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Incorporating KIPS into Parent-Focused Treatment as a Progress Monitor or Skill Identifier

By

Haley Ingram

A Doctoral Project Presented to Eastern Kentucky University in Partial Fulfillment of the Requirements for the Degree of Doctor of Psychology

2020

Abstract

Parents and caregivers hold an essential place in a child's development that contains the potential to influence behavior and model positive methods in which to perceive and cope with emotion. Filial therapy, a form of therapy that teaches parents play therapy skills to promote child positive behavior, is an approach that has grown in interest amongst professionals. The need for more research and data on the outcomes of parent-child relationship treatment has been expressed consistently as research on the topic is limited. Child Parent Relationship Therapy (CPRT) is a form of filial therapy that is conducted in a group format and focuses specifically on enhancing the child-parent relationship while also introducing behavioral techniques to parents for use at home with their child. Assessing this therapeutic approach through data gathering and analysis of program outcomes could allow for more opportunity to conduct research on filial therapy as a whole, as well as promote efficiency and focus on areas of growth throughout treatment. One avenue is via the Keys to Interactive Parenting Scale (KIPS), which is a tool used to identify and monitor parenting strengths and areas of growth regarding specific interactive skills a parent uses with their child. Many of the specific parenting behaviors monitored in KIPS are similar to the techniques taught in CPRT. A proposal for utilizing KIPS within the CPRT format is warranted to address the lack of research in filial therapy, as well as promote the efficacy of using measurable tools to monitor progress in treatment overall.

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Section 1: Introduction[WD1]

Developed by Bernard and Louise Guerney in the 1960's, filial therapy can be described as "a bridge between individual child treatment and family therapy" (Johnson 1995). This approach to treatment seeks to promote change and healing in a child by working with parents to help gain a better understanding of a child's behavior and strengthen the parent-child relationship. Filial therapy emphasizes the power of strengthening a parent-child bond rather than criticizing or "implying that a poor parent-child bond causes the childhood symptoms" (Wickstrom & Falke 2013). Research thus far has supported the efficacy of filial approaches such as Child-Parent Relationship Therapy (CPRT[WD2]) by demonstrating decreased child internalizing and externalizing behavior such as "withdrawal, aggression, and loss of control, and it notes positive changes such as increased confidence and communication" (Wickstrom & Falke 2013). Further, note has been taken of parents' and caregivers' abilities to display more confidence with communicating with their child, as well as adult increased awareness of the child's emotions and needs overall. Further, research developed thus far has pointed out positive impacts on relationships beyond the parent-child relationship, such as couple, family, and sibling relationships. [WD3]

In 2018, a CPRT (Bratton et al, 2006) group program was conducted in Eastern Kentucky specifically for parents of children with Autism Spectrum Disorder (ASD) in a rural setting. Keys for Interactive Parenting Scale (KIPS[WD4]) (Comfort et al, 2011) was used to gather data and monitor changes in parent interaction skills before and after treatment. Typically, in a CPRT program, video recordings are reviewed on a weekly basis by the parents and clinician to observe specific strategies taught in the previous sessions. Due to the inability to provide the technology needed for parents of this group to successfully complete these recording, the KIPS protocol was

used to record play sessions prior to and after treatment in a setting where the clinician could provide the recording technology. The use of KIPS in this program uncovered many similarities between the CPRT content taught to parents and the specific interactive skills measured in KIPS. Additionally, the method of using recorded play sessions in each made the combination of the two tools seamless. A specific observation made in the CPRT format during this group was a lack of progress monitoring opportunities in which to reveal growing strengths or consistent struggles in clients throughout treatment[WD5]. The benefits of including specific progress monitoring data for progress monitoring and client feedback has been discussed often in research. In a study discussed by Newman, Hooke, and Page (2010), results of using progress monitoring in outpatient therapy demonstrated that providing feedback on patients' treatment response improved rates of clinically significant outcomes and reduced negative outcomes from 20% to 8%. Additionally, studies that have demonstrated a significant improvement in outcomes have also revealed cost-efficient benefits for the use of ongoing monitoring[WD6].

The purpose of this project is to introduce a novel treatment plan in which KIPS is included as a progress monitoring tool and skill identifier in the CPRT program. In this project, the similarities between the two therapeutic tools will be reviewed to support the benefit of integrating the two in treatment. Additionally, several options in which how a clinician may approach utilizing KIPS in the CPRT format will be proposed. It is hypothesized that using KIPS within the CPRT curriculum will assist in systematically and consistently identifying parent strengths throughout treatment, as well as determine skills in which a parent may need further intervention or assistance.

Section II: Literature Review

Child-Parent Relationship

When describing the importance of the caregiver-child relationship for the development of children, a World Health Organization report stated:

Sensitive and responsive caregiving is a requirement for the healthy neuropsychological, physical, and psychological development of a child. Sensitivity and responsiveness have been identified as key features of caregiving behavior related to later positive health and development outcomes in young children (Dunst & Kassow, 2008).

