one in possession of the list of codes, and the list was kept in a locked file at her home.

Participants submitted their surveys by mailing them back to the researcher in the self-addressed stamped envelope provided for that purpose. The researcher also included the fax number of the university office in the cover letter, in the event that participants preferred to return their surveys by fax rather than by mailing them.

Participants were given two weeks in which to fill out and return the questionnaires. At that point, the directors who had not responded were sent another survey and cover letter (see Appendix C) with a similar, but slightly more personal message emphasizing the importance of their contribution and again requesting their participation. This second “round” of participants were given another two weeks in which to reply. Finally, pastel-colored postcards (see Appendix D) were mailed to the directors that had still not responded, checking on their receipt of the original packet, asking for their responses, and including the researcher’s contact information in the event that the participants needed to request another packet. Following another two weeks, all of the responses from these three waves of participants were then collected and the resulting data was entered into SPSS (statistical software) to generate a descriptive statistical analysis of the information. Participants’ answers to the open-ended questions were analyzed using the method of content analysis, which identified categorical themes in the data through the use of both qualitative and quantitative procedures.

#### Instrument

The questionnaire (Appendix A) is composed of eleven closed- and three open-ended questions and is organized into four sections. Section I consists of items concerning the demographics of the participants; Section II contains questions about parents’ stress levels and the effects of stress on parenting; the third section is focused on participants’ current awareness of the family therapy field; and Section IV is made up of items regarding potential for as well as any current collaboration between day care providers and family therapists. The three open-ended questions at the end of the survey allowed the participants to share their thoughts and opinions about the integration of family therapy into a child care environment.

## Analysis

Data from this study was analyzed using descriptive statistics to illustrate the profiles of the participants in terms of demographics (e.g. age, years of experience in child care, etc.) and also to describe their answers to the multiple choice items. For instance, how many directors out of the total number believe that parental stress is a major factor in childrens' problems while at day care?...What is the percentage of participants who are familiar with the role of marriage and family therapists?...How many of the centers are currently providing mental health services to their families? I will provide answers to questions such as these and others with regard to the closed-ended items.

In terms of the open-ended questions, content analysis was used to assess participants' responses. Content analysis is a research method involving qualitative coding procedures, whereby the researcher analyzes the non-numerical data and identifies recurring categories and themes, systematically codes the categories, and then employs a system of "checks and balances" (i.e. someone else also reviews the data to look for themes and then the findings are compared) to ensure reliability (Newfield et al., 1996). In this study, the data was reviewed by the committee chairperson after primary themes were identified by the researcher.

## CHAPTER IV: RESULTS

This chapter contains the results of a state-wide survey of preschool and/or child care center directors. To obtain these data, 197 schools and/or centers were selected for the survey based on their NAEYC (National Association for the Education of Young Children) – accreditation. A list of accredited centers in the state of Virginia was obtained from the NAEYC website ([www.naeyc.org](http://www.naeyc.org)). Participants were selected based on the following criteria: 1) director of a child care center or preschool located in the state of Virginia, and 2) school or center is currently recognized by NAEYC as officially meeting the requirements for national accreditation. Of the 197 surveyed, 72 (37%) returned a completed questionnaire. All of these responses were valid and used in the study.

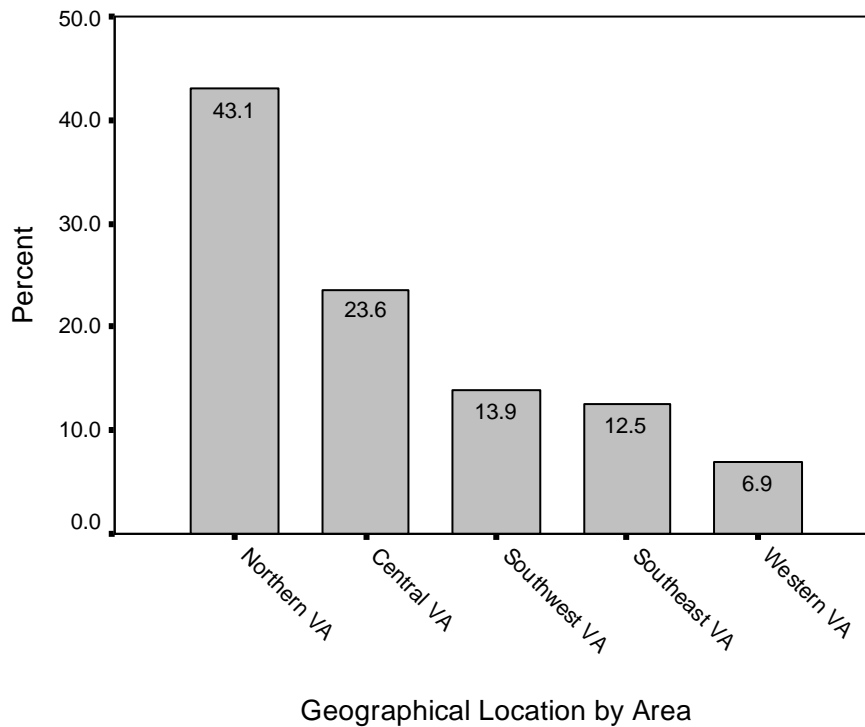
### Demographics

On average, the respondents had about 19.5 years of experience in the field of teaching and/or child care, with an average of about 9.6 years of experience in their current position as director. Their ages ranged from 25 to 62, with the average age being about 49 years. One hundred percent (N=70) of the respondents were female. Thirty-five percent (N=25) of the participants hold a Master's degree in various disciplines, with 19% (N=14) having earned their Master's in education, specifically. Twenty-eight percent (N=20) hold a Bachelor's degree, while 7% (N=5) of the participants have their Bachelor's in education. Four percent (N=3) hold an Associate's degree; 4% (N=3) have a Doctorate, and the remaining 3% (N=2) hold various other types of degrees (i.e. law) and/or certifications.

Many geographical areas of Virginia were represented in the sample (Figure 1). Forty-three percent (N=31) of the directors came from schools located in Northern Virginia, which included such areas as Alexandria/Annandale, Falls Church/McLean, Vienna/Fairfax,

Herndon/Reston and Springfield/Woodbridge. Twenty-four percent (N=17) of the respondents were from central Virginia, representing the areas of Fredericksburg, Richmond, Williamsburg, Midlothian, and Charlottesville. Fourteen percent (N=10) were from the southwest region of Virginia, consisting of Blacksburg, Roanoke, Salem and Vinton; and 13% (N=9) were located in southeastern Virginia, which included the Virginia Beach, Norfolk, Suffolk, Newport News, Yorktown, and Chesapeake areas. The remaining 7% (N=5) hailed from the western part of the state, representing Harrisonburg, Staunton, and Winchester.

Figure 1.



The demographics for the types of centers (i.e. child care, preschool, Head Start, etc.) are as follows: 40% (N=29) are preschool programs; 22% (N=16) are solely child care centers; 21% (N=15) offer both preschool and day care; 6% (N=4) are listed as Pre-Kindergarten programs; and 4% (N=3) are specifically Head Start programs. The other two types of centers were nursery

schools (3%; N=2) and cooperative preschools (also 3%; N=2). Most of the locations (37%; N=26) offer full-day programs, while 34% (N=24) offer only part-day programs and 30% (N=21) have both full-day and part-day programs available.

The number of children enrolled in the centers and schools in the sample ranged from 10 to 335, with an average of about 93 children enrolled. The number of teachers ranged from 1 to 30, with an average of 8 teachers; while the number of assistants or aides ranged from 0 to 60, averaging about 9 assistant teachers per school. The average for the total number of staff members (which could also include administrative staff) was 18, ranging from 3 to 81 people on-staff.

### Impact of Parental Stress on Children

Research Question 1:

*To what extent do directors consider children's psychological issues to be associated with parental and/or family stress?*

**On a scale from 1 to 5, with '1' being 'not at all a factor', and '5' being 'a major factor', how much is parental stress a factor in the problems you see with children at your center?**

The mean for this item was 3.7. Most of the participants (29%; N=20) considered parental stress to be either a significant factor in children's problems (i.e. '4' on the scale) or '5' - a 'major factor' (also 29%; N=20). Twenty-six percent (N=18) responded that parents' stress is somewhat of a factor (i.e. '3' on the scale). Seventeen percent (N=12) of the participants considered it to be only a slight factor (i.e. '2' on the scale). Interestingly, none of the respondents (0%; N=0) considered parents' stress to be 'not at all a factor' in the children's problems at their centers or schools.

