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Emotional Dysregulation in Children

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Emotional Dysregulation in Children

By

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, MN
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University and St. Thomas University School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the University Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The number of children diagnosed and struggling with a mental health disorder within the United States is increasing quickly (Lin and Bratton, 2015). With this population of children becoming bigger each day the need for effective prevention and intervention strategies to help children learn how to emotionally regulate continues to grow in importance. The following study asks the question: what do clinicians find to be the most effective interventions in helping children ages three to twelve learn how to regulate their emotions? Semi-structured interviews were conducted with mental health professionals within the Twin Cities metropolitan area to answer this question. The data collected was analyzed using the Grounded Theory model in order to identify major reoccurring themes within the interview data. The researcher discovered misdiagnosis of ADHD and other disorders whose symptoms mimic each other is a great concern of the clinicians studied. These clinicians believe the most common underlying issue with emotion dysregulation is childhood trauma. Clinicians also believe parent/caregiver/family involvement is crucial to the effectiveness of the skills and interventions being taught in therapy sessions. The types of therapy and/or skills being used by the therapist were deemed essential to therapeutic success, and the ways in which the clinicians learned to implement the skills and interventions they used in sessions were critical for positive child outcomes.

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Introduction

The childhood years are an essential time in human development. Children ages three to twelve are forming the foundation for the morals, values, beliefs and experiences they will have as adults. With this in mind, it is crucial we focus our attention on the importance of a child's ability to regulate their emotions. Without effectively being able to regulate their emotions, children may act out and exhibit signs in both external and internal ways (Kramer et al., 2014). However, if parents, teachers, and other adult figures are properly trained on assisting children in effective emotion regulation, children's difficulty with emotional regulation and resulting misdiagnosed mental health issues would decrease and hopefully dissipate altogether.

According to Thompson (1994), emotion regulation is "the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (pgs. 27-28). Effective emotion regulation skills help a child to regulate any and all emotions in order to keep themselves calm and collected. However, without effective emotion regulation skills a child may struggle in many areas of their life. With a proper definition and understanding of what emotion regulation is, parents and professions can help children develop these essential skills.

The focus on children's mental health and emotional health continues to grow as the rate of children being diagnosed with mental health disorders in the United States increases (Jayne & Ray, 2016). According to Mental Health America (n.d), "approximately 20% of children develop mental health problems severe enough to meet diagnostic criteria, but less than one third of them receive help" (Cited by Lin and Bratton, 2015). With this population of children becoming bigger each day, the need for effective prevention and intervention strategies continues to grow in importance. There are many issues which can manifest when children are struggling with

emotion regulation. Untreated mental health problems can disrupt children's functioning at home, school and in the community (Mental Health America, n.d). Each child is different, and therefore expresses symptoms differently. Some signs parents, caregivers, and teachers can look for include: constant worry or anxiety, repeated refusal to go to school or to take part in activities, hyperactivity or fidgeting, persistent nightmares, persistent disobedience or aggression, frequent temper tantrums, sadness, and irritability (Mental Health America, n.d). These symptoms can be common for a number of mental health disorders therefore it is important if children are exhibiting these behaviors that they receive a thorough and professional assessment.

Due to the increase in the number of children experiencing these problems, clinicians and researchers also need to stay current in their knowledge about the most effective therapeutic interventions being used to help children ages three to twelve manage emotion dysregulation when it occurs. Two popular interventions currently being used are Child Centered Play Therapy (CCPT) and Parent- Child Interaction Therapy (PCIT). While these two interventions are popular and well known, my research interest is finding the most effective interventions for assisting children struggling with emotion regulation.

I was interested in conducting this study because I have enjoyed working with children since I was a pre-teen babysitting on the weekends. However, all of my work with children has shown me that children who struggle with emotion regulation when they are young often receive mental health diagnoses in the future. I have found, through my previous research, these two things are largely connected. Therefore, I wanted to conduct a qualitative study to find out what interventions clinical professionals, on the ground, are finding to be effective in working with children struggling with emotion regulation to prevent a mental health diagnosis in their future.

The current study asked the question: what do clinicians find to be the most effective interventions in helping children ages three to twelve learn how to regulate their emotions?

Literature Review

This study examines what clinicians have found to be effective in helping children struggling with emotional dysregulation disruptions to gain control of their emotion. By defining childhood emotion regulation, I will help the reader better understand the topic and be able to understand why emotion regulation is so important in the lives of children. Discussing the current prevalence of mental health diagnoses and ineffective emotion regulation in children will give the reader an understanding of just how big of an issue this topic is in regards to children today. Identifying the problems associated with difficulties in emotion regulation can help the professional identify other issues that may need to be addressed when working with a child struggling with emotional regulation. Presenting the most common types of interventions used to effectively address problems with emotion regulation can help the professionals working with children within this population know what therapies, skills, and techniques to use in their sessions to help the child succeed. Lastly, discussing the effects the interventions are having on this population of children can help the professional know what to assess to know if the interventions are working or not. All of these topics will be further discussed in the review laid out below.

Definition of Emotion Regulation

Emotion regulation is not a common term used in everyday conversation. That being said, I felt giving the reader a definition of emotion regulation would be beneficial to the overall understanding of this research. According to Thompson (1994), emotion regulation is “the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional

reactions, especially their intensive and temporal features, to accomplish one's goals" (pgs. 27-28). Successful emotion regulation can be a complicated skill to master if not taught at a young age. Because the ability to regulate emotions begins at a very young age, it can be difficult to change an existing pattern that becomes so deeply engrained within an individual.