A secure attachment between caregiver and child is related to a plethora of beneficial outcomes found in many ~~a multitude of~~ studies[WD7]. From the writings of the CPRT manual, Landreth and Bratton (2006) noted a description of the child-caregiver relationship that stated "The parent-child relationship is nearly always the most significant one in a child's life…therefore, if a child were provided the experiences of expression, insight, and adult acceptance in the presence of such powerful people as parent, every bit of success the parent achieves in carrying out the therapeutic roles should be many more times more powerful than that of a therapist doing the same thing[WD8]." A secure attachment with a caregiver has been found to be related to enhanced cognitive, social, and emotional development[WD9]. Moreover, a positive and wholesome child-caregiver relationship is considered an essential piece that facilitates development of positive relationships later in life. [WD10]

When observing treatment that focuses specifically on the improvement of the child-caregiver relationship, Bavin-Hoffman, Jennings, and Landreth (1996) found that participants

reported improved family interpersonal communication skills, specifically improved parent-child communication and improved partner communication. Additionally, these couples reported increased marital unity, improved sibling functioning, and improved family-of-origin relationships (Cornett & Bratton, 2014).

In summary, the child-caregiver relationship holds priceless opportunity and benefit for many areas of life. First and foremost, a healthy child-caregiver relationship can assist in the development of confident children and their ability to develop wholesome self and interpersonal relationships throughout the lifespan. Beyond this, the skills and foundational perspectives that accompany a positive child-caregiver relationship may in turn positively influence marital relationships, sibling relationships, and more.

~~Need to include a transition to the next section~~In the next section, the benefits of play interaction, as well as supporting research, will be discussed.

Play Interaction

It is common for parents and caregivers to structure child's play to allow adult interaction and guidance. When in play with a caregiver, the child is given the value of an important individual which is valued and irreplaceable. Play-based interactions that are guided by filial therapy methodology can promote opportunities to learn basic life skills, express thoughts and emotion, and grow a wholesome attachment with caregivers[WD11]. Actions such as imitation, scaffolding, and role play are often observed between child and caregiver when both play together, offering opportunity for wholesome learning and growth[WD12]. Play throughout childhood overall is viewed as one form of the child's growing representational competence or capacity for symbolic thought.[WD13] In addition, when in play with a caregiver, the child is given the message that they are valued by an important individual which cannot be replaced through other means. Although a central goal of play-based therapy is to guide the child towards learning experiences, it is also aimed at building a child's sense of leadership, independence, and self-developed identity. By allowing a child to plan a play agenda with the caregiver offering facilitation when needed, the child can grow confident in their choices and actions in the safe and supportive environment that is caregiver interactive play (Gilbride et al, 1984).

In a study conducted by Rogoff, Malkin, and Gilbride (1984), caregiver and child play sessions were observed with children from the ages four months to three years. Over this period of time, adult’s control and interaction with child play naturally altered to better fit the developmental shifts as the children grew. This subtle yet important behavior in the caregiver revealed caregivers’ innate ability to show sensitivity to developmental changes and provide appropriately sophisticated learning opportunities as the child matures. O’Reilly and Bornstein (1993) consistently emphasized the opportunity for sophistication in children through parent interaction and play. Information such as this continues to support the developmental benefits of child-caregiver interactions through play. Research on the associations between adult behaviors and child play indicate that 1) children are receptive to parental suggestions and positive social interactions within the play setting; 2) children play at higher levels with a more sophisticated partner than when playing alone, a difference attributable directly to children’s responses to parental prompts; and 3) certain types of social and didactic interactions and characteristics of the caregiver-child relationship are associated with child play ability; most notable, the social domain of caregiver behaviors relates to child play that is symbolic (O’Reilly & Bornstein 1993).

In addition to the benefits play has on a child’s overall development, child-caregiver play can build and enhance the child relationship with the caregiver and other important figures. Play is one of the most natural ways for children to build relationships (Walters & Crane, 2014), and research has indicated that play-focused interventions between child and caregiver can positively impact the overall family system, strengthen the security of the parent-child attachment, and assist in the development of healthy relationships with others. Even further, play-based therapy and intervention utilizes play as a method in which children can more effectively communicate

thoughts, feelings and experiences they may not otherwise be able to articulate at their present level of development. Play interaction between caregiver and child offers an opportunity in which a child may communicate and receive validation or coping assistance from the caregiver. During play interactions in play therapy, one may see through the child's eyes and better understand the internal frame of reference of the child. Even further, research has received participant reports of improved communication beyond the caregiver-child relationship after play-based treatment, including couples/partner communication and family interpersonal communication skills.

Overall, play-based interactions between the caregiver and child ~~has~~have proven to hold valuable opportunities for a child's overall development and the security of the child-caregiver attachment. Based on research conducted thus far, play interaction holds the opportunity to assist in the strengthening of relationships a child has with their caregiver and others, allow modeling and teaching opportunities, and provide more ways in which a child can more successfully communicate with others. With this knowledge of play interaction in mind, parent group therapy and its consideration of play interaction will be examined in the next section.

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Parent Group Therapy

The group format for parent-focused services has shown to be a promising method in which to provide therapy, psychoeducation, and self-advocacy. Group therapy overall has a history of providing social and emotional support for its members in a confidential and safe setting. Group participants can find safety to express raw emotion and thoughts in the contained environment a group provides. In addition to structured learning opportunities in group settings, group therapy allows for more natural social learning to take place as well. Observing the behaviors of other participants in session and listening to reports of experiences and behaviors of participants outside of the therapeutic setting offer a plethora of knowledge and learning opportunity that individual therapy and the therapist in general cannot always provide alone. From the perspective of the therapist and group leader, group sessions allow the therapist more

interactive observation time and opportunity for interventions such as role play between participants.