**From your perspective, what percentage of the children at your center have parents who suffer from stress severe enough to negatively impact their parenting?**

The average response to this question was 32% (mode = 10%; range: 1% to 100%). One participant who responded with an answer of 100% also added, *“I think all parents suffer from stresses that impact their parenting.”*

#### Awareness of Family Therapy

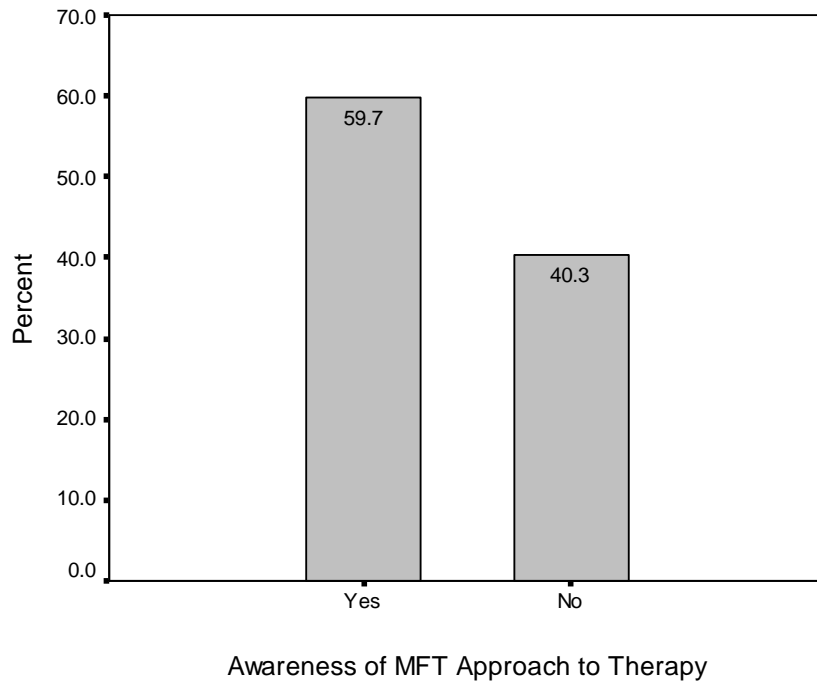
Research Question 2:

*To what extent are directors familiar with the field of family therapy and the family systems approach to psychotherapy?*

**Among the many mental health professionals licensed in Virginia, did you know that marriage and family therapists (LMFTs) are those who are trained to diagnose and treat mental and emotional disorders *within the context of the family*?**

Sixty percent of the respondents indicated that they were indeed aware of the MFT approach to therapy, while 40% of the respondents were not aware (Figure 2).

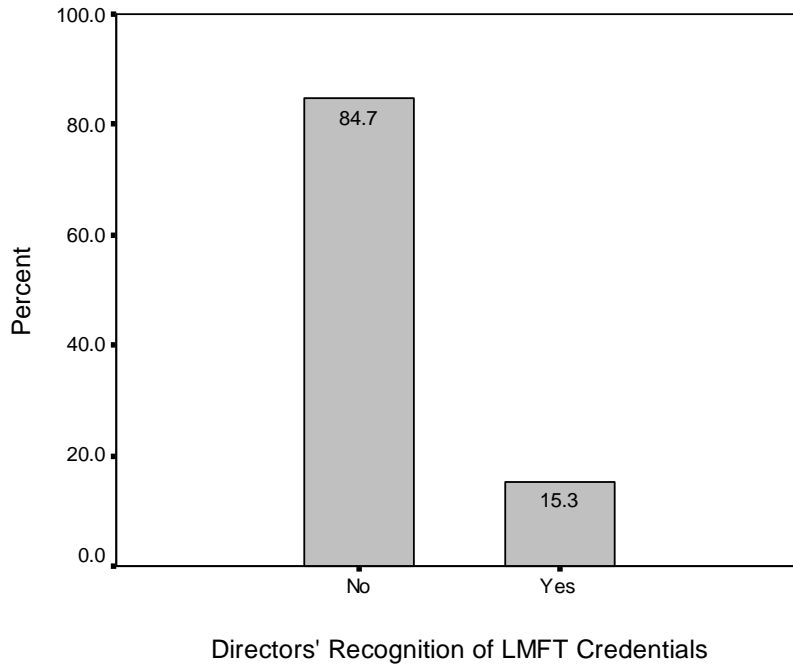
Figure 2.



**Prior to receiving this questionnaire, did you recognize the initials “LMFT” as credentials for a licensed marriage and family therapist?**

Only 15% of the respondents confirmed recognition of these initials as credentials, whereas 85% of the survey respondents were unfamiliar with the initials “LMFT” as indicative of someone who is a licensed marriage and family therapist (Figure 3).

Figure 3.



Collaboration Experiences

Research Question 3:

*To what extent are child care and preschool directors currently utilizing some type of mental health services in their work with children?*

**When parents ask you or your staff for a referral to a mental health professional for child behavior or parenting concerns, to whom do you typically refer them?**

Participants were provided with eleven multiple-choice answers and were asked to check as many that applied (Table 1). Fifty-three percent (N=38) of participants refer parents to a psychologist; 49% (N=35) refer them to some type of parent education program; 44% (N=32) refer to programs such as Child Find; and 40% (N=29) refer parents to a social worker. Other common responses were: behavioral specialists (38%; N=27), community mental health centers (29%; N=21), and resource specialists (28%; N=20). Fifteen percent (N=11) of participants refer

parents to a psychiatrist, while 29% (N=21) refer them to other various professionals (i.e. pediatrician, pastor, etc.). Only 14% (N=10) of the respondents use marriage and family therapists as referral sources, making that the smallest number of referrals. The remaining 3% (N=2) have never referred parents to any other professional(s).

Table 1. To Which Professionals are Directors Referring Parents?

<b>Variable</b>	<b>N</b>	<b>% of Respondents</b>
Psychiatrist	11	15.3
Psychologist	38	52.8
Social worker	29	40.3
Resource specialist	20	27.8
Marriage & family therapist	10	13.9
Comm. mental health ctr.	21	29.2
Child Find, etc.	32	44.4
Behavioral specialist	27	37.5
Parent ed. program	35	48.6
Other professional(s)	21	29.2
Never made outside referral	2	2.8

Note: Participants were given the option of selecting more than one referral source.

**When you or your staff need a consultation about a child’s behavioral or emotional problems at your center, with whom do you typically consult?**

This item’s multiple-choice answer set was identical to the one for the previous question, and participants were again requested to check as many that applied (Table 2). The most common responses were: psychologists, and programs such as Child Find; each made up 38% (N=27) of the total responses. Thirty-two percent (N=23) of the participants report consulting with a behavioral specialist, and the same number (32%, N=23) consult with a resource specialist. Twenty-nine percent (N=21) consult with a social worker; 26% (N=19) look to other professionals (i.e. pediatrician, pastor, etc.) for guidance; 19% (N=14) consult with a community

mental health center, and 14% (N=10) seek advice from parent education programs.

Psychologist consultations (7%; N=5) and consultations with marriage and family therapists (6%; N=4) were at the bottom of the list, while 1% (N=1) of the participants reported never having sought outside consultation.

Table 2. With Which Professionals are Directors Consulting?

<b>Variable</b>	<b>N</b>	<b>% of Respondents</b>
Psychiatrist	5	6.9
Psychologist	27	37.5
Social worker	21	29.2
Resource specialist	23	31.9
Marriage & family therapist	4	5.6
Comm. mental health ctr.	14	19.4
Child Find, etc.	27	37.5
Behavioral specialist	23	31.9
Parent ed. program	10	13.9
Other professional(s)	19	26.4
Never had outside consultation	1	1.4

Note: Participants had the option of selecting more than one professional.

**Do you have a mental health provider who regularly provides services to parents and children at your center’s location? If yes, what profession is your provider?**

Forty percent (N=29) of the respondents currently have a professional available to provide mental health services to children and families at their location, while 60% (N=43) of the respondents do not (Figure 4). Of those who do, 14% (N=10) employ a psychologist; 11% (N=8) employ a social worker; 10% (N=7) employ some other type of professional (i.e. occupational therapist, counselor, etc.); 3% (N=2) have a behavioral specialist available at their location, and another 3% (N=2), while reporting that they do have providers, did not specify the profession (Figure 5).

