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Parent Participation in Child Therapeutic Settings

By

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This thesis has been examined and approved by the following members of the student's committee.

Sarah Sifers, PhD, LP Advisor

Daniel Houlihan, PhD Committee Member

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Parent Participation in Child Therapeutic Settings

Researchers agree that more caregiver participation and higher levels of engagement in child therapeutic settings lead to better outcomes. However, challenges arise in families of low socioeconomic status (SES) where resources are already spread thin. The main challenge is that, while research shows that participation is often crucial, parents and caregivers may not be available to participate to the degree they might like due to high demands and limited resources. Supplementing an established coping skills group with physical activity components for children identified as needing intensive mental health services due to high needs and limited resources with a parent participation session and notes to parents might be a way to improve the effectiveness of such a program.

Caregiver participation in childcare takes different forms depending on the setting. Various degrees and topographies of participation are effective in both medical and therapeutic settings for children (Pasioli, 2012; Regev, Kedem, & Guttman, 2012; Stadnick, Drahotka, & Bookman-Frazer, 2012). For example, a 30-minute educational session for parents increased compliance with antibiotic administration, as well as satisfaction with treatment (Angoulvant, Rouault, Prot-Labarthe, Boizeau, Skumik...& Bourdon, 2013). However, participation in a mental health setting differs from a medical setting and can vary depending on the clinic or researcher, as well as the resources of the family.

For example, parents can participate in therapeutic activities in session, review therapeutic homework with professionals, discuss treatment goals with professionals, help children practice skills or complete therapeutic activities outside of sessions, and more (Stadnick, Drahotka, & Bookman-Frazer, 2012).

Conceptualizations of Participation

The base level of caregiver participation is mere presence. Silva, Prado, and Piccinini (2013) found that when fathers were present for their partner's postpartum depression therapy sessions, outcomes were positive. However, there was no control for the level of engagement within the session. Therapists reported being able to discuss parenting issues on a deeper level, as well as spread some responsibility regarding parenthood, but objective measures for these were not taken. Mere presence requires the fewest resources, but it does not guarantee benefit. For example, this conceptualization of participation on requires a parent or caregiver to show up to a session. It does not require any level of engagement during the session, nor does it require that the parent complies with health care or therapy directions at home. That said, as Angoulvant et al. (2013) noted, education in session can generalize to following treatment recommendations at home in a medical setting.

Other researchers reject the notion that the mere presence of a parent or caregiver during a session leads to better therapy outcomes for children. Haine-Schlagel and Walsh (2015) argue that attendance is a necessary but not sufficient factor, and that parent *engagement* is the key to better outcomes in child treatment. Staudt (2007) models caregiver engagement as an active process, as opposed to the implied passiveness of mere presence, marked by a complex interaction between parent behaviors and practitioner behaviors. The model describes two main components to engagement. The first component is behavioral, and includes behaviors such as keeping appointments and completing homework. The second component is attitudinal, and includes openness to treatment and change, and the perception that treatment is worth the time and energy required to achieve the desired outcomes. These two components are key differences when distinguishing between mere presence and engagement. While these components *can* be present in a caregiver's mere presence, it is not explicitly defined or required. Parent and

caregiver engagement has been found to provide better outcomes for children with depression, anxiety, and substance abuse (Haine-Schlagel & Walsh, 2015).

One further and more resource-intensive approach is parent or caregiver involvement in treatment. Aarhun and Akerjordet (2014) found that most parents tend to desire a strong parent-health professional relationship in medical settings. This included the desire to be involved in decision-making. Many parents considered treatment a shared process between caregivers and health professionals. However, this comes with unique barriers. For example, it is easy for parents to feel blamed by professional for their children's difficulties. Similarly, parents often come to appointments with different treatment expectations than the professional (Thompson, 2006). Researchers have found that establishing rapport early and not assigning blame to parents can lead to strong therapeutic relationships between the caregiver of the child client and the therapist of the client (Sanders & Burke, 2013). Following establishment of rapport, it is important for parents and practitioners to be on the same page in terms of expectations for treatment and outcomes, which leads to higher rates of treatment compliance and satisfaction with treatment outcomes (Stadnick, Drahotka, & Brookman-Frazee, 2013). In addition, a strong parent-therapist alliance has been linked to better outcomes in child clients with oppositional, aggressive, and antisocial behaviors (Kazdin, Whitley, & Marciano, 2006).