In a study conducted by Smith et al (2010), researchers sought to measure the success rate of a brief parent group therapy program that targeted parent-infant interaction, secure attachment, postnatal depression, and infant development. Evaluation of the program revealed many positive outcomes. Regarding parent participant feedback, social support and information sharing opportunity were among some of the areas in which participants were most satisfied. After treatment concluded, an increase in parenting confidence and strengthening of the parent-child relationship overall was observed. Being part of a group setting in which the parents were not marginalized and could identify and connect with other parents was highlighted as a positive experience throughout the treatment.

Child Parent Relationship Therapy

Child Parent Relationship Therapy (CPRT) (Bratton et al, 2006) is an empirically based, manualized intervention that integrates play therapy into a family-oriented approach. CPRT emphasizes the importance the child-caregiver relationship has on a child's wellbeing. CPRT utilizes toys and play as a "child's language" that provides a natural way to build understanding and strength in the child-caregiver relationship. Throughout the CPRT curriculum, parents are taught basic play therapy skills and attitudes to use in structured play sessions.

CPRT includes 10 group therapy sessions designed to enhance the relationship between the child and caregiver, as well as simultaneously enhancing the inner person of the child and what

the child is capable of becoming. The objective is "to help the parent relate to the child in ways that will release the child's inner directional, constructive, forward-moving, creative, self-healing power" (Landreth & Bratton 2006). This enhancement takes placing using family interaction and problem-solving strategies similar to the strategies used in structured play therapy sessions with a trained therapist. Each week focuses on a specific play therapy or parenting skill that is discussed and practiced in group sessions with fellow caregivers, as well as the review of weekly recorded 30-minute play sessions that occur with child and caregiver in the home setting between group sessions. These play times in the home offer one-on-one time with the child for the caregiver to practice new skills being taught in group sessions and take time to focus in the relationship they have with their child. Specific play session objectives include helping caregivers:

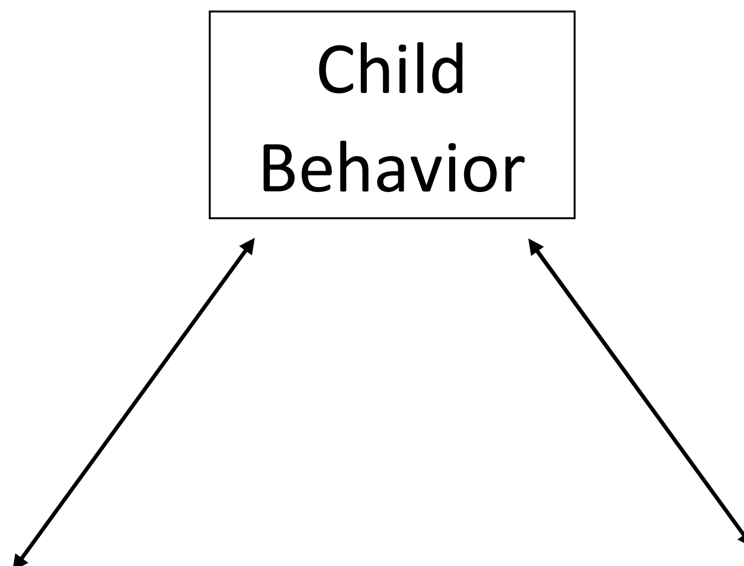
1) Understand and accept their child
2) Develop sensitivity to their child's feelings
3) Learn how to encourage their child's self-direction, self-responsibility, and self-reliance
4) Gain insight into self in relation to the child
5) Change their perception of their child
6) Learn child-centered play therapy principles and skills

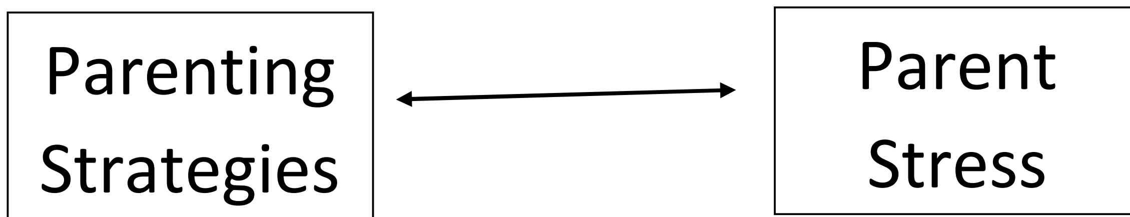
~~6)~~ (Landreth & Bratton 2006)

Practitioners have increasingly emphasized the need for and the importance of assessment and treatment that focuses on family dynamic. Although studies have shown that time spend by a child and caregiver playing together can strengthen and enhance the relationship between the two individuals, more specific research has shown that "the specific manner in which filial-trained parents conduct play sessions leads to greater outcomes compared to those

achieved by parents not trained in filial therapy who conducted regular play sessions with their children (Johnson-Clark, 1996). As the efforts to develop research and literature on the outcomes of CPRT and filial therapy overall, Cornett and Bratton (2014) examined the impact on the functioning of eight families after completing the CPRT treatment plan. A time series design was used to observe the effects of CPRT treatment over time, and data collection occurred preintervention, during intervention, and postintervention. Results indicated that all eight family's involvement in the treatment experienced an impact in family functioning based on self-report and behavioral observation. Statistically significant improvements pertaining to the target aims of CPRT were observed in all families. Self-reported and observational measure[WD14]s suggested that many families experienced positive impacts on their cohesion, flexibility, communication, and overall satisfaction (Cornett & Bratton).