Another definition, written in a more concise way, is presented by Zeman, Cassano, Perry-Parrish, & Stegall (2006), who state emotion regulation is "the ability to regulate how emotions are experienced and expressed, particularly within social relationships and challenging situations..." (as cited in Rawana, Flett, McPhie, Nguyen, & Norwood, 2014, p. 32). Emotion regulation is an essential ability that a child must learn in order to develop in a healthy manner across their lifespan (Rawana et al., 2014, p. 32). According to Gross and Thompson (2007), effective emotion regulation involves "initiating, maintaining, and modifying the occurrence, intensity, or duration of feelings" (as cited in Rawana et al., 2014, p. 32). Understanding the definition of emotion regulation, and all that goes into effective emotion regulation, will benefit the reader in understanding the topic and help professionals to better understand the importance of emotion regulation in the lives of children. Further research on the definition of emotion regulation is needed in order to ensure all professionals have a common conceptualization and understanding of its importance in children's lives.

Prevalence

Being aware of the current prevalence of children in the United States currently struggling with emotional and behavioral concerns is important as it often times points to ineffective emotion regulation abilities. According to Lin and Bratton (2015), "the number of young children in the United States with significant emotional and behavioral concerns is increasing at an alarming rate" (p. 45). With children struggling to manage their emotions and

behaviors comes an increase in mental health diagnoses. Hoagwood and Johnson (2003) indicate mental health conditions are at an all-time high in children with the number as high as 20% of students having a diagnosis (as cited in Kramer, Caldarella, Young, Fischer, & Warren, 2014, p. 660). Hoagwood and Johnson (2003) also explain 5% of the children with diagnosed mental health conditions have serious mental health needs due to the severity of their condition (as cited in Kramer et al., 2014, p. 660). With this severe increase in children being diagnosed with mental health conditions comes an increase in the need for better prevention techniques and intervention strategies.

Problems Associated with Difficulties in Emotion Regulation

Children struggling with emotion regulation may experience symptoms both externally and internally. According to Sanders, Merrell, & Cobb (1999), external symptoms can include “disruptive behaviors such as aggression, defiance, and hyperactivity” (as cited in Kramer et al., 2014, p. 660). These symptoms are expressed when a child is struggling to deter themselves from acting out (Kramer et al., 2014, p. 660). Sanders et al. (1999) explains that internal symptoms can include “depression, anxiety, and social withdrawal” and tend to be a result of a child trying to constrain themselves from acting out behaviorally (p. 660). While children may struggle with external and internal challenges due to emotional dysregulation, the adult and/or parents within the child’s life more often try to manage and/or regulate the external challenges (the behaviors) rather than the internal challenges (depression, anxiety, etc.). This is because the external challenges are easier for the parent to spot and pick up on than the internal challenges (Kramer et al., 2014, p. 660).

Common Types of Interventions

Given the increasing percentage of children experiencing problems in this area, and the negative impacts being seen in schools and at home, clinicians and researchers have been looking for types of intervention approaches most effective in helping children suffering from emotion dysregulation. One common intervention, currently found in the research, is Child-Centered Play Therapy (CCPT). According to Bratton, Ray, Rhine, & Jones (2015) CCPT is a widely-supported counseling technique (as cited in Lin & Bratton, 2015, p. 45). Russ (2003) and Vygotsky (1967) explain CCPT was developed using child development principles and strives to include play as a critical part of a child's all-inclusive development (as cited in Lin & Bratton, 2015, p. 45). CCPT includes two different forms of play/teaching: direct and indirect (Schaefer, 2011). According to Schaefer (2011), direct teaching

“allows you to overcome knowledge and skills deficits in client by direct instruction. For example, when you teach social skills to children using dolls, puppets, and role-plays, the children are more likely to learn and remember the lessons. The use of fun and games captures children's attention and increases their motivation to learn” (p. 17).

Schaefer (2009) goes on to explain that indirect teaching includes “storytelling and the use of play narratives [that] allow the child to join in interactive fantasy play with the therapist (as cited by Schaefer, 2011, p. 17). Indirect teaching provides children with the opportunity to learn their own lessons and find solutions to their own challenges (Gardner 1971, as cited by Schaefer 2011). According to Frey (1993), indirect teaching “is a gradual paced, indirect method with room for repetition that allows for less emotional arousal than direct confrontation” (as cited by Schaefer, 2011, p. 17).

Landreth (2012) states CCPT allows children to connect the existing gap between concrete and abstract thinking by allowing them to express their thoughts and feelings in a nonverbal way that they are familiar with (as cited in Lin & Bratton, 2015, p. 45). Play narratives allow for children to organize their disorganized experiences and memories into organized stories that their brains can more easily follow (Schaefer, 2011). Also, because play is natural, and is a universal expression for children, it can easily be used with children of all cultures and ethnic backgrounds (Schaefer, 2011).

Another common intervention currently being used is Parent-Child Interaction Therapy (PCIT). According to Hembree-Kigin & McNeil (1995) PCIT is an “individualized intervention developed for caregivers and their 4-7-year-old children with externalized behaviors” (as cited by Thomas and Zimmer-Gembeck, 2007, p.477). During PCIT therapy, a parent is coached through different strategies to try when interacting with their child with the anticipated outcome being that the child’s behavior will ultimately change as a result of the change in their parent’s behavior (Thomas and Zimmer-Gembeck, 2007, p. 477). PCIT also aims to improve the number of positive interactions that occur between the parent and child ultimately building up the dyad between the parent and child (Thomas and Zimmer-Gembeck, 2007, p. 477).

