ENLISTING APPROPRIATE PARENTAL COOPERATION AND INVOLVEMENT IN CHILDREN'S MENTAL HEALTH TREATMENT

31

Linda Taylor and Howard S. Adelman

Counselors and therapists working with children and adolescents are faced with important decisions about the extent to which the family should be involved. Some therapists prefer to work with the family unit; some seldom include family members. The reasons vary. For most, however, the decision about family involvement is based on the needs in each case. Thus, as they first encounter a minor referred for treatment, these therapists focus on assessing not only the individual and contextual considerations related to neighborhood, school, and culture, they also assess the need for and the likelihood of parental involvement.

Why involve parents? Therapists who work regularly with children and adolescents quickly encounter the realities of a lack of parental commitment to seeking out, maintaining, and being involved in the treatment for their youngster. For instance, parent follow-through on child referrals for counseling is estimated at less than 50%, and premature termination occurs in 40% to 60% of child cases (Kazdin, 1997). Clearly, parents must feel a sense of commitment or they will not facilitate their child's enrollment and ongoing participation in treatment. Moreover, parental involvement seems essential when they are the cause of or ongoing contributors to a youngster's problems. Even if this is not the case, family members almost always suffer when their child is not doing well and may need some guidance and support. In addition, in more cases than not, the therapist wants the family to facilitate, nurture, and support desired changes in the youngster. Equally important, what parents learn in the process may generalize to other venues, such as enhancing home involvement in school and parent advocacy.

Many factors shape parental involvement. One set involves the degree to which treatment is seen as positive and accessible. Obviously, negative perceptions and practical barriers can be counterproductive not only to parental connection, but to the youngster's progress. Some families referred for therapy feel uncomfortable with the concept of mental health/mental illness. They may worry that mental health treatment will stigmatize the child either now or by curbing opportunities in the future (Jensen, McNamara, & Gustafson, 1991). Other salient barriers perceived by parents include practicalities of access, feeling that treatment is demanding or not highly relevant to the child's problem, or feeling negatively about the therapist. Dropping out is a likely response when the family's perceptions are that the process is burdensome, unpleasant, or not worthwhile. Conversely, children seem to do better in therapy when parents perceive few negatives related to the process and potential outcomes (Kazdin & Wassell, 1999).

The above concerns are only a small part of the many socioeconomic, language, and racial or ethnic factors that may affect a family's motivational readiness to enroll and maintain a youngster in treatment and to be active participants in the process. The examples cited

underscore the importance of directly attending to parental motivation for involvement in child mental health treatment. Two aspects of such motivational considerations are outlined here: using initial processes of therapy to assess and address parental motivational readiness for involvement and maintaining their motivation and involvement throughout treatment.

ACCOUNTING FOR AND ENHANCING MOTIVATIONAL READINESS

It is helpful to think in terms of a range of motivational differences in family involvement. With respect to their youngster's participation in treatment and their own role in the intervention process, parents range from being highly involved (e.g., motivated and active participants who advocate for their children and seek out resources), to marginally involved (e.g., minimally motivated and cooperative), to reluctant to highly resistant (e.g., not at all motivated, uncooperative, avoidant, reactive). Those in this last group often have been pushed to pursue therapy for their youngsters by the school or the justice system.

At all points along the continuum, working with families to establish appropriate cooperation and involvement in their child's treatment often is a critical process objective. To account for motivational differences, a therapist, starting with the first contact, must assess parents' motivation for having their youngster treated and for their own possible involvement. In doing so, the assessment process itself should be designed to enhance the motivation of family members, or at least to minimize conditions that can reduce their motivation. Based on contemporary theories of intrinsic motivation (Ryan & Deci, 2000), this means using practices that can enhance (or at least reduce threats) to feelings of competence, feelings of self-determination, and feelings of relatedness to others.

Using Consent Agreements to Enhance Motivation

When a therapist first encounters family members, there are multiple opportunities to assess their motivation for therapy and to actively engage them. For instance, there are many steps that can be taken during the informed consent process to engender parent involvement. By using the procedure as an intervention step, the therapist provides a natural opportunity for parents to express their questions, concerns, doubts, and fears. A premise of informed consent is that participation is voluntary and that the family can terminate with no penalty or prejudice. If they agree to proceed, the family has taken a first and important step in making a commitment to cooperate with treatment.