Overall parental stress has also shown to decrease through CPRT. According to the model shown below, parent stress is often a heavy influencer on a caregiver's ability to effectively parent, which in turn negatively affects the child's behavior and upbringing.





In a research study discussed by Wickstrom and Falke (2013), 50 participants in CPRT completed a *Parent Stress Inventory* (PSI) before and after treatment. Results found a statistically significant decrease in Parent Domain scores from pre-test to post-test. The decrease in domain scores, which represent overall levels of parental stress, indicate that CPRT can impact more than the caregiver relationship, but also the caregiver's overall stress levels and confidence in or ease of parenting in general.

Progress Monitoring in Treatment

Research has shown the benefits of including progress monitoring tools and feedback to guide therapy and provide the most effective treatment possible to a client. Monitoring a client's symptoms, skills, behavior, and satisfaction with treatment holds valuable information to determine the current effectiveness of therapy, where there is need for further intervention, and if the treatment being provided is best for the client. Patient-focused research, also referred to as progress monitoring, may "alert treatment providers that a specific client is negatively deviating from the expected treatment response indicating that this patient is at increased risk of deterioration at the conclusion of treatmen[WD15]t" (Dyer, Geoff & Andrew, 2013). Regarding

group formats in treatment, progress monitoring could identify if or when a client amongst a group is falling behind and is in need of more attention. Further, progress monitoring may assist in monitoring where a group as a whole falls in their understanding of skills being taught throughout treatment and if additional sessions are needed to address the areas in which the group struggles.

Dyer et al (2013) conducted a study to address the question of whether there were additive benefits for patient outcome when progress monitoring information was gathered and enhanced feedback was provided. They compared the progress monitoring formats of single component and multicomponent tools. Overall, they sought to address the benefits of progress monitoring and feedback that targeted specific domains consistent with the behaviors and symptoms being addressed in a client's treatment. Results indicated that providing feedback on the wellbeing and results of progress monitoring of a client significantly improved "not-on-track" clients. In terms of providing multiple domain or single domain/composite score feedback, results indicated that feedback from multiple domains showed additional benefits. Group therapy was also addressed in this study, stating that "group therapy offers a dynamic environment in which lack of change may be highlighted or normalized depending on the progress of the group in which they are treated…Thus, the process of feedback within group settings has shown promise" (Dyer et al, 2013).

When considering the use of KIPS (Comfort et al, 2011) in CPRT, the consideration of the twelve specific items in individual feedback rather than the composite score as a whole may act as a beneficial guide for monitoring appropriate progress through the CPRT program. For example, focusing on scores for item 9 of KIPS, which focuses on appropriate limit setting skills, may assist with feedback on how well a parent was able to manage the limit setting skill taught

in week a specific of CPRT in recorded play sessions. CPRT currently does not offer such specific methods of measuring progress and providing feedback. When considering the results of the previously Dyer's study and the purposes of this specialty project, focusing more on the individual items of KIPS when providing progress feedback rather than the composite score may be the most beneficial method in which to use KIPS. Next, the Keys to Interactive Parenting Scale, a progress monitoring tool, will be discussed.

~~**Transition sentences**~~

~~**Next, the KIPS will be discussed…**~~

Keys to Interactive Parenting Scale

The Keys to Interactive Parenting Scale (KIPS) (Comfort et al 2011) was developed due to requests for a reliable way in which to assess parenting behaviors in an effective yet financially considerate manner. KIPS is considered "a practical parenting assessment that offers family

services providers a tool to use with families to jointly reflect on specific parenting behaviors that promote children's development in order to identify each family's strengths and needs, and partner more effectively with each family to support them in nurturing their children [WD16](Comfort et al (2011). Similar to CPRT approaaoch, KIPS is based on the idea that parenting behavior experienced by young children is an important contributor to health child development and wellbeing. An important aspect of family assessment and treatment that KIPS emphasizes is the value in identifying parenting behaviors that research has shown is impactful on child development. Also like CPRT, the specific areas in which KIPS focuses on observing and assessing the quality of the caregiver's ability to build the relationship with the child, promote learning, and support confidence in the child. KIPS provides the following opportunities that make it a unique and effective approach to parent behavior assessment:

1) KIPS measures key caregiver behaviors, tracks progress, and evaluates parenting outcomes.
2) KIPS helps one assess caregiver interactions with young children.
3) KIPS relies on direct observation rather than parents' self-reports.
4) KIPS rates specific parenting behaviors instead of relying on staff impressions.
5) KIPS is convenient, reliable, valid, and based on child development research.