Parent-Child Interaction Therapy has been shown to be an effective evidence-based treatment. Thomas and Zimmer-Gembeck (2007) conducted a meta-analysis of PCIT in which 24 articles were analyzed and found that PCIT interventions “improve parenting, such as improving parental self-efficacy, and reducing negative child behaviors, such as aggression and extreme tantrums and opposition” (p.491). The meta-analysis also found that PCIT reduced the stress level of the parents involved in the PCIT services (Allen, Timmer, and Urquiza, 2014).

Parent Child Interaction Therapy is also utilized by therapists working with children of adoption to work on the attachment between them and their adoptive parents. (Allen, Timmer, and Urquiza, 2014). Results of a pilot data study on adopted children found that Parent-Child Interaction Therapy resulted in a substantial increase in positive parenting techniques, decrease in parenting stress, and decreases in externalizing and internalizing troubles in the child (Allen, Timmer, and Urquiza, 2014).

Understanding the most common types of interventions used in emotion regulation training is important because it helps the professional know, ahead of time, what techniques have been shown to be effective so he or she has a place to start. More research still needs to be conducted in this area, however. There needs to be more information out there about what specific skills and techniques within play therapy have been found to be effective.

Conceptual Framework

The conceptual framework I found most relevant to this study is Bronfenbrenner's Ecological Model. Bronfenbrenner's Ecological Model was first introduced in the late 1970s and made a huge contribution to the psychological research world of the mid-twentieth century (Bronfenbrenner, 1977). Previous psychological research at that time provided very little information in regards to the environmental aspects of children's psychological development (Bronfenbrenner, 1977). Bronfenbrenner's Ecological Model was the first model to use an ecological systems approach to explain the influence social and cultural aspects of a child's life have on their environment (Bronfenbrenner, 1977).

The defining properties of the Bronfenbrenner's Ecological Model are as follows:

especially in its early phases, and to a great extent course, human development takes place through processes of progressively more complex reciprocal

interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment. To be effective the interaction must occur on a fairly regular basis over extended periods of time. Such enduring forms of interaction in the immediate environment are referred to as *proximal processes*. Examples of enduring proximal processes are found in parent-child and child-child activities, group or solitary play, reading, learning new skills, studying, athletic activities, and performing complex tasks (Gauvain & Cole, 2005, p. 1).

In other words, Bronfenbrenner's Ecological Model stresses the importance of positive reciprocal interactions between a child and a positive adult caretaker beginning in the earliest phases of the child's development. Bronfenbrenner's model also explains that in order for the interactions to be effective they must occur on a fairly regular basis over an extended period of time (Bronfenbrenner, 1977). When the child experiences these positive reciprocal interactions on a regular basis over an extended period of time it allows for them to develop healthy relationships with others and allows for them to develop in a natural and positive way.

Bronfenbrenner's Ecological Model also goes on to explain the importance of microsystems, mesosystems, exosystems, and macrosystems in a child's development. A microsystem is "the complex of relations between the developing person and environment in an immediate setting containing that person (e.g., home, school, workplace, etc.) (Bronfenbrenner, 1977, p. 514). A mesosystem

"comprises the interrelations among major settings containing the developing person at a particular point in his or her life. Thus, for an American 12-year-old, the mesosystem typically encompasses interactions among family, school, and a

peer group; for some children it might also include church, camp, or workplace...” (Bronfenbrenner, 1977, p. 515).

According to Bronfenbrenner (1977) an exosystem

“is an extension of the mesosystem embracing other specific social structures both formal and informal, that do not themselves contain the developing person but impinge upon or encompass the immediate settings in which that person is found, and thereby influence, delimit, or even determine what goes on there. These structures include the major institutions of the society, both deliberately structured and spontaneously evolving, as they at a concrete local level” (p. 515).

Two examples of exosystems effecting a developing child would be the relation/s that exist between the child’s home environment and the parent’s workplace environment and/or the relation/s that exist between the child’s school environment and the community in which they live. A macrosystem “refers to the overarching institutional patterns of the culture or subculture such as the economic, social, educational, legal, and political systems of which micro-, meso-, and exo- systems are the concrete manifestations” (Bronfenbrenner, 1977, p. 515). Another way to look at macrosystems is by thinking of them as “a societal blueprint for a particular culture or subculture” (Gauvain & Cole, 2005).

Bronfenbrenner’s Ecological Model applies to this study because it assesses the developing child as a whole. What I mean by this is that the model not only looks at the child’s psychological development, as previous models have, but it also looks at things within the child’s environment, people within the child’s life, and the pre-existing societal norms that may affect the child’s development. As a social worker, I appreciate this model because it assists me in looking at all the different systems that may be affecting the child’s development and mental

state. This model can help the clinical professional look at all the moving parts, within the child's life, to better assess the sources of the child's emotion dysregulation and behavioral challenges.

Methods

Research Design

The purpose of this study is to further investigate and describe the interventions currently being used with children who are seeking therapy services for emotional dysregulation. This study sought to answer the research question: what do clinicians find to be the most effective interventions in helping children ages three to twelve learn how to regulate their emotions? A qualitative design was used because, as described by Grinnell, Williams, and Unrau (2016), "qualitative data are collected to 'build' a story or understanding of a concept or variable" (p. 372). This was ideal for this particular study because I was seeking to build an understanding of the interventions therapists find most effective in the emotional regulation of children's mental health development.

This study included qualitative interviews with professionals to gather the results. I held semi-structured interviews with clinical professionals working with children ages three to twelve struggling with emotion dysregulation. Qualitative interview questions (Appendix A) were designed based on my previous research, the literature review and discussion with my MSW Research Committee.

Sample

The sample was collected from a large Midwest metropolitan area. A purposive sample was used to recruit clinical professionals working with children who are struggling with emotion dysregulation. I consulted with peers, professional contacts, and members of my MSW Research

committee for assistance in recruitment. Communication with these peers and professionals was via email. The email script is attached below (Appendix B).