Filial therapy (Guerney, 1964) was developed to increase involvement of parents in child behavior therapy. The process involves training parents to conduct their own play sessions with their children, interacting in validating ways with the child in an open play environment. The parent is trained by a filial therapist to reinforce the child's play themes through reflective statements, while setting reasonable restrictions on certain play behaviors. After training, parents and therapists do not achieve significantly different results from each other (Stover &

Guarney, 1967). In other words, parents can facilitate filial play therapy as competently as a trained therapist can. In addition, mothers who use filial therapy report significant behavioral improvement in their children over a control non-treatment group, as well as significantly higher satisfaction scores (Oxman, 1972). Since early studies, formal curricula for training and conducting filial therapy have been developed and empirically supported (VanFleet, 2005). Filial therapy was not used in the current study, but these findings illustrate the effectiveness of deeper levels of parent participation in child psychotherapy.

Barriers to Participation

Greater levels of involvement and engagement require more resources. Unfortunately, many parents and caregivers do not have the resources required to be as involved in their children's treatment as they might like. Families of low socioeconomic status (SES) commonly have higher levels of stress, and are at greater risk of depression and physical health problems (van der Waerden, Hoefnagels, Jansen, & Hosman, 2010). Higher stress also tends to lead to less effective parenting (Lewallen & Neece, 2015). Other researchers note the prevalence of caregiver burden in parents of children with mental health concerns (Oliveira, Neto, Camargo, Lucchetti, Espinha, & Lucchetti, 2015). This burden can lead to loss of productivity in and out of work, need for job accommodations, reduced work attendance, and job loss (Neri, Lucidi, Catastini, & Colombo, 2016). As a result, parents of low SES participate significantly less in child treatment (van Mourik, Crone, Pels, & Reis, 2015). Having established that various degrees of caregiver participation in child treatment positively affect outcomes for children, this puts families of low SES at a disadvantage, especially considering that mental health issues often are ignored in low SES populations (van der Waerden et al., 2010).

Parents of low SES tend to attribute their children's problems to external factors, such as poor living conditions and lack of resources (van Mourik et al., 2016). While these are important and powerful factors that should not be ignored from a therapeutic standpoint, parenting support is considered less important by parents who believe that their children's situation is due to these external factors (2016). In other words, learned helplessness leads to parents who are victims of poor conditions feeling as though they have no control over their child's mental health outcomes when, in fact, they do.

Even if parents and caregivers are able to overcome the inability to recognize the possibility for change, they still may not have the resources available to pursue assistance. Little research has been done regarding how to make parent participation in child therapeutic settings accessible for parents of low SES. Some clinics have used home visits to minimize the resources necessary to attend appointments. The greatest amount of involvement may not be possible, but participation in one session and receiving information on the contents of all sessions might increase the effectiveness of child mental health interventions.

Purpose of the Study

Caregiver participation in tailored interventions is important to effective treatment of childhood behavioral and mental health difficulties. Therefore, this study looks at a program geared toward improving children's behavioral and emotional functioning that specifically targets caregiver participation. Specifically, the program is hypothesized to 1) have high rates of parent satisfaction, 2) lead to significant improvements in children's behavioral and emotional functioning, and 3) lead to greater improvements in children than the previous year without the caregiver participation component.

Methods

Participants

Participants are children between the ages of 6 and 9 years old. The participants' parents were contacted and asked if their children would be willing to participate in an eight-week behavior and emotion regulation program with elements of play and physical activity. All participants were recruited through a client-centered community support agency in the Midwest. Participants were clients of the agency at the time of recruitment, receiving psychotherapy and/or therapeutic services and supports because of mental health needs. All participating children had a mental health diagnosis and multiple psychosocial stressors.

Group

The program involved physical activities that teach children skills to cope with emotional distress. The skills included strategies related to relaxing the body, keeping the hands busy, clearing the head, and engaging in pleasurable activities or being around supportive people. Sessions teaching these adaptive coping strategies and provide opportunities for the children to practice them. The group was designed to provide the children with safe adults and a predictable, consistent environment while teaching coping skills pair with physical activity. The goals of the group were to establish trust and group cohesiveness, improve self-regulation, and decrease mental health symptoms and problematic behaviors.

The groups utilized a manualized curriculum designed by agency staff based on clinical experience and a review of the literature on effective strategies for teaching youth mindfulness skills and emotional regulation. The curriculum was geared toward improving self-control, play skills, social skills, self-esteem, problem solving, and communication skills. Groups had six to eight participants who were close in age with similar issues, personalities, and developmental levels. There were two co-leaders for each group and sessions were once a week for two hours

for eight weeks. Each session consisted of a snack, group ritual, and two physical activities featuring the goal(s) of the day, and a closing ritual. For example, one activity has the children getting into a circle and holding hands with the person to their left and a person across from them. They are then asked to get out of this “human knot” without letting go of anyone. This teaches communication and problem solving.