In the KIPS protocol, a trained individual observes a caregiver and a child as they play together for approximately 15 to 20 minutes. This session is recorded for rating and reflective purposes. Three areas of the parenting are considered in the KIPS scoring protocol, which are building the relationship, promoting learning, and supporting confidence. There are Ttwelve specific parenting behaviors in all that are measured within these three areas. The in the KIPS scoring formatKIPS protocol that are is set on 5-point scales for each item with behavioral

descriptions at the points of 1, 3, and 5. A rating of 5 is most favorable, while a rating of 1 is least favorable. For example, when observing the rating scale of item 9, which measures the instances in which the parent allows the child to lead the play session, a most favorable rating of 5 indicates that the parent follows the child's lead, guiding them to pursue his/her own activities, while supporting and extending choices and interests throughout. A rating of 3 would indicate that in play the parent sometimes chooses the activities and the child sometimes chooses the activities. A rating of 1 for item 9 would indicate that the parent engages in most of the play agenda and organizes the session in a way that limits of controls the child's activities; little flexibility is observed in the parent even when the child disagrees or is uncooperative. This rating scale for item 9 can be viewed below.

9. How open is the Caregiver to the Child's agenda? ☐ **NOB**				
1	**2**	**3**	**4**	**5**
CG organizes or controls the choice of C's activities, and shows little flexibility whether or not C cooperates.		CG sometimes chooses activities and C sometimes chooses activities.		CG follows C's lead, guiding C to pursue his/her own activities. CG supports and extends C's choices and interests.

The 12 items measured as well as the specific parenting behavior being questioned for each can be seen below:

-1. Sensitivity of Responses- How sensitive are the caregiver's responses to the child's cues, actions, or words?

-2. Supports Emotions- How well does the caregiver support the child's emotions?

-3. Physical Interaction- How well does the caregiver physically interact with the child?

-4. Involvement in Child's Activities- Howe well is the caregiver involved in the child's activities?

-5. Open to Child's Agenda- How open is the caregiver to the child's agenda?

-6. Language Experiences- How actively does the caregiver engage the child in language experiences?

-7. Reasonable Expectations- How reasonable are the caregiver's expectations for the child's abilities?

-8. Adapts Strategies to Child- How well does the caregiver adapt the strategies to the child's interests and behaviors?

-9. Limits and Consequences- How appropriate are the limits and consequences the caregiver sets for the child?

-10. Supportive Directions- How supportive are the caregiver's directions to the child?

-11. Encouragement- How encouraging are the caregiver's words and actions regarding the child's needs?

12. Promotes Exploration/Curiosity[WD17]- How well does the caregiver promote exploration and curiosity?

(Comfort et al 2011)

To observe ways in which a rating of 5 may be exhibited for each item in play, consider the following examples noted throughout the KIPS training manual. These are observed behaviors that were considered for a rating of 5 in past KIPS administrations:

1. Sensitivity to Responses: *A Dad notices his 5-month-old child gaze at a squeak toy at the end of the couch. "So, you're tired of playing patty cake? It looks like you want Squeaker the Mouse."*

2. Supports Emotions: *A two-year-old child begins to have a tantrum. The parent ignores the behavior for one minute. When the child continues, the parent helps her find words for her distress and then distracts her with her favorite doll.*
3. Physical Interaction: *A parent moves in close proximity with hands extended as the 10-month-old child tries to pull herself to her feet at the table.*
4. Involvement in the Child's Activities: *A parent takes turns with their child as they stack blocks.*
5. Open to Child's Agenda: *A parent lets her child turn pages in a book to see preferred pictures in any order she chooses.*
6. Language Experiences: *A parent reads a book to their 4-year-old child about food and asks, "Do you remember what we ate for breakfast?.......Eggs! What color were they?"*
7. Reasonable Expectations: *A 4-year-old child sings the ABC song, and the parents helps her sing the parts she forgets by singing along with her.*
8. Adapts Strategies to Child: *A 7-month-old child shows interest in a ball, so the parent places it just out of reach and encourages her to go get it.*
9. Limits and Consequences: *A child is crying at the grocery store. The parents tells her, "You can't have any candy, but you can choose the fruit we are going to have for our snack."*
10. Supportive Directions: *While working on a puzzle, the child struggles to fit pieces together. The parent says, "What do you think about turning that puzzle piece to see if it will fit?"*
11. Encouragement: *A parent watches a child and says, "Wow, you stacked those blocks all by yourself!"*

12. Promotes Exploration/Curiosity: *While a parent and child play with a barnyard set, the parent asks questions about each of the animals as the child plays with them such as, "where do you think the chicken sleeps?" or "What do you think the cow eats?"*

- (Comfort et al 2011)

Comfort, Gordon, and Naples (2011) conducted a study to validate KIPS with 397 diverse families. The study aimed to observe the construct validity of KIPS when used with families from racially diverse groups. The 12 items used on KIPS can be calculated to determine one total scores. This method resulted in high internal consistency and indicated that combining KIPS items into one single scale could be beneficial and that each item in KIPS were valuable contributions to the overall scale. When observing the use of KIPS across diverse families, no significant differences were detected in parenting quality among African American, White, and Latino caregivers. This result indicated that KIPS is anchored by behavioral descriptors that allow for cultural differences and diversity[WD18]. In summary, these behaviors were found to be consistent and applicable across many cultural settings and belief systems.

~~Transitions sentences…next…~~In Section III, the similarities between and proposed treatment plan collaborating the KIPS and CPRT tools will be explained in detail.