When individuals were interested to know more about the study they were instructed to contact me directly via email or phone. During this first contact I described the study in more detail, reviewed the consent form with the interested individual, asked if they had any questions, and asked if they were still interested in participating in the study. If the individual was still interested in participating I then scheduled a date, time, and location to host the interview. Six clinical professionals, with varying master's level degrees, were interviewed for this research project. Two participants had their Doctoral Degree in Psychology while the other four participants were Licensed Independent Clinical Social Workers (LICSW). Although it was not required to participate in the study, all six participants also held a professional certificate in Trauma-Based Cognitive Behavioral Therapy.

Protection of Human Subjects

Those who decided to participate in the research study were asked to sign a consent form at the beginning of the interview. The consent form included background information about the study, the procedures of the study, and the risks and benefits the study poses. The consent form was based on a template designed by the St. Catherine's University Institutional Review Board (IRB) and was edited to fit the context of the current study.

When interested respondents first contacted me, I explained that all contact information would be locked up in a file cabinet or on a password protected computer. I ensured the participants understood the confidentiality of the study and that since their participation was voluntary that they could back out at any time if they chose to. I also informed all participants that there are no negative consequences if they choose to withdraw from participation in the

study (Appendix C). Consent forms will be kept in a locked filing cabinet and destroyed three years after completion of the study.

All recordings of interviews are being kept on a password protected computer, on OneDrive, and the password protected computer is being kept in a locked and secure location at all times. All recordings will be destroyed by June 1st, 2017. Any and all identifying information about the research participants has been omitted from the findings and results.

Data Collection

The only instrument used in this research study was the semi-structured interview questions listed in Appendix A of this proposal. The qualitative interviews were conducted in person in a private location of the participant's choice. In the case that the participant couldn't meet in person, the interview was conducted via phone in a private location (only one interview was conducted over the phone). I recorded the interviews in order to go back later and transcribe the interview. The participants' names were changed in the transcriptions to protect their confidentiality. Also, all transcripts, are saved on a locked computer on OneDrive, with an assigned study number to prevent names being used. All recordings will be destroyed by June 1st, 2017.

Data Analysis

Upon completion of the interviews, I hired rev.com to transcribe the data recorded from each interview conducted. This researcher ensured the confidentiality of the transcription services offered by this company by reading through and signing their electronic consent form. The typed-out transcriptions were then used for analysis by me and my MSW committee.

A Grounded Theory approach was used to analyze the data collected from the interviews. Grounded Theory was used because of the limited information on this topic. Grounded theory

was also used because it allowed for inductive theory building which means I was able to begin with the specific information gained from the subjects and develop the information into more generalizable themes. Lastly, Grounded Theory was used because the coding process within Grounded Theory is unrestricted and allows for concepts to emerge from the data itself and did not rely upon prior knowledge or theory (Patton, 2002).

According to Strauss & Corbin (1990), Grounded Theory analysis consists of three phases “open, axial, and selective” (as cited by Creswell, 2007). Therefore, the first stage of my coding process was the “open coding” stage. This stage, according to Strauss and Corbin (1990), consists of “developing categories of information” (as cited by Creswell, 2007). So during this first stage I read through my transcriptions and created themes from the information shared during all six interviews. The next stage was the “axial stage” during which I “interconnect[ed] the categories” meaning that the data and themes were compared and related to one another to determine how they related to the central focus, emotion dysregulation in children (Creswell, 2007). Lastly, I performed the selective stage of coding which according to Strauss and Corbin (1990) consists of “building a ‘story’ that connects the categories and ending with a discursive set of theoretical propositions” (as cited by Creswell, 2007). For this final stage I created a “story” connecting all the themes back to the main theme, emotion dysregulation, and conceptual framework, Bronfenbrenner’s Ecological Model, and included this information in the discussion section of this paper.

Findings

This research study was conducted in an attempt to answer the following question: what do clinicians find to be the most effective interventions in helping children ages three to twelve learn how to regulate their emotions? A review of data from six study participants revealed four

themes that emerged from the interview questions asked. The six study participants consisted of four clinicians working in outpatient children's mental health settings and two clinicians working in school-linked mental health therapist positions. Five of the six participants were female with the sixth participant being male. Of the six participants five were Caucasian and the sixth participant was Latino.

ADHD Misdiagnosis and Other Misdiagnoses

All six of the study participants began the interview by discussing the importance of the correct diagnosis for each client they are working with. Clinicians discussed ADHD misdiagnoses and/or other mental health misdiagnoses and how misdiagnosis can derail the effectiveness of treatment until the clinician is able to find the correct diagnosis for the child and work on skills and interventions that have been found to be effective for that diagnosis. They explained that their methods, skills, interventions, and treatments will not be effective unless they are ones with a strong evidence base for their client's specific diagnosis.

All the participants explained how many parents come in to their agency stating their child is hyperactive, acting out a lot, and therefore must have ADHD and needs help. However, the clinicians explained often it takes a clinician's perspective to evaluate what is going on for that client. Clinicians explained often times children can be given a diagnosis that is later discovered to be a misdiagnosis because the child is actually suffering from trauma and not the original diagnosis he or she was given. One participant stated,

“I see that ideology come in my room. My kid has ADHD, my kid has ADHD, my kid has ADHD. Once we assess, no he doesn't. The kid sits in my office for 50 minutes and focuses and doesn't have all of the typical ADHD stuff, he has trauma”.

Another clinician explained this by stating that “PTSD and ADHD mimic each other. Irritability, impulsiveness, hyper arousal, sounds like ADHD. Well, it’s also Post Traumatic Stress Disorder. So, I’ve been here three years, and in the three years I’ve diagnosed ADHD maybe twice...”