In this context, the therapist works from the initial interactions to minimize any sense of coercion and enhance feelings of control and competence by involving parents in decisions. One of the first decisions is whether to have initial meeting(s) with or without the youngster present. The parents' decision provides important assessment data. For example, many who choose to meet without the youngster indicate it is because they don't want to embarrass their child; others feel they can't say things in front of the youngster; still others know that what they have to say will lead to an argument that they want to avoid. At this stage, it is especially important to counter feelings of coercion and intimidation among those who have been pushed to enter therapy. For such cases, when discussing the events or behaviors that led to the referral, it is well to structure the interaction as one of exploring all *their* options for improving the situation, including any changes at school and home they think are worth pursuing. Exploring goals and how to work together on these reassures some families as to the worthwhile nature of the endeavor. Suggesting a short time frame (e.g., three sessions, with a chance to review the progress and concerns after that) provides some families with confidence that the decision to come back is theirs. If there are choices that can be made with respect to a therapist (e.g., age, sex, ethnicity, language), these also should be explored. Families who clearly are not ready or willing to engage in therapy may need the option of holding off for a time so that they can view the need for treatment in a less reactive

manner. To this end, the parents must be assured that they will be able to initiate services when they decide help is necessary.

To elicit appropriate involvement, a therapist needs to demonstrate respect for the parents' role and for the efforts they expend related to the youngster's day-to-day experiences. This involves validating those aspects of what they are doing right. Then, the process of opening up discussion about what they might want to change can be initiated as one basis for clarifying why their inclusion in the process is necessary.

Sharing assessment information with them to arrive at an agreed upon definition of the problem(s) and the plan for treatment can be especially helpful. Many times, parents will come in with school reports, testing reports, report cards, and other documents that can, when analyzed and collated, provide a helpful picture of the child's development and a context for the current problem. This establishes for parents a perspective from which to see the need for intervention and for their involvement in the process.

In many settings, the assent of the youngster also must be provided. This is especially important in working with adolescent clients. Modeling for parents how to explain the nature of mental health treatment and eliciting the youngster's response not only can help enhance the youngster's participation, it helps parents further understand the importance of their involvement. Thus, besides protecting client rights, the consent process can reduce feelings of coercion and promote feelings of self-determination, enhance feelings of competence, and foster feelings of positive relatedness between the family and the therapist.

A special problem arises related to children whose parents are divorced or are remarried. Such situations require clarifying the dynamics related to the extended family and the role each member will play in supporting the child's treatment. Setting extended family goals and clarifying respective involvements is essential to increasing the family's communication and problem-solving capabilities in ways that serve the aims of the therapeutic intervention (Lew & Bettner, 1999).

Contracting for Involvement

Many counselors and therapists are fortunate enough to work in agencies or schools that provide service without fees. Whether or not fees are paid by the family, the process of negotiating a "contract" that clarifies treatment arrangements (e.g., costs, expected benefits) can also help clarify mutual expectations about parent involvement. At the outset, the focus with parents who are not highly motivated may just be on agreements about scheduling (e.g., regular appointments, arriving on time) and sharing relevant information. Over time, such initial agreements may be renegotiated to encompass greater degrees of family involvement.

Handling Privacy and Confidentiality Concerns

Families vary widely in how much they want therapists to share information with others. Parents may want their individual discussions with the therapist kept confidential from the youngster and even from each other. There are variations in how much a family wants the school to know. Some parents are uncomfortable with the notion of allowing the youngster and therapist to hold conversations that will not be shared with them. The family's concerns about privacy and confidentiality influence the nature and scope of their involvement.

For many families, initial assurances of privacy and confidentiality are sufficient in enlisting cooperation and participation. For others, discussion of these matters must be done in a way that goes beyond describing the importance and parameters of confidentiality. This is particularly critical in clarifying when confidentiality must be broken. For example, clarifying reporting requirements is unlikely to enhance the involvement of abusive parents.

There is no easy solution to the confidentiality dilemma. One strategy that can pay dividends with respect to parent participation is to reframe the topic in ways that clarify that the intent isn't to play a game of "keeping secrets" from each other or to elicit information to report to the authorities. To the contrary, the intent is to encourage the

flow of information that is essential to solving problems, and, when mutual sharing of information is necessary to make things better, the intent is to find ways to facilitate such sharing (Taylor & Adelman, 1998).

Handling Parent Reactions to Initial Contacts and Assessment

In public agencies, enrollment procedures usually require that families complete extensive paperwork. This may include questionnaires asking adolescents and parents to note which of a long list of psychological problems have been experienced. Completing such forms requires literacy skills and candor in self-reporting that may exceed a family's skills or motivational readiness and may reinforce negative feelings about participation. If this appears likely, the therapist must be prepared to make these processes more consumer-friendly, including taking steps to ensure that the level of discourse is a good match for the family's level of literacy, communication skills, and motivation.