Section III

Similarities between KIPS and CPRT

Many similarities can be observed in the CPRT format and KIPS assessment items. Some of these similarities will be discussed within this project. First, ~~s. Such similarities include but are not limited to:~~

~~T~~the foundational technique of using video recordings to measure or observe parenting skills that promote learning opportunity, relationship development, and self- confidence within the child can be viewed within both tools. CPRT uses video to record play sessions that are reviewed in group sessions as a method in which to monitor parenting behaviors and utilization of techniques taught in the treatment plan. KIPS also utilizes video recordings for later review and reflection of the specific parenting behaviors that KIPS deems as supportive to the child. Additionally, and similar to CPRT, the KIPS format utilizes the recordings to monitor increase in preferred parenting behaviors over time.~~.~~

The use of play as a method in which to teach caregivers appropriate parenting skills while also strengthening the child-parent relationship is also similar across both tools. As previously noted, a foundational piece of the CPRT treatment plan includes at-home play sessions in which the parent-child relationship can be provided individual attention and care while also providing opportunity to practice specific parenting techniques in a controlled environment. The KIPS format seeks to utilize the play session setting to measure those preferred parent-child interactions and techniques. Those interactions and techniques measured in KIPS are ultimately intended to strengthen the child-parent relationship and promote appropriate parenting behaviors.

CPRT and KIPS also both place emphasis on the caregiver showing active interest in the child's actions during play. Within the CPRT play sessions, an important goal is to provide the child with undivided attention from the parent. In fact, a rule of thumb taught in a CPRT session helps parents remember to keep their focus on the child during the structured play sessions (Landreth & Bratton 2006). Many of the KIPS items measured indicate a need to be similarly physically and mentally present with a child during play. For example, item 3, Physical Interaction, considers the following physical behaviors as most favorable in play:

- Interacts in a way that matches the child's current preferences for physical involvement
- Ensures trust with physical presentation
- Consistently and appropriately attempts to meet the child's needs

- The definition of physical involvement in KIPS may include facial expressions, body language, touch, proximity to the child, and movement (Comfort et al 2011).

Within both tools, a ~~A~~ focus on the acceptance of the child’s own thoughts, emotions, and decisions in play so as to promote effective and whole some communication between caregiver and child exists. The CPRT format teaches reflection of the child’s thoughts, emotions, and decisions through behavioral and emotional tracking methods in play sessions (Landreth & Bratton 2006). Items within KIPS such as sensitivity of responses, supports emotion, openness to agenda, encouragement, and promotion of exploration/curiosity are a few that deem this behavior as most favorable. For example, favorable behaviors within the KIPS item “sensitivity of responses” includes that in reaction to the child, the parent consistently:~~.~~

- Reads the child’s emotional cues
- Understands the child’s point of view
- Responds appropriately to meet the child’s needs.

(Comfort et al 2011)

Favorable behaviors within the KIPS item “supports emotions” includes that the parent consistently and appropriately:

- Interprets, supports and shares the child’s emotions
- Consoles if hurt or anxious
- Guides problem solving if angry or frustrated.
- Helps modulate excitement if needed
- Models appropriate expressions of emotions
- Acknowledges or comments on the child’s emotions.

(Comfort et al 2011)

- These favorable behaviors imply the same kind of importance on acceptance of the child's emotions, thoughts, and decisions that CPRT attempts to teach parents in treatment. In addition to this accepting approach, both tools emphasize the power of emotional reflection in emotional regulation development and measure or teach modeling of appropriate ways in which to express and regulate emotion. CPRT spends time practicing labeling and noting a child's expression of emotion in a candid and nonjudgmental fashion, while the favorable behaviors within KIP item 2 Supports Emotions, for example, expects the parent to consistently interpret, validate, and share the child's emotion while also modeling how the child may express those emotions themselves in an appropriate and healthy way (Comfort et al 2011).

~~-~~ Consideration of the benefits of having a strong child-caregiver relationship that emits safety and support for decisions and identity the child expresses can also be seen within these tools. Both CPRT and KIPS identify one of their goals as creating an environment that strengthens the child-parent relationship through play and quality time. There is a push for freedom for~~.~~

~~- Emphasis on the power of reflection of emotions in a child's emotional regulation development.~~

- ~~Freedom for the~~ the child to lead and make decisions in play can increase a child's confidence. The weekly play sessions in CPRT focus on allowing the child to lead play and decide the activities (Landreth & Bratton 2006). KIPs item 5, Openness to the Child's Agenda, measures how often the parent allows the child to choose activities during play as well. Overall, these similarities show that both tools seek to empower and encourage confidence in the child's decisions and emotions.

Finally, CPRT and KIPS both put in place reasonable and appropriate limit setting skills when necessary. Although, as mentioned previously, there is a heavy emphasis on providing freedom of choice and emotion in play within these tools. However, both bring awareness to safety and that there are times in which a parent must provide a limit for the child's wellbeing. CPRT takes time to teach appropriate limit setting skills, which includes setting an appropriate and specific limit, validating the child's associated emotion or desire, and offering a safer alternative (Landreth & Bratton 2006). Similarly, KIPS item 9, Limits and Consequences, considers a level 5 parenting behavior for limit setting as the following:

- Caregiver consistently sets reasonable limits and consequences that fit the child's comprehension and behaviors
- Caregiver's limits and consequences are consistently firm, clear, and thoughtful
- Caregiver consistently helps child learn appropriate alternative behavior by using distractions, redirection, choices, or reasoning.

(Comfort et al 2011)

These common points between KIPS and CPRT are a few of the many similarities that support utilization of two within one treatment plan. In the next section, this specific treatment plan and possible avenues will be proposed.