Procedures

Parent consent and child assent was obtained before data collection. Participants were administered the BASC-2 before and after the eight-week program and a satisfaction survey after the program. After feedback from the previous year’s parents that they wished to be more involved in the process, two components were added to the second year group. The first was an open session for caregivers, in which parents and caregivers of the children participating in the group were invited to an open house. During this two-hour session, parents were asked to partake in various activities children also engaged in during group. For example, parents were asked to practice deep breathing using a balloon. Parents were taught about the four coping skills introduced to the children: relaxing the body, keeping the hands busy, clearing the head, and activities that children like or people that children like to be around that make them feel good. The program ended with advice on how to utilize the skills at home and reinforce their children’s use of these skills.

The second added component was a strength-based handout. At the end of each session, group leaders filled out a sheet of paper with the topics of the session and specific skills the child demonstrated well during that session. The children were asked to show these to their parents in hopes that the parents and caregivers would 1) gain a better understanding of what is happening

during the group meetings, and 2) focus on their child's strengths as opposed to their perceived weaknesses.

Measure

The Behavioral Assessment System for Children, second edition (BASC-2; Reynolds & Kamphaus, 2004) is a parent-report measure of child behavioral and emotional functioning. It has an excellent normative sample and good reliability and validity, suggesting it accurately and consistently measures what it claims to and provides useful comparisons to other children. It provides rich diagnostic and clinically useful information as well as being developmentally appropriate with separate forms for youth of varying ages. Chronbach's alpha values range from .81 to .96 (good to excellent), and test-retest reliability scores for the parent and student forms range from .77 to .90 (fair to excellent). Test-retest reliability scores were rated for use one to eight weeks from pre- to post-test, with a mean of six weeks between tests, suggesting that it is appropriate for program evaluation such as in this study. Interrater reliability for parent forms range from .70 to .84 (fair to good). The BASC-2 has strong convergent validity with similar assessments, such as The Achenbach System of Empirically Based Assessment (ASEBA; 2004). Correlations with the ASEBA range from .53 to .83 on individual subscales. The BASC-2 also shows correlations ranging -.49 to -.79 with the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), as well as with the Behavior Rating Inventory of Executive Function (BRIEF), ranging .55 to .85 on independent subscales (2004). The BASC-2 was selected because of its ability to detect both adaptive and maladaptive behaviors and emotion regulation in children. The BASC-3 would be a logical choice in most cases, but since the comparison group already has data measured using the BASC-2, using the BASC-2 to measure the research group is the most methodologically sound choice.

Results

The first research hypothesis was that there will be significant improvements in children between their pre-test before the intervention and their post-test after the intervention. Paired-samples *t*-test were used to determine whether there were significant individual differences for children between pre- and post-test. There were significant improvements in several behaviors according to BASC-2 scores overall when taking both years into account. A paired-samples *t*-test found significant improvements in externalizing behaviors, $t(54) = 2.446, p = .018$; the BASC-2 behavioral symptoms index (BSI), $t(54) = 2.941, t = .005$; hyperactivity, $t(54) = 3.665, p = .001$; aggression, $t(54) = 2.518, p = .015$; and depression, $t(54) = 2.112, p = .039$.

The second research hypothesis was that children's improvements will be significantly greater in the experimental group (year two, with the parent component) than in the control group (year one, without the parent component). To analyze this, a change variable was created for each child's subscale scores reflect the change from before the intervention to after the intervention. An independent samples *t*-test was run using experimental condition (with or without parent component) as the grouping variable and change scores as the dependent variable. There were no significant differences between the control group and the experimental group in change in BASC-2 scores from pre- to post-test.

Discussion

Results indicated that participants had improved scores on five subscales after the group. Hyperactivity, aggression, externalizing behaviors, depression, and overall behavioral symptoms all improved significantly. This could be an indication that the goal of improving adaptive coping and reducing mental health symptoms and behavior problems was met. That said, only three specific behavior subscales – aggression, hyperactivity, and depression – improved

individually. These results are consistent with other research suggesting some benefit from mindfulness-based strategies (Zenner, Herrnleben-Kurz, & Walach, 2013). Many of the activities offer substitutes for maladaptive behaviors in the form of engaging activities that apply adaptive coping strategies. It is also possible that the activities are fun for children and physically active, elevating their mood and easing the negative effects of depressive symptoms (Biddle & Asare, 2011).