Part of the initial assessment usually is a review of the youngster's developmental history. This provides a major opportunity to demonstrate and validate the importance of parent involvement and provides an indication of their willingness and skills for doing so. Because causal attributions for problems often play a major role in shaping behavior, data about such attributions require special attention. If parents blame themselves or each other for the child's problems, the therapist must be ready to explore these perceptions quickly and nonjudgmentally. Extra effort may be required to convince parents that such feelings are natural and that the therapist is not interested in assigning blame but mainly wants to explore causes to find the best way to correct problems.

Carried out effectively, the above practices can help move parents to perceive the therapist as a potential ally rather than an enforcer or an agent of social control. Such a perception allows for a reasonable appreciation of the potential contributions of therapy.

Toward the other end of the continuum, occasionally, families are overly or inappropriately involved in their youngster's therapy.

This may not be evident until after the first few encounters. Such parents may be reluctant to allow the youngster to meet alone with the therapist; they may want more frequent appointments than is common practice or may call frequently between appointments; they may self-generate lists or logs of problem behaviors. Such behavior often calls for separate sessions with the parents to clarify what the underlying motivation is and to elicit changes that will facilitate rather than hinder the youngster's progress.

As the above examples suggest, the therapist's concern about parent involvement begins at first contact. Good practice calls for using processes that both assess and enhance motivational factors influencing involvement not only initially, but throughout treatment.

MAINTAINING MOTIVATION AND INVOLVEMENT DURING THE PROCESS

Extrapolating from available research and theory on intrinsic motivation (e.g., Ryan & Deci, 2000), three considerations seem basic for maintaining involvement:

1. Ensuring parents feel a growing sense of relatedness to the therapist.
2. Enhancing parents' valuing of involvement by ensuring that there are a variety of ways they can participate and then facilitating their decision making among desirable options (including ongoing decision making about changing how they are involved).
3. Providing continuing support for learning, growth, and success (including feedback about how their involvement is benefiting the youngster).

These considerations are discussed below with respect to the overlapping topics of therapeutic alliances and assignments, therapy formats, and engaging the family in the evaluation process.

Therapeutic Alliances and Assignments

All therapists create some form of alliance with their child and adolescent clients in

order to facilitate change. On the basis of their theoretical models and training experiences, interveners differ in the nature and scope of their alliances with the rest of the family. As already noted, such alliances can determine the course of treatment. Adolescents raise special concerns in this respect. Many teenagers are at a stage of developing separate identities from their families. Therapists are caught in a situation where the youngster may view contacts between the therapist and a parent as undesirable. However, avoiding parents can make them feel excluded and alienated from the process and lead to their abruptly and prematurely withdrawing the youngster from treatment.

Another common problem is that parents may feel threatened by the growing bond between therapist and youngster and by the therapist's interest in eliciting the youngster's perspective on the causes of and potential solutions for the referral problem. The bonding can produce competitive feelings. Eliciting a youngster's perceptions of cause may be seen as buying into ill-informed and self-serving information, especially if the youngster is likely to place blame on the parents. Similar feelings can arise in working with parents who are in conflict with each other.

Interveners must consistently (1) help all concerned parties appreciate the appropriateness and value of various alliances, (2) listen to all perspectives, and (3) validate the feelings that accompany such perceptions. The danger in not doing so is to be seen by parents as a biased, overly permissive, and untrustworthy person. In contrast, when parents understand the process and feel heard and validated, the therapist is more likely to be perceived as an ally. And, should the youngster want to discontinue treatment, the alliance with the parents can prevent premature termination.

There are, of course, instances when parents want the therapist to take over and are satisfied not to form a close alliance. In these instances, the need is to move the youngster and parents to a middle ground as soon as feasible. This requires a constant focus on clarifying and demonstrating to all parties that specific forms of contact are beneficial (e.g., with respect to

making progress and for purposes of anticipating and preventing problems).