Proposed Outline

When considering the proposal of this doctoral specialty project, the previously mentioned similarities between the skills CPRT teaches caregivers and the specific caregiver behaviors KIPS measures support that using KIPS as a progress monitor in CPRT would create an effective modification that includes several benefits. For example, including KIPS as a progress monitor may increase the efficiency of CPRT and add a measurability component that guides treatment according to the client's strengths and weaknesses measured individually. Including KIPS within the CPRT treatment plan would also serve as opportunity to gather data and conduct research that aids in the development of more family-based treatment.

Regarding the best way in which to incorporate KIPS into the CPRT session formats, several methods may be considered. First, KIPS may be used as a way to track caregiver behavior in play sessions on a weekly basis as a progress monitor. Each week in CPRT participants supply 30-minute play session recordings completed with their child prior to each group meeting. These recordings are reviewed and reflected upon as a group or individually. The clinician conducting the CPRT group may consider scoring the video recordings with KIPS and monitoring the results week-by-week. Discussing the signs of improvement or struggle indicated in weekly KIPS results could be discussed with caregivers or used as a guide in which the clinician may determine areas in the CPRT curriculum that may need more or less time in session in order for participants to succeed. A second approach in which to incorporate KIPS into the CPRT session format may include scoring weekly play session recordings using KIPS as mentioned in the previous result, but also including a graph in which to display the group's scores as a whole and discuss strengths or struggles in session. Comparing current to previous graphed results from week to week may allow the clinician and participants to view overall progress as a group and monitor any areas of learning that may require further discussion,

instruction, or assistance in general. A third method in which to incorporate KIPS into the CPRT session format is considering holding individual sessions before, once during, and after CPRT. During these individual meetings, the clinician may discuss and reflect on the progress of the participants KIPS scores individually. This may allow more opportunity for individualized assistance and/or praise regarding the participants' progress half-way through and at the end of CPRT.

Participant[WD20]s

Caregivers who typically are referred to CPRT may present with a variety of concerns. "Reasons parents are referred for CPRT training have been varied and have included many of the more typical child adjustment problems and parent-child relationship difficulties as well as children who were experiencing behavioral and emotional difficulties" (Landreth & Bratton, 2006). Many parents, however, have been reported to attend CPRT simply with the desire to

improve their parenting in general and better understand their child. Research gathered on the CPRT model has proven that CPRT can be used with a variety of diverse populations including incarcerated mothers or fathers, mothers residing in domestic violence shelters, nonoffending parents of sexually abused children, parents of children with learning disabilities, and more. Similarly, KIPS has proven through research to be compatible with parents of many cultures and children with presenting concerns such as intellectual disability, Autism Spectrum Disorder (ASD), and trauma to name a few. Regarding participants in the practice and provision of this treatment plan, many mental health professionals may consider receiving training and utilizing this treatment plan with clients. KIPS is designed for professionals including "family support providers, parent educators, home visitors, early head start staff, early intervention staff, mental health practitioners, nurse practitioners, psychologists, social workers, and family therapists" (Comfort et al 2011). CPRT, with appropriate training and supervision, may also be used by a similar group of professionals.

Clinician Requirements

KIPS Requirements:

In order to be qualified to utilize the KIPS assessment, an online training must be completed. This training includes an overview of the KIPS curriculum, in depth discussion of each of the 12 KIPS items, practice videos to learn to accurately score parent behavior, and instruction on how to interpret KIPS results. A video library is also provided that includes play session recordings one can use to practice scoring KIPS items. After passing the final exam within the KIPS training and obtaining KIPS certification, one must be re-assessed online annually to be recertificated. Many professionals have the credentials needed to qualify for the KIPS training, including social workers, family therapists, visiting nurse services, early intervention programs, child abuse/neglect preventionists, psychologists, and Early Head Start employees to name a few.

CPRT Requirements:

In order to gain qualification to utilize CPRT, an extensive amount of play therapy or filial coursework and supervised experience is recommended. Landreth and Bratton (2006) note that many professionals who consider themselves filial therapists completed introductory play therapy courses in their graduate experiences and typically have a master's degree or higher. Additionally, supervision from a play-focused therapist during direct and practicum experiences is encouraged as well. Finally, several personal characteristics are noted as essential of filial therapists which include: self-understanding and insight; qualities that facilitate the learning environment in the filial therapy relationship; warmth and caring personality; an attitude and tone that promotes learning; intentionality about creating a positive atmosphere; free of the threat of anxiety and openness to parents as they are; the ability to be accepting; future-mindedness; personal courage; patience; a sense of humor.

Conclusion

The power of the caregiver bond can heavily influence a child's overall development. Further, this relationship has the potential to positively impact child characteristics such as self-confidence, emotional regulation and understanding, sense of security, and the ability to create healthy relationships in the world around them. CPRT and KIPS seek to harness the tool that is the child-caregiver relationship by enhancing its strength through play while also teaching valuable parenting skills. The use of CPRT and KIPS simultaneously within one regimen may provide a filial treatment that is efficient and individualized to each participant.