Participants went on to explain ways in which therapists can assure the child has been correctly diagnosed. All the participants stressed the importance of assessment and collecting data from multiple individuals involved in the child’s life. One participant stated that they, use the [Strengths and Difficulties Questionnaire] for everything, it’s just part of our [Diagnostic Assessment] process because that can be a really good guide to just let you know are parents and teacher seeing problems more emotion, conduct, behavior, inattention. You know, what are they kind of seeing. Once you can narrow down that spectrum, then there is a trauma assessment called the UCLA-5, which is actually a check list that you go through with the child that have every possible trauma that could happen. Another participant explained they believe some of the misdiagnoses come from the fact that our culture is focusing strictly on the behaviors we are seeing from the child and not what may be causing the behavior,

I’m still seeing things in the community where there is a difference in perspective and in perception of what is wrong with a child. And it’s focused mainly on behavior only. So that’s just what I encourage people to continue to push through that. What is driving that behavior? What’s really going on? ‘Cause those two diagnosis [PTSD and ADHD] mimic each other, for sure.

Parent/Caregiver/Family Involvement

All six of the study participants stressed the importance of parent/caregiver/family involvement in the therapy process in order for the skills and interventions to truly be effective.

One participant explained that “chances of success, I feel, go up when everybody’s involved”. However, the clinicians also explained that they can’t force the parents to get involved. One participant expressed that they “try to encourage the families” by “send[ing] home another copy of the social story, but do I think those books ever get opened again? In a lot of cases, no.”. All participants stressed that they often wish they could increase parent/caregiver/family involvement but at the end of the day it is their choice.

All six of the study participants also addressed the importance of consistency within the child’s life as an important factor in ensuring the success of methods and interventions used. One participant explained that some children may be more challenging to work with due to the fact that a diagnosis has not yet been given leaving the clinician unsure of what interventions and methods would be effective, “the most challenging kids I can think of right now didn’t have a diagnosis because they don’t have parents that follow through and get that diagnosis...”. The same clinician explained that she and her team will

sometimes we’ll do scheduling to help keep things consistent at home. We’ll help them a visual schedule or some stuff like that...More of the interventions at home are more just around structure and routine for kids, because yeah, unfortunately a lot of families are at the point where they aren’t even wanting to participate in any kind of social emotional intervention...in some cases, we are the only mental health intervention that some of the kids get, and it’s just so little. It’s something that can get frustrating.

Four of the six participants discussed the struggles that an unhealthy, unsafe, and/or chaotic home environment can create. One participant stated,

I think what’s more important is if they [the families] can stabilize the home life. So, most of the time when I’m talking to parents, it’s about getting the services they need to

have a more stable home. As far as the actual interventions, I don't usually get to that point with families because it's more life, okay how do we get your kids back because they're in foster care right now. Or, how do we avoid getting them taken away because [Child Protective Services] is involved, or how do we just have a calm enough environment that you can get them to school on a regular basis. The majority of the families I work with, it doesn't even feel logical to ask them to do any kind of practice at home.

Three of the six participants also discussed the crisis that families may be in at the time of starting therapy services. One participant explained this by stating,

I can't stress enough the crisis our families are in. I came in with a lot of experience, but I was blown away. Even I was shocked. It was like every Diagnostic Assessment I was like 'oh my God, oh my God, oh my God'. Just horrific stories. It's a very small percentage that are involved in doing family therapy. Of my 21 or 22 clients, I can't say 20 of them are involved. Maybe seven or eight. And then we have some who are just not involved at all. It's minimal phone contact. So, I wish they were more involved.

Types of Therapy and Skills being Used

All the study participants touched on the different types of skills and/or therapies they have found to be successful in their work with children struggling with emotion dysregulation. For one clinician, she explained that she has found Cognitive Behavior Therapy (CBT) to be extremely helpful in helping her clients learn the basic skills necessary to continue to more challenging things in therapy. She explained the success of CBT for her clients by stating:

I think for an emotionally dysregulated kiddo, Cognitive Behavioral Therapy is great because they need those skills that you do in CBT. They need to know the calming

strategies because they don't have them. They need to know affect identification and regulation because a lot of times they don't have that skill. Then the cognitive coping piece, I have found is really huge to helping them to just understand the link between behaviors and moods. A lot of times, it's just super beneficial to get them to understand the piece of it. Then they have kind of an 'aha moment' like 'oh, I am angry right now. I get to choose. I get to choose how I act'. That's huge.

All six participants within the study explained that Child Centered Play Therapy (CCPT) is a huge part of their practice, whether it be indirect or direct play. As one participant indicated by stating,

I do a lot of play therapy. It's hard to talk as a kid. It's hard to verbalize everything and intellectualize everything, so I do a lot of play therapy to help support the emotional expression and processing, but also to help them feel comfortable in the setting. To also provide those breaks and that positive reward too, for when we do the tough stuff.

Another clinician discussed CCPT by explaining the difference between direct and indirect play and how they decide when to use which by stating,

The client goes and I just kind of follow. So, with that, it non-direct play therapy. So, the theory is play is how the client's gonna process what he needs to process. So that's my foundation, but then as we do the assessment and intake, it may become relevant that we may need to jump into more direct play. Because the kid doesn't have an ability, has limited skills, or just not quite moving, so let me jump into some direct stuff.