Figure 4.

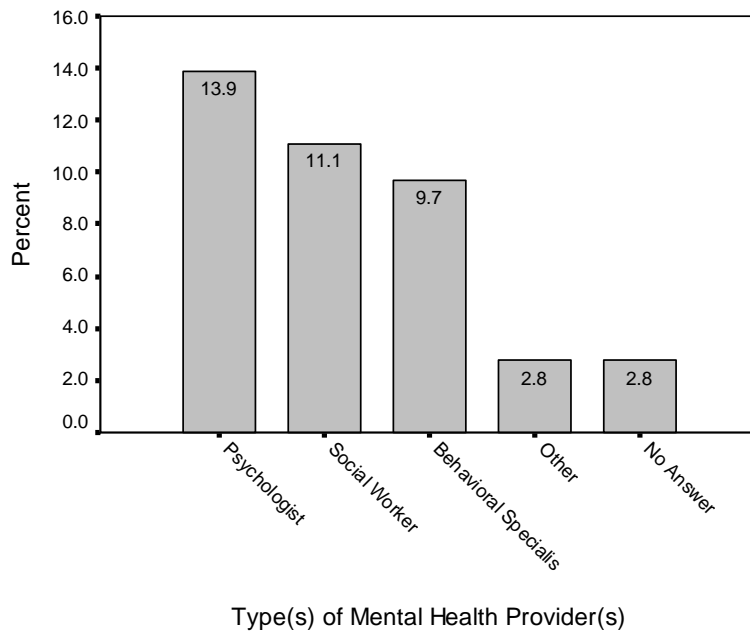
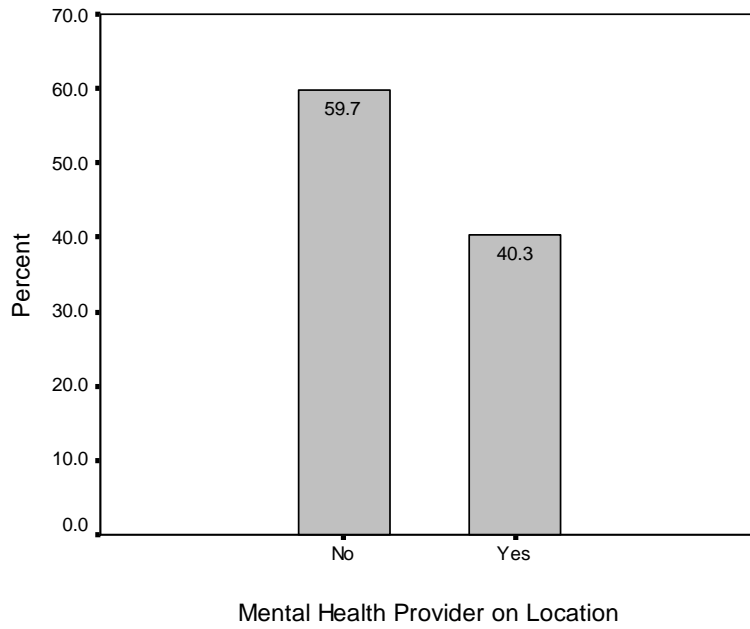


Figure 5. Qualitative responses pertaining to the profession of the mental health provider available to children and families on location, if applicable.

**What services are provided [by the mental health professional at your location]?**

This item was a multiple-choice item; participants were given a list of eight options, and were asked to select all that applied (Table 3). Twenty-six percent (N=19) of the respondents who provide services offer individual therapy; 25% (N=18) offer family therapy, and another 25% (N=18) offer both individual and family therapy. Twenty-two percent (N=16) of the participants make parent education groups and/or workshops available to the parents, while 14% (N=10) have art and/or play therapy as an option for helping children. The remaining types of services were group therapy (7%; N=5) and mediation (3%; N=2).

Table 3. Services Available Through Mental Health Provider(s) on Location

<b>Variable</b>	<b>N</b>	<b>% of Respondents</b>
Individual therapy	19	26.4
Family therapy	18	25.0
Both indiv. & family therapy	18	25.0
Parent ed. groups/Workshops	16	22.2
Group therapy	5	6.9
Art/Play therapy	10	13.9
Mediation	2	2.8

Note: Applies to participants who indicated that a mental health professional is available to provide services at their location. More than one service could be selected.

**If you do not have such a provider, to what extent do you think it would be valuable to have a marriage and family therapist who regularly provides services to children and families at your center’s location?**

For this question, a scale from ‘1’ to ‘5’ was supplied, with ‘1’ being ‘not at all valuable’, and ‘5’ being ‘extremely valuable’ (Figure 6). The mean was 4.4. Eighteen percent (N=13) of the respondents indicated that having a MFT on location would be ‘somewhat valuable’ (i.e. ‘3’ on the scale); 13% (N=9) said that it would be ‘extremely valuable’, and the responses of

‘slightly valuable’ (‘2’ on the scale) and ‘significantly valuable’ (‘4’ on the scale) had the same response rate of 11% (N=8) for each. The remaining 6% (N=4) indicated a belief that MFT services available on location would not be at all valuable.

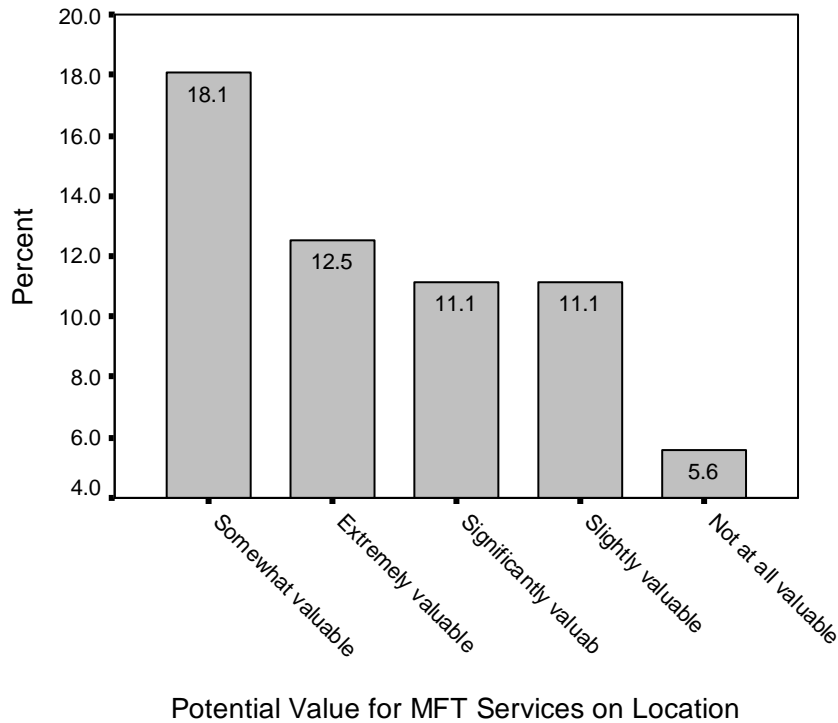


Figure 6. Participants who do not currently have an on-site provider were asked to rate on a scale of 1 to 5 the potential value of offering family therapy-related services at their locations.