References

Beijan, L. L. (2020). Incorporating interpersonal neurobiology in child parent relationship therapy. International Journal of Play Therapy, 29(2), 65–73. https://doi-org.libproxy.eku.edu/10.1037/pla0000113

Blair, K., Topitzes, J., & Mersky, J. P. (2019). Brief, group-based parent-child interaction therapy: Examination of treatment attrition, non-adherence, and non-response. Children and Youth Services Review, 106. https://doi-org.libproxy.eku.edu/10.1016/j.childyouth.2019.104463M Comfort & PR Gordon (2006). The Keys to Interactive Parenting Scale (KIPS): A Practical Observational Assessment of Parenting Behavior. NHSA Dialog: A Research-To-Practice Journal for the Early Intervention Field, Volume 9(1), 22-48. Alexandria, VA: National Head Start Association Research and Evaluation Department.

Bratton, S. C., Landreth, G. L., Kellam, T., & Blackard, S. R. (2006). Child parent relationship therapy (CPRT) treatment manual: A 10-session filial therapy model for training parents. Routledge/Taylor & Francis Group.

Comfort, M., Gordon, P.R. & Naples, D. (2011). KIPS: An Evidence-Based Tool for Assessing Parenting Strengths and Needs in Diverse Families. Infants & Young Children: An Interdisciplinary Journal of Early Childhood Intervention, 24(1), 56-74.

Comfort, M., Gordon, P. R., & Naples, D. (2011). KIPS: An evidence-based tool for assessing parenting strengths and needs in diverse families. Infants & Young Children, 24(1), 56–74. https://doi-org.libproxy.eku.edu/10.1097/IYC.0b013e3182001bd3

Cornett, N., & Bratton, S. C. (2014). Examining the impact of child parent relationship therapy (CPRT) on family functioning. Journal of Marital and Family Therapy, 40(3), 302–318. https://doi-org.libproxy.eku.edu/10.1111/jmft.12014

Dunst, C. J., & Kassow, D. Z. (2008). Caregiver sensitivity, contingent social responsiveness, and secure infant attachment. Journal of Early and Intensive Behavior Intervention, 5(1), 40–56. https://doi-org.libproxy.eku.edu/10.1037/h0100409

Dyer, K., Hooke, G. R., & Page, A. C. (2016). Effects of providing domain specific progress monitoring and feedback to therapists and patients on outcome. Psychotherapy Research, 26(3), 297–306. https://doi-org.libproxy.eku.edu/10.1080/10503307.2014.983207

Johnson-Clark, K. A. (1996). *The effect of filial therapy on child conduct behavior problems and the quality fo the parent-child relationship* (Doctoral dissertation). Retrieved from ProQuest Dissertation and Theses. (AAT 9626460).

Ley, T. A. (2018). Child parent relationship therapy: A program evaluation [ProQuest Information & Learning]. In Dissertation Abstracts International Section A: Humanities and Social Sciences (Vol. 78, Issue 7–A(E)).

Newnham, E. A., Hooke, G. R., & Page, A. C. (2010). Progress monitoring and feedback in psychiatric care reduces depressive symptoms. Journal of Affective Disorders, 127(1–3), 139–146. https://doi-org.libproxy.eku.edu/10.1016/j.jad.2010.05.003

O'Reilly, A. W., & Bornstein, M. H. (1993). Caregiver–child interaction in play. In M. H. Bornstein, A. W. O'Reilly, M. H. Bornstein (Ed), & A. W. O'Reilly (Ed) (Eds.), The role of play in the development of thought. (pp. 55–66). Jossey-Bass.

Parr, J. R., Gray, L., Wigham, S., McConachie, H., & Couteur, A. L. (2015). Measuring the relationship between the parental broader autism phenotype, parent–child interaction, and children's progress following parent mediated intervention. Research in Autism Spectrum Disorders, 20, 24–30. https://doi-org.libproxy.eku.edu/10.1016/j.rasd.2015.07.006

Rogoff, B., Malkin, C., and Gilbride, K. "Interaction with Babies as Guidance in Development." In B. Rogoff and J. V. Wertsch (eds.), *Children's Learning in the Zone of Proximal Development.* New Directions for Child Development, no. 23, San Francisco: Jossey-Bass, 1984.

Ros, R., Graziano, P. A., & Hart, K. C. (2017). Parental homework completion and treatment knowledge during group parent–child interaction therapy. Journal of Early Intervention, 39(4), 299–320. https://doi-org.libproxy.eku.edu/10.1177/1053815117718491

Smith, J.C., Cumming, S., Xeros-Constantinides, S. (2010). A Decade of Parent and Infant Relationship Support Group Therapy Programs. International Journal of Group Psychotherapy; 60(1); Academic Research Library pg. 59

Tal, R., & Tal, K. (2017). Child-parent relationship therapy—A dialogue with Winnicott's theory. International Journal of Play Therapy, 26(3), 151–159. https://doi-org.libproxy.eku.edu/10.1037/pla0000051

Wickstrom, A. C., & Falke, S. I. (2013). Parental perceptions of an advanced filial therapy model. Contemporary Family Therapy: An International Journal, 35(1), 161–175. https://doi-org.libproxy.eku.edu/10.1007/s10591-012-9228-0

Willis, A. B., Walters, L. H., & Crane, D. R. (2014). Assessing play-based activities, child talk, and single session outcome in family therapy with young children. Journal of Marital and Family Therapy, 40(3), 287–301. https://doi-org.libproxy.eku.edu/10.1111/jmft.12048