All six of the study participants happened to be trained and certified in Trauma Based Cognitive Behavioral Therapy (TBCBT). This was not something that I had come across in my initial

review of the literature. All clinicians had great things to say about their TBCBT training including one clinician who explained,

I'm also certified in Trauma Based Cognitive Behavioral Therapy. So, with my trauma kiddos, not all of them, but many of them at some point during their course of working with me, I'll utilize that model with them as well... because the kids I work with right now are so explosive, have such a level of aggression, are so overwhelmed by their emotions, part of the therapy session is often just giving them that context to get the feelings out and then the additional work we're doing on coping skills and processing. But sometimes it's just a matter of let's get it out in a safe way, in more of an acceptable way.

Three of the six clinicians also talked about the importance of meeting the client and their family where they are. They also discussed the importance of knowing what the child's needs are and placing them in order of importance to decide what to work on first. One clinician explained this process by stating, "I base it upon the kiddos needs and what their goals are. So, driven by their Diagnostic Assessment and their treatment plan, the identified hopes and goals that they have for themselves, but then their parents as well."

Another clinician explained that they base their methods and/or interventions on

what the emotional dysregulation looks like, and the behaviors. In schools, unfortunately, that's where the focus is, it's very behavioral based. I take that consideration, and I take the diagnosis, the behavior, and what it is that the child is saying. I also consider what their level of awareness is.

All six clinicians talked a lot about the breathing techniques, calming strategies, and mindfulness practices that they have found to be helpful in their practice with children. One clinician explained by stating,

I almost always start out self-regulation type of stuff with doing exercises with the child about body awareness. What are you noticing? What do you notice in your body when you're angry? Where are you feeling that in your body? That will tell me a lot. I always tend to go toward breathing first because it's the easiest. It's one that can be applicable across the board for anxiety, trauma, and ADHD grounding. Mindfulness are really, really helpful because a lot of times it's just drawing them back into the environment is what they need, and that's apt to do that. For my kids that are really impulsive and do lots of body movement stuff, they're leaving the classroom, they're running around the school all day, I'll do body movement stuff. It's clear that is their sensory need is to move their body. So we'll do muscle relaxation. I'll start out with easy muscle relaxation that they can do in the class likes seared, but nobody would have to know. Also yoga type stuff, ways that they can engage their body.

All six of the study participants stated that their interventions stayed the same across the cultural gamut, however, they also stated that they want to be aware of the cultural background of their clients. One participant stated,

I make it a priority to be aware of and to take cultural considerations. I offer time and space to give the family the opportunity to express any concerns or anything they want me to take into consideration. I haven't had any families give me feedback about anything specific, but that doesn't mean it won't happen. So yeah, it's there on the table for me to give that space, is what I would say.

The clinicians stressed the importance of keeping culture in mind when choosing a method and/or intervention to use with the client. For example, one clinician explained

I had a kiddo who had a lot of nightmares. I wanted to do a dream catcher with him, but I had to check it out with his mom. They were Jehovah Witnesses, and she wasn't okay with us calling it a dream catcher, but it was okay for us to call it like a worry web. So, I kind of check those things out so we're not being disrespectful.

How Clinicians Have Learned to Implement the Strategies and/ or Interventions Used

When study participants were asked about how they learned to implement the methods and/or interventions that they are now using in their practice their answers were all very similar in nature. One participant did a great job of summing it all up by stating,

lots and lots of practice...I'd say just the combination of reading lots of research, and then actually putting it into practice, and then consulting when it feeling like I'm trying to do something new...Also, years of just videotapes and actually watching my videotapes, maybe sometimes eventually when I'm watching the ones where I feel like that was a challenge and then bringing that to supervision and specifically going over 'okay, here's a part that I thought didn't go well' to see what another professional would say. Really working hard in coping in my own mind 'okay, this is the feedback I got. If that were to happen again, this is how I'd try to do it differently. Rehearsing before having sessions.

When clinicians were asked about how they know that their methods and/or interventions are working/ how they measure success, all six individuals had very similar answers once again.

None of the clinicians shared if there are any specific scales and/or measurements tools that they use to assess and measure the success of the interventions used. I felt one clinician did a good job of summing up all that was said by all participants by stating,

I'll measure from feedback from the client directly. And then people I collaborate with. Teachers, anyone involved in the kid's life. Mom, dad, grandpa, neighbor. So, we look for frequency, duration, and intensity... This is the context that we're dealing with, years and years of severe trauma that has ultimately resulted in inability to emotionally regulate. We'll check in with the child, is he able to recognize emotions?

Discussion

This study examined the methods that clinicians are finding to be effective when working with children struggling with emotion dysregulation. The research aimed to understand how the clinicians learned to use the methods and interventions that they use, how they implement them in their practice with children, and how they evaluate the effectiveness of the methods and interventions being used. Five clinicians were Master's level clinicians and one had a Doctorate in Psychology. Although it was not required, all were certified in Trauma Focused Cognitive Behavioral Therapy on top of their clinical degree. The discussion will expand upon the connections of the findings from this research study to the research discussed in the literature review.

ADHD Misdiagnoses and Other Misdiagnoses

The findings about ADHD misdiagnoses and other misdiagnoses were unique to this study. This was not information this researcher found or read about in the previous research findings. The current findings indicate that many children are coming in with symptoms similar to that of ADHD: hyperarousal, inability to focus, and inability to sit still. However, as the study participants indicated, there are many diagnoses whose symptoms mimic that of ADHD, one of the main ones being trauma exposure and PTSD.

Because symptoms can mimic one another, it was made clear through the interviews thorough assessments are needed for all children struggling with emotion dysregulation challenges in order to ensure proper diagnoses. With proper diagnoses clinicians felt they were able to devise the most appropriate methods and interventions and hopefully effective therapy sessions.