### Obstacles to Providing Family Therapy-Related Services

Research Question 4:

*What do child care and preschool directors perceive to be potential limitations, if any, to implementing and utilizing family therapy-related services in a child care or preschool environment?*

**What, if any, do you perceive to be obstacle(s) to providing family therapy-related services to the children and families in your preschool or day care center?**

Participants could select as many as applied from a list of fourteen options (Table 4). The factors that had two of the highest response rates were those related to finances: ‘cost for parents’ (65%; N=46), and ‘therapist’s salary’ (56%; N=40). ‘Health insurance considerations’ (32%; N=23) was also part of this group and scored fairly high in response rates as well. The next highest group of factors were related to people’s perceptions of therapy: 42% (N=30) of respondents thought that ‘non-receptive parents’ would be an obstacle to implementing therapy in schools and day care centers, while 34% (N=24) considered people’s ‘negative perception[s] of therapy’ to be a significant obstacle. Twenty-seven percent (N=19) of the respondents indicated that ‘lack of support from parents’ would be a consideration, and 21% (N=15) thought that ‘maintaining families’ privacy/confidentiality’ might stand in the way of having a family therapist on-location. The final group of answers were related to logistical issues; ‘lack of available office space’ rated highest in this group at 30% (N=21), followed by ‘liability issues’, which trailed at a response rate of 13% (N=9). Other logistical considerations were: ‘supervisory/personnel management concerns’ (11%; N=8), and ‘competition with other therapists in the area’, (3%; N=2). One answer that constituted its own category was ‘lack of need for therapy’, which had a response rate of 16% (N=11). Eleven percent (N=8) of the participants specified other obstacles to providing services, such as *“indifference,” “lack of LMFTs in [the] area,”* and *“being part of a school system.”* Another participant explained that *“services [are] available other places on [the military] base, [which would result in] duplication of services,”* and two different respondents mentioned families’ lack of time as an obstacle for offering on-site services. Another director of a part-day preschool program stated that their *“day is too short”*, presumably making it difficult to find the time for families to participate in therapy, and one person explained that *“many cultures have misconception[s] of mental health.”*

Similarly, “*difficulty in finding [a] Spanish-speaking therapist,*” was specified as a perceived obstacle.

Table 4. Perceived obstacles to providing family therapy-related services in day cares, preschools

<b>Variable</b>	<b>N</b>	<b>% of Respondents</b>
Therapist’s salary	40	56.3
Cost for parents	46	64.8
Health insurance considerations	23	32.4
Lack of avail. office space	21	29.6
Lack of need for therapy	11	15.5
Non-receptive parents	30	42.3
Liability issues	9	12.7
Maintaining privacy/confidentiality	15	21.1
Supervisory/personnel mgmt. concerns	8	11.3
Negative perception of therapy	24	33.8
Lack of support from parents	19	26.8
Competition with other local therapists	2	2.8
Other obstacle(s)	8	11.3
Perceive no obstacle(s)	2	2.8

Note: Participants could select more than one.

What Do Preschool and Center Directors Think About the Idea of Family Therapy Integration?

Three open-ended questions were included at the end of the survey in order to enhance the data obtained:

**Please take a moment to share your thoughts and opinions (positive OR negative) about the potential for introducing family therapy and/or related services into a preschool or child care environment.**

Ninety percent of all participants (N=65) wrote a response to this question, and a content analysis of the responses revealed two major themes: 1) Positive Feedback, and 2) “It’s unrealistic because...”.

## Positive Feedback.

Thirty-seven participants (57% of the 65 respondents) indicated that they were in favor of the concept of integrating family therapy into a child care/preschool environment. One director wrote, *“I think this would be a positive service to offer. We see so many issues developing as a result of stressors in a child’s family environment.”* Another said, *“I think having the whole family involved in therapy...would be great! When there is dysfunction...it affects everyone. And the earlier the intervention the better.”* One director talked about the benefits from first-hand experience: *“Our center has had great success with our family therapist. We feel fortunate to have great resources.”* Another wrote, *“When problems...are dealt with at this level,...the impact could only be positive.”* Several participants indicated that being in the Northern Virginia area was a factor: *“...a wonderful idea, especially in this area [Northern Virginia] where parents are under a lot of pressure to be successful and to have only successful children.”* One director at a military child care center said, *“This type of therapy could be beneficial...because of deployment of one or both parents...”*. Perhaps the positive feedback can best be summarized by quoting one participant: *“A healthy family sends us a healthy child.”*

Two secondary themes that emerged from the “positive feedback” category are: 1) directors being ill-equipped to handle families’ problems, and 2) having MFT connections. In terms of participants feeling ill-prepared when it comes to problems, one director wrote candidly about her experience: *“I deal with issues that require my ‘counselor’ hat, so to speak, on a[n almost] daily basis. ...We see many different challenges that families are facing...[and] the stress levels are sometimes high...”*. Her sentiments are echoed by another director: *“Often...I need help with situations that I do not feel trained to handle.”* Another respondent

explained simply, *“I spend a lot of time counseling parents on many issues,”* thus, having a family therapist available would *“alleviate some of my work.”*

The other secondary theme was related to participants expressing interest in having more connections to MFTs as referral sources. Several participants explained their hesitation regarding having a therapist on-staff (i.e. insufficient need, part-time program, etc.), but emphasized the benefits of being able to refer families to them. One respondent in particular wrote, *“An LMFT would be a wonderful resource or consultant to help figure out what is going on with some children...”* while another said, *“...it would be extremely helpful to have a convenient method to refer families for counseling.”*

#### It's Unrealistic Because...

Twenty-five of the participants (35% of the 65 respondents) answered this item from a less positive perspective. Using content analysis, the overall theme that emerged from these responses was a feeling that the idea of bringing family therapy services into schools and day care centers would be a rather unrealistic goal. Why would it be unrealistic? Most of the answers fit into one or more of two distinct categories: 1) having to do with cost, and 2) having to do with confidentiality/privacy.

Nine responses were in some way related to the cost of providing mental health services. Two participants specifically mentioned the potential difficulty in justifying the salary of an additional staff member, given the struggle just to pay teachers fairly: *“I cannot imagine adding additional non-teaching positions within our budget.”* The other responses were less specific but equally skeptical about being able to manage the financial implications of employing another staff person, such as: *“If the services must be included as a cost to the programs, that is a significant roadblock for many centers who must count pennies to get by.”* Other participants

wrote, *“I think it would be extremely cost prohibitive in a small setting [such as half-] day church programs,... etc.”* and, *“We are a cooperative preschool[,] meaning the parents are the governing body – the Board of Directors. I am not confident they would feel it is cost effective to have a family therapist on staff,”* and one director mentioned the possibility of conflicts with families’ health insurance coverage.

Another dominant sub-theme was that of client confidentiality. Six participants talked about the challenges of being able to maintain families’ privacy, such as: *“...a center is a very public place. I believe it is not the location for therapy sessions.”* Another director of a cooperative school explained, *“...there are always parents in the building. There would be serious confidentiality issue to deal w[ith].”* A participant who described their center as being *“located on a military installation,”* wrote, *“Parents are very concerned about confidentiality [and] would not be receptive of such services at our location.”*

There were other responses worth noting that did not fit into either of the above categories. Among them were those related to utilization of services: *“Many families don’t see the need to seek professional help, even for simple counseling,”* and, *“The people who need [therapy] the most would probably not use it.”* Other responses had to do with families’ perceptions of therapy, such as: *“It may make [parents] feel as if I think they can not do it on their own,”* and, *“In my experience in public education, ‘therapy’ has a more negative implication for parents [than for those in private schools].”* One director summed up her feelings about the integration of family therapy by writing simply, *“I would not want to be the initiator of such a service for a family/parent,”* but did not elaborate any further.

**How might the integration of family therapy and preschool/child care be helpful to you or your staff in your day-to-day work with children (or how is it currently helpful)?**

Eighty-eight percent (N=63) of all participants submitted a response to this question. Content analysis of the responses revealed four major themes: 1) having to do with staff education in learning how to better serve children and families, 2) having to do with receiving validation from an “expert,” 3) having to do with “all parties involved” in the child’s care/education, and 4) having to do with parenting skills/education.