Results also indicate that there was no difference between the program with and without the parent component. This is consistent with the research of Haine-Schlagel and Walsh (2015), which argues that participation is not sufficient for significant improvement in children. Perhaps manipulating engagement levels in parents is the key to further significant improvements. Alpert and Britner (2009) devised a parent engagement scale for parents of children in foster care with strong internal consistency (Cronbach's $\alpha = .94$) that may be able to be altered for use in multiple parenting settings. The Child Engagement in Daily Life measure (Chiarello et al., 2014) has also been developed and has been studied in parents of children with cerebral palsy, with Cronbach's alpha values ranging from .86 to .91 and test-retest reliabilities of .70 and .96, depending on the subscale. The Family Involvement Questionnaire (FIQ; Fantuzzo, Tighe, & Childs, 2000) measures parent and caregiver involvement on three domains: school-based involvement, home-based involvement, and home-school conferencing. This allows assessment of caregiver involvement across multiple settings. The listed measures could all prove to be viable in assessing parent and caregiver involvement in child mental health treatment settings. Finally, it is also possible that a single caregiver participation session is simply not enough to determine whether participation is or is not a key factor in child therapeutic improvements. That is, the effects of the parent component might be dose-dependent and the dose was not sufficient for

therapeutic effects. The addition of another condition offering two caregiver participation sessions may be necessary.

Most results of the current study are consistent with those of Woik & Sifers' (2015) evaluation of year one participants. However, the subscales of functional communication and adaptive skills that were significant during the original study were not significant in the current study when accounting for participants in year two. It is possible that the increased number of participants exposed no effect overall on functional communication ability in participants. It is also possible that the year two sample was unique in having already elevated functional communication scores, although this is not likely because initial group differences in functional communication were not significant, $t(54) = .906, p = .369$.

Similarly, depression emerged as a new significantly improved subscale with the addition of year two participants. It makes sense that this effect was not detectable during the first year of participants as it was a small effect in year two. With the inclusion of second year participants, Cohen's d for effect size of depression from pre- to post-test is .28, which is relatively small.

It is important to note that there were no significant declines in any BASC-2 subscales after group participation. It does not appear that group participation caused harm. Thus, it is suggested that this program continue to be studied with the reasonable expectation that it will not have a negative effect on clients or participants.

Limitations

This study is not without its limitations. First, parents and caregiver of all participants were not able to attend the caregiver participation session. Records of who attended were not kept, so the best approximation the researchers have is year one and year two, as opposed to caregiver participation and caregiver nonparticipation. This may have impeded some measures

of improvement, since some participants in the most recent group had parents or caregivers who did not, in fact, participate in the offered session.

Considering that most participants had quite extreme scores when pre-tested, regression to the mean could have been an issue (Bouckenooghe & Buelens, 2009). When participants initially score in the 1st or 99th percentiles, it is statistically quite likely that their score will regress toward the 50th percentile (2009). Improvements could be explained by this phenomenon as opposed to group effectiveness, since there was no control group to compare against. Similarly, it is possible that, due to the large number of analyses run simultaneously, significant results could be type I errors due to family-wise error (Field, 2012).

It is possible that parent and caregiver respondents filling out the BASC-2 experienced response bias. Research has found that parent-child reporting discrepancies exist in the assessment of child cognitive and behavioral difficulties (Stokes, Pogge, Wecksell, & Zaccario, 2011). This effect is exacerbated by parenting stress (2011) which, as another limitation to the study, was not measured in the current sample and was not controlled for in analysis.

As mentioned, the results suggest that a single caregiver participation session may not be sufficient for changes in emotion and behavior beyond those provided by the group sessions alone. It is possible that one participation session simply is not enough to provide the support and education necessary for parents and caregivers to generalize the behaviors learned in group to a home environment. Since only one session was offered, conclusions cannot be drawn regarding the effectiveness of multiple caregiver sessions.

Future Research

Future research should implement measures of parent involvement and engagement, such as the FIQ (Fantuzzo, Tighe, & Childs, 2000), the Child Involvement in Daily Life questionnaire

(Chiarello et al., 2014), or the scale developed by Alpert and Britner (2009). Research measuring engagement levels of parents and caregivers, coupled with the study of the implementation of caregiver participation sessions, could provide a more controlled and detailed description of the mechanisms involved in caregiver participation's role in child therapeutic improvements.

Future research should keep records of parents and caregivers who attend the participation session(s) to more accurately draw conclusions regarding participation therein. Future studies could also implement multiple experimental groups, in which a different numbers of participation sessions are provided. However, ethical considerations of withholding potentially beneficial treatment should be taken into account. The most ethical way to do this might be to randomly assign children to groups with zero, one, or two parent sessions and after measuring effects open the group with parent sessions to participant who had not received the parent sessions. Finally, more participants would help increase the statistical power of analyses (Field, 2012). Participants could be acquired by spreading the intervention to other sites and agencies.

Conclusion

Considering the limitations of the current study, there is plenty of room for research on caregiver participation in child therapeutic settings. It is evident that the current program improves some, but not all, of the children's emotional and behavioral regulation and functioning and did not cause harm, according to scores on the BASC-2. Although results regarding the efficacy of a parent participation session over the program alone are inconclusive, there is room for tighter experimental control over factors such as parent engagement in multiple settings,

suggesting continued research on the role or parental participation in therapeutic groups for children.

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