When considering Bronfenbrenner's Ecological Model, I would say that the ADHD misdiagnoses and other misdiagnoses represent mezzosystems that may emerge for a child struggling with mental health diagnoses and emotion regulation difficulties. The interactions between a child's caregivers, school teachers, and other individuals working with him or her and their communication with the professionals working to diagnose the child is essential. In order to ensure the correct diagnosis, and the correct treatment to follow up the diagnosis, the professional needs to talk to those who are working with the child on a daily basis to collect all the necessary information to make a diagnosis.

Parent/Caregiver/Family Involvement

Parent/Caregiver/Family involvement came up frequently in the current study. All six participants within this study stressed the importance of family member involvement in order to ensure successful and effective interventions. However, all clinicians also discussed the lack of parent involvement in their current practice. They all explained they wished their clients' families were more involved as they know higher levels of family involvement would result in more positive movement forward in the child's ability to cope and handle their struggles.

In Bronfenbrenner's Ecological Model parent/caregiver/family involvement would be considered the microsystem present within the lives of these children. The relationships present between the child and the individuals present within their school, home, and community would

be considered microsystems that affect their lives and their development. Children's parents, teachers, neighbors, friends, etc. play a big role in the development of the child and the development of their ability to regulate their emotions effectively. If the children's microsystems are chaotic and/or unstable the child may develop ineffective coping strategies and struggle with emotion regulation.

Types of Therapy and Skills Being Used

Child Centered Play Therapy came up in both the literature review and this study. Both previous research and this current research stress the success and effectiveness of this form of therapy with children struggling with emotion regulation.

When beginning my research, I had originally wanted to focus on children ages three to five and did not originally consider the importance of Cognitive Behavioral Therapy and its role in emotion regulation. However, after expanding my age range to ages three to twelve it became clear Cognitive Behavioral Therapy is an effective therapy to use with older children, as stated by many of my study participants. Multiple participants explained the effectiveness of CBT for the older end of my age range as it helps them develop the basic self-regulation skills that they didn't develop at a younger age.

Even more specifically, all clinicians talked about the role of trauma and were trained in Trauma-Focused CBT (TF-CBT). TF-CBT is an evidence-based intervention that has been "shown to help children, adolescents, and their caregivers overcome trauma-related difficulties" (Child Welfare Information Gateway, 2012, p. 1). According to Child Welfare Information Gateway (2012) TF-CBT

"is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic events...The

treatment-based on learning and cognitive theories-addresses distorted beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experience (p. 1).

Another evidence-based intervention which focuses on healing childhood trauma is Child Parent Psychotherapy (CPP). Child Parent Psychotherapy is a therapeutic intervention used for “children and their parents who have experienced at least one form of trauma (e.g. maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and are presenting with different problems as a result” (National Resource Center for Permanency and Family Connections, 2013, p. 1). According to Center for Permanency and Family Connections (2013) “the primary goal [of CPP] is to support and strengthen the relationship between a child and his or her parent (or caregiver) in order to repair the child’s sense of safety, attachment, and appropriate affect to ultimately improve the child’s cognitive, behavioral, and social functioning” (p. 1). Neither TF-CBT or CPP came up during the initial literature review which may indicate conceptual or professional silos.

Taking cultural considerations when planning methods and intervention to use with a client is of great importance. This will ensure that a strong trust and rapport remains between the client and clinician and the family. It’s better to be sensitive than to be sorry later when your method or intervention crosses a boundary that the client and/or family may have due to culture.

Implications for Social Work Practice

Being aware of the problems associated with difficulties in emotion regulation is important because it can help the professional be aware of these difficulties ahead of time and better intervene when they are encountered. Understanding the effects the interventions have on a child struggling with emotion regulation is important because it helps the professional

determine whether or not the therapies, skills, and techniques they are using are working. If the professional finds the child is still not effectively managing their emotions after a specific time period, the professional may need to re-evaluate and decide to try a different strategy with the child. This research can help individuals working with these children in order to best meet their needs and help them and their families achieve their treatment goals and personal goals.

Professionals should use this research to help better their practice and to help advocate for betterment of the current services being offered to children struggling with emotion regulation.

Implications for Policy

As the public becomes aware of how important of an issue emotion regulation is the more willing they will be to demand policies and services addressing the need. Previous research and current research on children's struggles with emotion dysregulation justify the need for a mental health policy change to help children and families be able to afford the help these children so desperately need. It is a social worker's ethical responsibility to create and advocate for policies addressing the gap in services for this population of children. Future policies should consider previous research and current research findings in order to better strengthen their argument for the need for change in this area.

Implications for Future Research

Understanding the prevalence of mental health diagnoses and ineffective emotion regulation skills in children is important because it conveys how big of an effect this issue is having on children in our country today. Further research needs to be done on different ways to measure the effectiveness of the strategies being used to address emotion regulation. A more specific measuring tool, or questionnaire, may be useful in this situation.

Research on the barriers to therapeutic services and how to address those barriers would be beneficial to the mental health profession. Including more individuals in additional research studies would also be beneficial to ensure that the information collected covers a large majority of mental health professionals working under different licenses, in different agencies, in different locations.

More research needs to be done regarding the exact number of children suffering from an inability to regulate their emotions effectively. Research also needs to be done on the population that ineffective emotion regulation most heavily affects; does it impact one population more than another? If so, why is it that way? Professionals and students can also use this research as a building block to work toward furthering research around this topic as there is much more that is still needed.

Strengths and Limitations

The current study consists of strengths and limitations that influence the validity and reliability. The strengths of this qualitative research study include the open-ended question use allowing for more in-depth answers and information from the participants. Another benefit of this study is that it gave the therapists being interviewed a chance to talk about and reflect upon their experiences. The participants were all able to describe, in detail, the struggles these children face and the methods and interventions they are finding to be effective when working in a therapy setting with them.