Staff Education

This was, by far, the most common of the four themes. Twenty-seven of the sixty-three respondents made some reference to how their staff would, or currently does, benefit from therapeutic services being provided to children and families. Several directors specifically mentioned that these services would give their staff more tools to help children and families. One of these directors explained, “*Staff need resources and strategies to effectively deal with the...symptoms of family-related [stress]...that children exhibit.*” There were also quite a few participants who made references to noticing increases in children’s issues and/or being unqualified to handle these issues. For example, one respondent wrote, “*I know [my] staff has more questions regarding special needs and behavioral problems because we seem to be seeing more children with these difficulties. We could really use a consultant...*”. Another said having therapeutic services would help “*eliminate some of the unnecessary time we spend in addressing issues that we are not really qualified to [handle].*” Most of the remaining responses were positive reactions to the benefits of family therapy and were similar in nature to a statement made by one participant: “*I believe it would be extremely helpful as a resource to the staff as*

*they attempt to determine the causes of specific behaviors in children and appropriate responses to them.”*

#### Validation by an “Expert”

Another theme that emerged through content analysis was that of being able to use an on-staff family therapist as an “expert.” There were six respondents whose answers fell into this category and most of the responses consisted of something similar to what this participant wrote: *“It is wonderful to have an opinion from an expert to validate what you already know about a child’s behavior. It becomes more real for parents to hear this info[rmation] from a professional.”* Other participants explained that having a family therapist available would provide an *“expert opinion on ways to work with...families,”* and one child care center currently utilizes the psychologist on-staff to *“make observations in the classroom... [which] can then be used as validation of a perceived issue.”*

#### “All Parties Involved”

Responses related to this theme had to do with the family therapist working as part of the “team” in order to help children and families. Overall, five of the responses fit into this category of “All Parties Involved.” One participant wrote, for example, *“The ‘bridge’ between the child, [therapist],...parents and... teachers is very effective,”* while another respondent echoed her sentiments: *“Raising the next generation is always a team effort: parents, teachers, physicians, therapists, etc.”*

#### Parent Education

The final theme to emerge following content analysis was that of utilizing family therapy to increase parenting skills. One center who currently offers services to families via a behavior specialist explained that this professional *“has been extremely helpful in upgrading parenting*

*skills so that the child's behavior and performance in school has improved.*" Another participant described that by offering family therapy, "...families would be more apt to receive guidance in dealing with...parenting issues before they negatively impacted children's...social adjustment [and] personal growth." Finally, one director wrote simply that family therapy services would be beneficial in terms of "provid[ing] parent training and assistance."

**Please include any other general comments, opinions, or ideas you might have about the topic of family therapy/child care integration.**

38% of the participants (N=27) responded to this question, and the majority of the responses were in favor of the current effectiveness or the potential for effectiveness of integrating family therapy with schools and child care centers. Two participants who had first-hand knowledge of the benefits of on-site family therapy commented on their experiences: "We are very fortunate to receive services. It is critical to have an 'outside person' help w[ith] parent issues [and] behavior concerns..." while the other participant wrote, "Our center had funding through a grant attained by [Northern Virginia] Family Services for an on site mental health provider for 6 hours per week...Very effective!!" Another director expressed her support of the idea by writing, "...Most of the time, the problem is due to something that has happened in the family. It makes perfect sense to include the family...to find a solution. The family therapist adds that expert,...non-bias piece to the puzzle...". One participant implied that an on-staff family therapist would be helpful because she "feel[s] ill-equipped to handle the family issues that [she is] sometimes confronted with."

The remaining responses were neutral about offering family therapy services, and two of these, in particular, were worth noting. They would fall under a category such as "Barriers" or

“Obstacles.” The first participant commented, *“There is still unfortunately a stigma to getting help to improve family dynamics, reduce stress, and improve performance of children in school,”* while the other wrote, *“Our biggest obstacle to getting parents to seek out therapy...is denial. Parents often think that their child will ‘outgrow’ problems.”*

## CHAPTER V: DISCUSSION

The purpose of this research was to explore preschool and child care center directors' perceived need for integration of family therapy services in school and day care environments. In order to accomplish this, a questionnaire was developed to encompass the following areas: directors' attitudes about the relationship between stress, children's problems, and parenting behavior; awareness of marriage and family therapy; experience with current provision of mental health services to children and families; and the obstacles they perceive to being able to provide therapeutic services in child care and preschool settings. Three open-ended questions were included in the survey for the purpose of enriching the data. Via these questions, participants had the opportunity to add further comments about the topic of child care/family therapy integration, and their experiences with or interest in collaborating with marriage and family therapists. Systems theory guided this study as the researcher focused on the consideration of children's problems relative to their families', and whether those children might benefit from participating in systemically-oriented family therapy.

One hundred ninety-seven preschool and/or child care center directors received the state-wide questionnaire via U.S. mail. After three mailings, 72 (37%) returned a completed survey, and all of these responses were considered valid for inclusion in the study. Data was analyzed using both quantitative and qualitative methods. The quantitative analysis consisted of a variety of descriptive statistics, and qualitative data was analyzed using the method of content analysis. While quantitative and qualitative data are presented at length in the previous chapter, this chapter seeks to summarize the results, discuss the limitations of the study, and present implications for family therapists and future research endeavors.

## Summary of Findings

### Primary Themes

There were four major themes that emerged from the data in this study: 1) Pre-school/child care center directors are largely receptive to the idea of collaborating with marriage and family therapists and believe it would be beneficial in many different capacities; 2) Although many agree that parental stress may be a factor in children's problems, a significant number of pre-schools/day care centers do not currently refer families to and/or consult with marriage and family therapists, despite their indications that they are familiar with the systems-oriented field of marriage and family therapy; 3) Many child care centers/pre-schools do not currently have mental health services available at their locations; and 4) Many directors perceive certain obstacles which could possibly stand in the way of integrating family therapy-related services into a child care/pre-school environment.

### Receptiveness to Collaboration

It appears that, of the 60% of directors whose centers do not currently offer on-location mental health services, over half of them believe that having a marriage and family therapist to regularly provide services at their center would be valuable to some extent. Only 6% of these participants indicated that having an on-site marriage and family therapist would not be at all valuable. Additionally, over half of the participants who responded to the first open-ended question regarding the potential for family therapy and child care/pre-school integration were in favor of making those services available to the children and families at their centers. In particular, several participants mentioned feeling unqualified to handle certain children's issues, and would therefore benefit from a marriage and family therapist's experience and assistance. Similarly, the responses to the second open-ended item about the helpfulness of collaborating

with family therapists were also mostly positive in nature. Four themes emerged from these responses regarding how family therapy-related services could specifically be useful: 1) To provide staff training and education; 2) To act as an “expert” to validate teachers’ concerns about children’s behavior and facilitate communication with parents; 3) To foster a “team” approach among teachers, directors, and parents; and 4) To provide services designed to enhance parenting skills.

### Referral and Consultation Practices

Many of the participants confirmed an association between children’s problems and parents’ stress, to some degree. Fifty-eight percent of the directors who responded indicated that family stress is either a ‘significant’ or ‘major’ factor in the problems they see in children at their schools and centers. The majority of the participants also indicated a familiarity with the systems approach to marriage and family therapy. Sixty percent of the directors reported an awareness of licensed marriage and family therapists (LMFTs) as mental health professionals who are trained to diagnose and treat problems within the context of the family. Despite these acknowledgments that: 1) children’s problems may likely be systemic in nature; and 2) there are professionals who specialize in addressing these problems within a corresponding framework, many directors are currently not referring families to, nor consulting with, marriage and family therapists when concerns arise about a child’s behavior or emotional development. Of the nine types of professionals (listed in the multiple-choice question – see Appendix A) to whom directors refer parents, marriage and family therapists received the lowest response rate, with only 14% (N=10) of the participants referring parents to MFTs. Similarly, regarding consultation practices, directors were least likely to consult with a marriage and family therapist about children’s emotional or behavioral problems. Only 6% (N=4) of the participants report

typically seeking consultation with a marriage and family therapist in particular, as opposed to another type of mental health professional.

#### Limited Mental Health Services at Centers and Schools

Results indicate that the majority of child care centers and schools do not currently have a professional on-staff who is regularly available to provide mental health services to children and families. Sixty percent of the participants reported that they do not offer therapeutic services via a mental health provider. While 40% of the centers and schools are fortunate enough to have a provider on-staff, only 3% (N=1) indicated that the mental health professional is specifically a LMFT. What is heartening, however, despite the low number of LMFTs employed in day cares and pre-schools, is the fact that many of the other types of mental health professionals are currently offering family therapy services as well. Twenty-five percent of the participants indicated that their service provider holds family sessions, and 25% reported that their provider offers both individual and family therapy. This is a positive indication that many families are at least getting psychosocial help, presumably within a systemic framework, even if it is from a professional other than a LMFT.

#### Obstacles to Integration

As predicted, most participants perceived some barriers to bringing family therapy-related services into more pre-schools and child care centers. Financial considerations were the most commonly perceived obstacles. In particular, ‘cost for parents’ had the highest response rate, with 65% of the directors believing it to be a significant factor standing in the way of including a family therapist on-staff. ‘Therapist’s salary’ rated the second highest in responses, with 56% of the participants indicating that they believed salary to be a considerable obstacle to providing family therapy services. A third of the participants (32%; N=23) also identified health

insurance issues as a cost-related consideration regarding family therapy integration. Another factor that many directors selected was ‘non-receptive parents.’ Forty-two percent of the directors considered parents’ lack of openness to be something that might impede the capability to offer family therapy-related services in that environment. Several participants later reiterated some of the same issues in the qualitative section of the questionnaire, especially those factors specifically related to cost. Other issues were identified to be obstacles as well, such as concern about maintaining families’ privacy, the “stigma” of going to therapy, and parents’ “denial” of the problem(s). Only 3% (N=2) of the directors indicated that they perceived no barriers to the provision of therapeutic family services, while the remaining participants identified at least one obstacle, with many of them indicating a perception of multiple factors.