The growing use of manualized treatments and use of homework or exercises that the family is called on to facilitate provides many opportunities to involve parents and develop strong, positive alliances. Other occasions arise around the family's role in facilitating, supporting, and nurturing the youngster's progress. In this respect, parents have a special role to play as their child's primary advocate. This role offers many possibilities for the therapist not only to enhance parent involvement, but to increase their positive involvement in other aspects of the youngster's life—especially those venues where problems are being experienced. One example is schooling. Child therapists often find that changes at school are needed to support the treatment process. Whereas direct contacts between therapist and teachers often are helpful, there are benefits to encouraging and preparing the family to become positive advocates. This, of course, is one of the most natural forms of parent involvement. In particular, parents can be taught about the types of special assistance a school might provide (counseling groups, Section 504 accommodations, special education, etc.). Then, the therapist can prepare them with respect to how to approach the school effectively. This includes teaching parents the difference between positive advocacy and the type of adversarial role that often results in youngsters being caught in the middle. Properly done, the results lead to interactions among parents, school staff, and students that are mutually beneficial, encourage special feelings of connectedness, and support treatment processes and results (Friesen & Stephens, 1998).

Therapy Formats

There are a variety of ways in which parents can participate, some of which have been mentioned already. A few other examples will suffice as illustrations.

Youngsters may be seen in groups or individually or with family members included as "collaborative" partners. In many instances, family members will become primary clients with a focus on making family changes (e.g.,

parents changing their own behaviors to respond differently to their children). This is especially necessary in cases where the family has experienced a shared trauma (e.g., a child has been abused or has experienced a natural disaster or the sudden and violent death of a family member). Shifting from focusing primarily on the child to the whole family can be difficult and calls for recontracting so that the parents understand what will be asked of them and become active participants in the decision making.

Some therapists and agencies find that a family/parent support group provides a useful way to enlist appropriate involvement. Such a format allows for exchanges about common problems and solutions. Not only can participants learn from others, they may experience a growing sense of personal validation, as well as enhance their commitment to treatment processes. These groups may be most helpful when the nature of the youngsters' problems are similar (e.g., crisis situations, specific problem focus, long-standing problems) and when they are composed of parents with the same background.

Homework assignments provide another form of involvement. Such activity is implemented between therapy sessions with reports back to the therapist. For example, parents can assist their child in pursuing problem-solving strategies, can make changes in how they interact with the youngster, and can monitor reduction of symptoms and problems.

Engaging the Family in the Evaluation Process

Evaluation of progress is an additional opportunity to involve parents and provides an essential ongoing perspective on therapeutic processes and outcomes. Research supports the positive impact of including a family-initiated evaluation model on treatment outcome (Stoep, Williams, Jones, Green, & Trupin, 1999). One problem, of course, is that parent and youngster perspectives frequently differ. Moreover, parents often are not inclined to account for the perspectives of the child or adolescent.

Through interactions designed to translate therapist, parent, and youngster perspectives into a shared set of outcome indicators, strong alliances can be created. Again, this involves a focus on clarifying how to ensure that all perspectives are given a serious hearing. It also requires arriving at a working perspective that can be used to generate a feasible solution to a referral problem (Adelman & Taylor, 1994).

CONCLUDING COMMENTS

Therapists who want to enlist parent involvement must be clear about the value of, forms of, and barriers to such involvement. From initial contact, they must include a focus on the family's motivation and incorporate processes that can at least minimize a lowering of motivational readiness and, when necessary, can enhance such motivation. Clearly, this is an area where the full implications for research, theory, practice, and professional training are just beginning to be appreciated.

References

Adelman, H.S., & Taylor, L. (1994). *On understanding intervention in psychology and education.* Westport, CT: Praeger.

Friesen, B.J., & Stephens, B. (1998). Expanding family roles in the system of care: Research and practice. In M.H. Epstein & K. Kutash (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 231–259). Austin, TX: ProEd.

Jensen, J.A., McNamara, J.R., & Gustafson, K.E. (1991). Parents' and clinicians' attitudes toward the risks and benefits of child psychotherapy: A study of informed-consent content. *Professional Psychology: Research and Practice, 22,* 161–170.

Kazdin, A.E. (1997). A model for developing effective treatments: Progression and interplay of theory, research, and practice. *Journal of Clinical Child Psychology, 26,* 114–129.

Kazdin, A.E., & Wassell, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology, 28,* 160–172.

Lew, A., & Bettner, B.L. (1999). Establishing a family goal. *Journal of Individual Psychology, 55,* 105–108.

Ryan, R.M., & Deci, E.L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55,* 68–78.

Stoep, A.V., Williams, M., Jones, R., Green, L., & Trupin, E. (1999). Families as full research partners: What's in it for us? *Journal of Behavioral Health Services and Research, 26,* 329–344.

Taylor, L., & Adelman, H.S. (1998). Confidentiality: Competing principles, inevitable dilemmas. *Journal of Educational and Psychological Consultation, 9,* 267–275.