One limitation of this qualitative research study is that the answers the participants gave are personally biased as they are answering them from their personal therapy practice lens. Therapists may have only shared their successes with me or the things I they thought I wanted to hear rather than choosing to share their true feelings on certain questions. Another limitation is

my inability to interview more professionals due to time constraints for this project. This study included a short time frame which didn't allow for data collection until reaching saturation. Another limitation was my inability to triangulate the data because of the limited scope and resources of the project. According to Patton (2002) "triangulation strengthens a study by combining methods or data, including using both quantitative and qualitative approaches" (p. 247). Because I was unable to triangulate my research data, my data is not as strong as it could have been had I had more time to do more research and interview more participants.

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Appendix A

Interview Questions

- 1) Tell me about your job at _____
 - a. What does your daily schedule look like?

- 11) How are the parents/guardians/families of the children that you work with involved in the child's therapy?
- 12) How do you work with other systems helping the child?
- 13) What role does the parent play in the effectiveness of your intervention?
- 14) What are some other resources that your clients and client's families utilize?
- 15) How do you work with other systems serving this child?
- 16) Is there anything more that you'd like to share with me that you think is important for me to know but that I didn't ask about?
- 17) Do you have any questions for me?

Appendix B

Dear _____,

My name is Ali Kath and I am currently working toward my Masters in Social Work (MSW) degree at St. Catherine University/University of St. Thomas. One of the requirements of my MSW program is to complete a clinical research project. For my clinical research project, I have chosen to explore the experiences of therapists helping children develop effective emotion regulation skills.

If you are interested in participating in this study, please contact me via phone or email to receive more detailed information on the study. If you are still interested in participating after hearing more about the study, we will then set up a time to conduct the interview.

Thank you for your time,

Ali Kath
651-600-1325
Kath5369@stthomas.edu

Appendix C

CONSENT FORM UNIVERSITY OF ST. THOMAS GRSW682 RESEARCH PROJECT

Emotion Regulation with Children

I am conducting a study about effective techniques clinicians use to work on emotion regulation disruptions in order to work toward gaining control of the children's emotions. I invite you to participate in this research. You were selected as a possible participant because you are an clinical professional working with children on emotion regulation. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Alison Kath, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Mary Nienow.

Background Information:

Previous research has shown certain types of therapy, such as play therapy and Parent-Child Interaction Therapy, have been effective in helping children learn to regulate their emotions, disruptions, and gain control of their emotions. For this reason, I would like to talk with you more about what methods you have found to be effective when working with children with emotion dysregulation struggles.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in an audio recorded interview, over the phone or in person. The interview will be transcribed prior to the interview. All personal, identifiable information will be redacted from the interview.

Risks and Benefits of Being in the Study:

The study has minimal risk.

The study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential. Research records will be kept in a locked filing cabinet drawer within personal residence. I will also keep the electronic copy of the transcript in a password protected file on my computer. The audiotape and transcript will be destroyed by June 1st, 2017. This consent form will be destroyed three years from completion of the research, by June 1, 2017.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. However, de-identified data that I collected from you may be used in my final report.

Contacts and Questions

My name is Alison Kath. You may ask any questions you have now. If you have questions later, you may contact me at 651-600-1325. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date



Consent Form

[IRBNet Tracking Number] *Emotion Dysregulation in Children*

You are invited to participate in a research study about effective techniques clinicians use to work on emotion dysregulation disruptions in order to work toward emotion regulation. I invite you to participate in this research. You were selected as a possible participant because you are a clinical professional working with children ages three to five struggling with emotion dysregulation challenges. You are eligible to participate in this study because you have a graduate level clinical degree and are working with children ages three to five on emotion regulation skills. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Alison Kath, a graduate student at the University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

Previous research has shown certain types of therapy, such as play therapy and Parent-Child Interaction Therapy, have been effective in helping children learn to regulate their emotions, disruptions, and gain control of their emotions. For this reason, I would like to talk with you more about what methods you have found to be effective when working with children with emotion dysregulation struggles.

Procedures

If you agree to be in this study, I will ask you to do the following things: Participate in an audio recorded interview, over the phone or in person. The interview will be transcribed prior to the interview. All personal, identifiable information will be redacted from the interview.

Risks and Benefits of Being in the Study

The study has risks. Three possible risks of participating in this study are possible emotional distress, recalling traumatic or distressing events, and any probing for personal or sensitive information in interview. This researcher will take precautions and safeguards to minimize the above listed risks. I will let the participants know ahead of time the content of the questions that she will be asking them so that they are aware of the sensitivity and vulnerability of the topic. I will also inform the

participants, before the start of the interview, that they can choose to not answer a question if they choose not to. Lastly, I will let the participants know that at anytime if the interview is feeling too overwhelming or triggering that the interview can be stopped.

There are no direct benefits to participating in this study.

Compensation

No compensation will be given for participating in this study.

Privacy

Your privacy will be protected while you participate in this study. I will protect the participants' privacy by allowing them to choose the time and location of the interview that works best and is most comfortable for them.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include consent forms, audio recordings, and personal notes taken during the interview process. Only I and her research chair/professor will have access to these records. These records will be stored on OneDrive on a locked computer. The data will be coded so that participants' names are not used. Names will be changed to numbers and all identifying information will be deleted. I will ensure confidentiality while traveling by keeping my laptop on me at all times and ensuring that when confidential information is open on the computer that I am the only one in the room. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with I or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected from you may be used in my final report. You can withdraw by calling or emailing me at any time. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Alison (Ali) Kath. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 651-600-1325 or Kath5369@stthomas.edu. You may also contact my research chair/professor, Mary Nienow, at 651-295-3774. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with I about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date