#### Integration of Findings with Current Literature

The four primary themes that emerged from this study will be discussed in comparison to previously published research. To review, the major themes, in brief, are: 1) Receptiveness to collaboration, 2) Effects of parental stress on children, 3) Limited comprehensive mental health services, and 4) Obstacles to integration.

#### Receptiveness to Collaboration

The findings from this study indicate that directors are largely in favor of increased cooperation with MFTs, and believe that this cooperation would be beneficial for children, families, and staff, which corresponds to current research by Alkon, Ramler, & MacLennan (2003). When Alkon and colleagues examined the effectiveness of mental health consultation to child care, based on child care providers’ experiences of working with the consultant for one year, they found: 1) teachers felt heard and supported by the consultant, which improved their interactions with the children, 2) teachers gained a new sense of empathy for the children and a

curiosity about challenging behavior they did not possess prior to working with the consultant, and 3) teachers appreciated having the consultant available to facilitate communication with parents, and between staff members. These findings are in keeping with this study's data gathered from the directors' qualitative survey responses regarding the potential helpfulness of collaboration with MFTs. Similar to results from the research by Alkon et al., directors indicated in their responses that they believed working with a MFT would be beneficial, especially in terms of having a teacher-parent liaison for increased communication, adopting a "team approach" to helping children, and being able to provide additional staff resources. Furthermore, in Alkon and colleagues' study, participants' overall experience with a mental health consultant was positive, much like the directors' experiences in this study. Qualitative responses to open-ended questions indicated that, of the directors who had the benefit of working in conjunction with a mental health provider, their experiences were primarily positive.

### Effects of Parental Stress on Children

The findings from this study suggest that directors recognize the correlation between parents' stress and children's problems, which has been extensively documented in the literature, and in this section I will highlight a few of those studies, previously reviewed in Chapter II. In research by Crnic and Acevedo (1995), we learned that, while stress itself may not have a direct impact on children, the way in which parents handle stressful situations and the resulting effects on parenting behavior is what ultimately influences children's functioning and development, although research also indicates that the impact of stress can be moderated by the quality of parent-child interactions (Webster-Stratton, 1990). Creasey and colleagues (1997) suggest, on the other hand, that, even if parenting behavior remains unchanged during times of stress, young children may still be indirectly affected because of their acute awareness of parents' emotions,

often mimicking their coping responses to stressful or uncertain situations based on how their parents respond.

While a good deal of the existing research primarily concerns stress resulting from major life events, Crnic and Greenberg (1990) instead examined how the accumulation of what they called “minor parenting stresses” influenced parent, child, and family functioning. They found that the build-up of minor stress was actually more predictive of maternal/child/family status than were major life stressors, confirming that major stressful life events need not be present in order for parents to experience distress. Overall, their study revealed that minor parenting hassles were linked to greater family dysfunction and less satisfied parenting.

Findings from research by Patterson and colleagues (1991) indicated that parental stress may also play a part in children’s peer relationships, in the sense that exposure to parents’ stress seemed to compromise children’s ability to sustain friendships. Gaylord et al. (2003) suggest that parents’ stress leads to children’s internalizing and externalizing behaviors, which then increases the likelihood of peer rejection. Difficulties with early social development may have implications for being able to form and maintain relationships later in life as well.

One of the more prominent themes appearing multiple times throughout the literature had to do with the dysfunctional cycle in the family system created by stress. One example was present in research conducted by Morgan et al. (2002), who suggested that as parental stress increases, perceptions of children’s behavior become more negative, and parents tend to fixate on this behavior. Because the way in which parents perceive the behavior largely determines the behavior, children then become more likely to act out, in a self-fulfilling prophecy of sorts. Another earlier study by Webster-Stratton and Eyberg (1982) indicated that mothers who described their children’s temperaments as “difficult” were also more likely to react negatively

toward their children. In response, their children were more likely to display behavior problems, therefore maintaining a dysfunctional cycle in the system.

### Limited Comprehensive Mental Health Services

Current literature indicates that, although there has been a push from those in the mental health profession to develop better connections with child care providers so as to serve children and families more efficiently and adequately, the goal of building these partnerships seems, so far, to be just out of reach (Collins et al., 2003), resulting in a good idea in theory but one that has yet to materialize much beyond a limited number of programs at the local level. These findings are in agreement with the survey results from this study, which indicate that the majority of child care centers and preschools who participated (i.e. 60%) do not currently offer mental health services to children and families at their locations. While most participants reported that they routinely refer parents to and engage in consultation with some type of mental health professional, it seems that, as the research implies, closer connections between the two fields have yet to be built.

### Obstacles to Integration

Research suggests the following explanation for the continuing struggle to bridge mental health and child care: roadblocks such as lack of provider expertise, limited access to services, and inconsistency in coordination of services (U.S. Public Health Service, 2000). These barriers apply more to the federal and state levels; in other words, these are obstacles to the implementation of changes on a grander scale. However, when participants in this study were questioned about the possibility of being able to bring family therapy-related services into a day care or preschool environment, they perceived obstacles at the local levels as well. Many of the directors surveyed believed cost to be a factor, both in terms of paying another employee's

salary, as well as considering the additional cost for parents. Whereas these particular barriers have more to do with the logistics of providing family therapy-related services, many other directors reported that factors related to public opinion, such as non-receptive or non-supportive parents, or negative views about therapy, would stand in the way of successfully integrating services. Only further research will help to distinguish whether this is indeed “typical” of most directors, or if the participants in this study are the exception with regard to perceived obstacles.

### Research Questions and Goals of Study

In Chapter II, I reviewed research that discussed examples of programs that are currently offering mental health services in conjunction with child care and, in describing their success, made a case for more widespread collaboration between the two professions. Johnston and Brinamen (2005) wrote about the Daycare Consultants program they founded, in which mental health professionals work collaboratively in a child care setting with administrators, teachers, and parents to provide a broad range of services benefiting everyone involved. Similarly, Alkon et al. (2005) studied the effectiveness of mental health consultation in day care, and found that the teachers and staff who worked with the consultant for one year had good experiences and felt that these experiences translated to more positive interactions in the classroom. These examples lend support to the overall goal which guided this study: to determine if, in fact, there is a place for family therapy within a child care or preschool environment. Based on the two studies by Johnston and Brinamen, and Alkon and colleagues, it is clear that there is indeed a place for mental health services and that those programs that have managed to implement these services have met with success. We can also see that there is a place in the field of child care for marriage and family therapists, but what still needs to be explored, and where this study fits into

the literature, is how to promote wider recognition by child care professionals of marriage and family therapists.

### Limitations

Although this study has yielded some useful data, it has certain drawbacks as well. In this case, survey research proved to be an ideal method for an exploratory study of the opinions of this sample, but it would be remiss not to acknowledge that it also comes with limitations. What is appealing about this method is that an ample amount of data can be easily gathered in a fairly short amount of time. One downside, however, is that survey research is generally not easily replicable. Even if each step of the procedure is outlined in detail and followed accordingly, one cannot possibly control for such aspects as the unique responses of the participants, or the recall ability (Nelson, 1996). In addition, the instrument used in this study has not previously been tested for reliability or validity.

The fact that a nonprobability convenience sampling technique was used significantly adds to the sampling error and gives a certain amount of bias to the sample, calling into question the issue of representativeness. While the sample chosen may sufficiently represent the population in Virginia, it does not necessarily represent the population of preschool and child care center directors in the other forty-nine states in the country. As a result, the analyzed data has limited generalizability. However, Nelson (1996) states that nonprobability sampling is often used if generalization is not crucial and less error-prone probability methods are unfeasible or too expensive, all of which apply to this study. Therefore, since this is relatively initial research on the topic and is for exploratory purposes, I have tried as much as possible to avoid interpreting meaning from the data, instead focusing solely on the descriptive results.

There are some other limitations to the selected sample. For one, by surveying only NAEYC-accredited child care centers and preschools, information about a considerable number of non-accredited centers in Virginia are therefore excluded from the study. While it was necessary to limit the sample to accredited centers because of the researcher's time and financial resources, it would, of course, have been ideal to gather data from all Virginia locations and then compare the findings between accredited and non-accredited centers. Similarly, it is possible that Virginia may not be representative of the U.S. in terms of its number of accredited centers. We can surmise that the administration and staff in NAEYC-accredited centers tend to have higher levels of education than staff at non-accredited centers, and that because of the significant number of affluent areas in Virginia, which typically indicates a greater number of residents with higher education, it would ultimately result in more accredited centers on average than in other states with lower per-capita income. Similarly, it is possible that NAEYC-accredited schools would be more interested in the topic of the study, in part because they might have access to more funding which would further facilitate the implementation of on-site mental health. On the other hand, perhaps being accredited has less to do with education level or money and is more so associated with individual schools' preferences, or state or federal incentives for earning accreditation.

There is also the possibility of response selection bias, such that the directors who responded to the survey are probably more invested in the topic of bringing family therapy into child care and preschool. Ideally, it would be useful to know more about the potential biases of the nonrespondents as well, but as that information is virtually impossible to obtain, we can only make rough hypotheses regarding their motivations for not responding to the questionnaire.

The response rate of those who did respond, however, was fairly low and can be considered another limitation in this study. Several steps were taken in an attempt to maximize the response rate. For instance, the questionnaire and a signed cover letter with a handwritten “thank-you” Post-It® note were mailed along with a self-addressed stamped envelope, all in a hand-addressed envelope. Non-respondents were sent a second packet, identical with the exception of a slightly different cover letter, and finally, the third and final mailing consisted of a signed postcard sent to the remaining non-responsive subjects. The goal of this multi-phase process was to achieve a response rate of at least 50%. It is not clear why the final rate was a disappointing 37%. As a former child care/preschool teacher, I can hypothesize from my own work experience that the majority of the participants’ time was occupied by more pressing matters, and the survey, therefore, was set aside and perhaps forgotten. Maybe the survey, lacking an actual person’s name as the addressee, never made it into the directors’ hands. Perhaps those subjects who never responded were the ones who did not foresee a need for family therapy-related services or perceived the concept to be unachievable, and thus, considered it futile to even bother completing and submitting the questionnaire. Another quite probable factor might be the time of year when the survey was mailed, which was during the months of May and June. This is traditionally a time of transition for most schools and centers, what with summer vacations and children moving to new classrooms. On the back of her questionnaire, one participant actually wrote that she had been delayed in returning her survey due to the hectic nature of end-of-school-year obligations. Hence, it is a good possibility that many subjects did not respond because it was simply not an ideal time for them to do so. At any rate, because the response rate is fairly low relative to the sample size, the confidence interval is lower and the results, therefore, decrease the potential for generalizing the study’s findings.

## Clinical Implications

This study presents several implications for clinical practice. The responses from the qualitative questions yielded useful information about various aspects of collaboration between family therapists and child care/preschool teachers. From this data, family therapists can begin to develop an awareness of the types of therapeutic services that would be helpful in a child care or preschool setting. For example, in addition to facilitating family therapy, it might also be beneficial for a marriage and family therapist to handle child observations, staff training, and parent education. This study may let family therapists know that many directors responded positively to the topic of bridging family therapy and child care, and that a significant number have had some prior experience collaborating with various mental health professionals in the child care/preschool setting. Especially notable is that several directors expressed their satisfaction with these collaboration experiences by describing feeling supported and validated by the mental health professional(s). Other participants' responses elucidate directors' and teachers' goals of wanting to help children and their families to be as well-adjusted and successful as possible, which is something they have in common with family therapists. Perhaps this and the other information resulting from this study will aid in the future when further research helps make it possible for more centers to successfully integrate family therapy and child care.

## Implications for Future Research

It is clear that more research on the topic of current collaboration between family therapists and preschool/child care teachers is necessary. More studies are warranted so as to expand on this study's findings to include collaboration experiences and practices occurring throughout non-accredited child care centers in Virginia, as well as non-accredited and/or

accredited centers across the U.S., in order to have a more accurate representation of the population. Other research might seek to obtain further details about the schools and day care centers that are presently working in collaboration with mental health professionals who provide family-centered services, taking into account, for instance, their demographics and individual philosophies; the organizational aspects of their programs; and how they were able to effectively bring family therapy (via a MFT or other mental health professional) into a child care or preschool environment. It would be useful to explore the variables that contribute to making collaboration a successful endeavor, or, if applicable, information concerning the reasons why perhaps any previous attempts might have been unsuccessful. It would also be helpful to find out more about directors' attitudes about offering off-site services versus on-site services. For instance, do they think parents would be more inclined to seek help if therapy is available at their child's center, instead of having to go elsewhere, or vice versa? Perhaps mental health services need not be only on-location in order for families to make it a point to take advantage of them.

Results from this study revealed that many child care and preschool directors perceive obstacles to providing family therapy-related services. Do other directors perceive similar or different obstacles? How can these obstacles be addressed in such a way that they do not become permanent roadblocks to the implementation of systems-oriented services, and is that even a possibility? In a society in which the child care system is already overburdened and in need of vast, costly improvements, overcoming obstacles which would entitle families to even better quality, more comprehensive services is admittedly difficult to imagine, yet this is a crucial part of evaluating the potential for family therapists and child care providers to work together effectively in the future.

Additionally, it would behoove our field to explore the attitudes of parents in the child care community. Some directors in this study indicated a belief that parents would be unsupportive or non-receptive to the notion of family therapy in combination with child care or preschool. How do the parents themselves feel about the idea? What obstacles do they perceive, if any? And, if parents are indeed non-receptive to the idea of participating in family therapy via their children's day care or preschool, how can MFTs and child care professionals help to decrease their reluctance? Topics such as these, however, are just a few directions for future research. Because the primary aim of this study was to gather initial data on the subject, there are many other possibilities for avenues of exploration.

Ultimately, the field of marriage and family therapy would benefit from having a clearer understanding of what is effective in terms of working as a therapist in conjunction with child care and preschool professionals, and how to facilitate increased accessibility of therapeutic services to child care families. In other words, what can we, as therapists, do to promote the growth of family therapy/day care integration? One possibility is to consider forming a national partnership between the two professional organizations, NAEYC and AAMFT (American Association for Marriage and Family Therapy) in order for each to publicize their profession to the other and introduce the possibility of working more closely together. If we are to explore the potential for integrating the two fields, it would be necessary as well to consider what, if any, additional training, such as courses in child development or play therapy, for example, is needed for family therapists to effectively work in child care with young children and their families. Likewise, it may also be useful to consider whether preschool and child care teachers might benefit from MFT coursework related to the family systems approach. If both sides – marriage and family therapists and day care providers – made a commitment to participate in continuing

education having to do with each other's professions, we could surmise that the transition to a complete and successful integration of the two fields would be a smoother proposition for everyone involved.

Despite the barriers and limitations of this particular study, its findings indicate the following: 1) Many directors observe a connection between parents' stress and children's problems; 2) Many directors are already referring to or consulting with other mental health professionals; 3) If their center does not have access to services via a mental health provider, many directors at least recognize the potential value of having a MFT available to offer services on-location; and 4) Many directors perceive some obstacles to being able to make these types of services available to the families and children in their care. The qualitative feedback from the open-ended questions suggests a positive overall reaction from the directors regarding the concept of bridging family therapy and child care/preschool, indicating that families, children, administration, and staff alike would stand to benefit from greater cooperation between the two professions. It is the hope of this researcher that the exploration of the potential for integrating family therapy and child care/preschool will continue, and that the two fields may eventually work more closely together. Hopefully, by offering these children and their families comprehensive services addressing their mental health needs in a familiar environment will ultimately make it possible for them to enjoy a higher quality of life, both at the time, and in the future as well.

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APPENDIX A

Perceived Need of Child Care Center Directors for Family Therapy-Related Services in a Child Care Setting

**I. Demographics.**

Age: \_\_\_\_\_ Number of staff: \_\_\_\_\_ Teachers  
 Gender: M \_\_\_\_\_ F \_\_\_\_\_ \_\_\_\_\_ Teachers' assistants/  
 Highest Degree Earned: \_\_\_\_\_ aides  
 Years of experience in child care field: \_\_\_\_\_ Total staff members  
 Years of experience as center director: \_\_\_\_\_  
 Number of children currently enrolled: \_\_\_\_\_ Is your program - \_\_\_\_\_ Full-day only  
 \_\_\_\_\_ Part-day only  
 \_\_\_\_\_ Both

**II. Impact of Parental Stress on Children.**

*In this questionnaire, "parental stress" refers to a variety of problems parents and families may face, such as work pressures, financial strain, marital difficulties, etc.*

**On a scale from 1 to 5, with '1' being 'not at all a factor,' and '5' being 'a major factor,' how much is parental stress a factor in the problems you see with children at your center?**

Not at all Major factor  
 1 2 3 4 5

**From your perspective, what percentage of the children at your center have parents who suffer from stress severe enough to negatively impact their parenting? \_\_\_\_\_%**

**III. Awareness of Family Therapy.**

*Family therapy is one area of psychotherapy that focuses on addressing the mental health needs of all family members. Therapy sessions may involve the whole family, or just certain members as necessary.*

**Among the many mental health professionals licensed in Virginia, did you know that marriage and family therapists (LMFTs) are those who are trained to diagnose and treat mental and emotional disorders *within the context of the family*? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Prior to receiving this questionnaire, did you recognize the initials "LMFT" as credentials for a licensed marriage and family therapist? Yes \_\_\_\_\_ No \_\_\_\_\_**



**What, if any, do you perceive to be obstacle(s) to providing family therapy-related services to the children and families in your day care center? (Check all that apply.)**

- |   |  |
|---|--|
| <input type="checkbox"/> Therapist's salary             | <input type="checkbox"/> Maintaining families' privacy/confidentiality |
| <input type="checkbox"/> Cost for parents               | <input type="checkbox"/> Supervisory/personnel management concerns     |
| <input type="checkbox"/> Health insurance issues        | <input type="checkbox"/> Negative perception of therapy                |
| <input type="checkbox"/> Lack of available office space | <input type="checkbox"/> Lack of support from parents                  |
| <input type="checkbox"/> Lack of need for therapy       | <input type="checkbox"/> Competition with other therapists in the area |
| <input type="checkbox"/> Non-receptive parents          |  |
| <input type="checkbox"/> Liability                      |  |
| <input type="checkbox"/> Other (please specify) _____   |  |
| <input type="checkbox"/> None                           |  |

**Please take a moment to share your thoughts and opinions (positive OR negative) about the potential for introducing family therapy and/or related services into a child care environment.**

**How might the integration of family therapy and child care be helpful to you or your staff in your day-to-day work with children (or how is it currently helpful)?**

**Please include any other general comments, opinions, or ideas you might have about the topic of family therapy/child care integration.**

*Thank you for your time and participation!!*

## APPENDIX B

7054 Haycock Road  
Falls Church, VA 22043

Dear Director:

**H**ello! My name is Lisa Haines and I have been a child care/preschool teacher in Fairfax County, Virginia for the past four years. I am hoping you will take just a few minutes to fill out the enclosed questionnaire, which is part of my thesis research for my Master's degree in Marriage and Family Therapy.

Picture this...

- While at day care, a 5 year-old complains of a stomachache every day right before his class is due to go out to the playground.
- A once-mild-mannered 3 year-old suddenly begins biting her peers, on a near-daily basis. You find out later that the child's parents are divorcing.
- A 4 year-old displays severe anger management problems, exhibits an inability to relate to peers, and his behavior is extremely impulsive. His mother is expecting a third child in a few months.

...Sound familiar?

The goal of my study is to assess whether there may be a need for family therapists and child care providers to work together to help children and families. I hope that this research will shed some light on the possibility that families with kids in day care could benefit from a collaborative relationship between their children's teachers and family therapists.

**E**xcept for the short time it takes to answer the questions on the survey, nothing else is required. But your responses are vital to the success of my study. The outcome of this research depends on getting a high response rate from people like you, so I need your help!

**L**et me assure you that your identity will be kept strictly confidential at all times. The number you see on the questionnaire is simply to help me organize follow-up mailings at a later date. There are minimal anticipated risks for you as a participant. *This study has been approved by the Institutional Review Board for Research Involving Human Subjects at Virginia Tech.* Your returned questionnaire indicates your consent to participate in the study.

**P**lease take a few minutes right now to fill out the survey! If you are interested, I will be more than happy to send you a summary of my findings when the study is finished. Feel free to contact me at **(703) 258-2642** or my research advisor, Dr. Eric McCollum, at **(703) 538-8463** with any questions or concerns regarding this study or if you experience any adverse effects from your involvement in the study.

I look forward to receiving your completed questionnaire, either in the enclosed envelope or by fax (see number below) within **two weeks**. Please accept my gratitude for your participation in my thesis research.

Sincerely,

Lisa C. Haines, Master's candidate  
Virginia Tech, Northern Virginia campus **FAX: (703) 538-8465**

## APPENDIX C

7054 Haycock Road  
Falls Church, VA 22043

Dear Director:

My name is Lisa Haines and, in addition to working in child care, I am conducting thesis research as part of my Master's program in Marriage and Family Therapy. My study explores the potential for the integration of family therapy and child care. This information might sound familiar; approximately two weeks ago, I sent you a letter similar to the one you are reading now, along with a brief survey to get an idea of your thoughts on the subject. I am still looking forward to hearing back from you!

If you have already mailed or faxed your responses, please disregard this letter and accept my sincere thanks for your participation. But if you have not yet had an opportunity to fill out the questionnaire, here is your chance! It will only take about ten to fifteen minutes, and your responses are very valuable to the outcome of this study!

I would like to emphasize to you that, **under no circumstances, will your identity be revealed.** And there are minimal, if any, anticipated risks for you as a participant in this study. (*The project has been approved by the Institutional Review Board at Virginia Tech.*)\* All it takes is a few minutes of your time.

So, please don't throw this out! Just imagine the impact you could have on the future for collaboration between family therapists and child care providers – and how many families could be helped as a result – simply by sharing your opinions on a survey such as this one.

Please feel free to contact me or my research advisor, Dr. Eric McCollum, at the numbers below with any questions or concerns about the study, or if you experience any negative effects as a result of your participation.

I will be anticipating your responses by mail or fax within the next **two weeks**, and again, I remain extremely grateful for your time and participation.

Sincerely,

Lisa C. Haines  
Master's candidate, Virginia Tech – Northern Virginia campus  
**(703) 258-2642** or **FAX: (703) 538-8465**  
Eric McCollum, research advisor **(703) 538-8463**

*\*By completing and returning this questionnaire, you are indicating your consent to participate in this study.*

## APPENDIX D

### Postcard

#### INTEGRATING CHILD CARE & FAMILY THERAPY STUDY

I hope you have already received a packet from me in the mail containing a survey about the topic of **integrating child care and family therapy**. I am still looking forward to hearing back from you!

If your responses are in the mail, please disregard this postcard and accept my thanks for your participation. But if you have not had a chance to fill out the survey, it's not too late! It will only take about 10 minutes, and your responses are so extremely valuable to the outcome of my study.

I look forward to receiving your responses within the next 2 weeks!

**Do you need another copy of the questionnaire? E-mail me at: [haineslc@hotmail.com](mailto:haineslc@hotmail.com) or call me at: 703/258-2642, and I will be more than happy to send you a new packet.**



DATE: May 11, 2006

MEMORANDUM

TO: Eric E. McCollum  
Lisa Haines

FROM: David M. Moore 

Approval date: 5/10/2006  
Continuing Review Due Date:4/25/2007  
Expiration Date: 5/9/2007

SUBJECT: **IRB Expedited Approval:** "The Need for Family Therapy-Related Services in Child Care Settings as Perceived by Child Care Center Directors in Virginia", IRB # 06-301

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective May 10, 2006.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

**Important:**

If you are conducting **federally funded non-exempt research**, this approval letter must state that the IRB has compared the OSP grant application and IRB application and found the documents to be consistent. Otherwise, this approval letter is invalid for OSP to release funds. Visit our website at <http://www.irb.vt.edu/pages/newstudy.htm#OSP> for further information.

cc: File  
Department Reviewer:Angela J. Huebner