Parent Form - Decision Tree

Not-On-Track Feedback Cases

1. Does the parent report low Parenting Self-Efficacy?
   - YES → See Parenting Self-Efficacy Interventions handout. Proceed to #2.
   - NO ↓
2. Does the parent report low Social Support?
   - YES → See Parent Social Support Interventions handout. Proceed to #3.
   - NO ↓
3. Does the parent report concerns with Parenting Skills?
   - YES → See Parenting Skills Interventions handout. Proceed to #4.
   - NO ↓
4. Does the parent report high levels of Parent Distress?
   - YES → See Parent Distress Interventions handout. Proceed to #5.
   - NO ↓
5. Does the parent report concerns with the Therapeutic Alliance?
   - YES → See Parent Therapeutic Alliance Interventions handout. Proceed to #6.
   - NO ↓
6. Reassess the diagnostic formulation. Is there an effective treatment option that has not been attempted?
   - YES → Consult relevant resources and alter the treatment plan.

Parenting Self-Efficacy Interventions

Self-efficacy refers to a self-perception of one's ability to perform competently and effectively in a particular task or setting (Bandura 1982, 1989). Consequently, parenting self-efficacy is defined as beliefs or judgments about one's competency or ability to be successful in the parenting role (Hess, Teti, & Hussey-Gardner, 2004). Several similar terms have been used to describe this construct, including parental self-efficacy, parental confidence, parental self-esteem, parental self-definition, and parental sense of competence (Coleman & Karraker, 1997). Despite the variation in terms used for this construct, they all relate to parental feelings of competence in the parental role.

According to Bandura's model (1982, 1989), parents who possess a high sense of efficacy believe they have the skills and qualities necessary to have a positive influence on their children's behavior and development. Parents who believe that they can be effective in the parenting role are more likely to persevere in the face of challenges. This self-belief is likely to be advantageous in challenging situations, such as dealing with a temperamentally difficult child or a child whose behavior is difficult to interpret (Teti, O'Connell, & Reiner, 1996).

Numerous studies support the link between parenting self-efficacy and children's development and psychosocial functioning. Parenting self-efficacy has been shown to directly affect the quality of care provided to children (Tucker, Gross, Fogg, Delaney, & Lapporte, 1998). High maternal self-efficacy is related to maternal sensitivity, warmth (Teti & Gelfand 1991), and responsiveness (Stifter & Bono 1998). These parental characteristics appear to be protective factors against the development of child and adolescent behavior problems (Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Pettit & Bates 1989), and promote higher child self-esteem, school performance, social competence, and lower levels of anxiety and depression (Patterson, DeBaryshe, & Ramsey, 1989). Low parenting self-efficacy has been shown to be negatively related to a wide range of risk-related variables, including parent stress, dysfunctional family interaction patterns, parent physical and mental health problems, negative parental emotional arousal, and decreased quality of parent/child interactions (Gelfand, Teti, & Radin, 1992; Kwok & Wong, 2000; Scheel & Rieckmann, 1998; Webster-Stratton, 1990). Furthermore, in the longitudinal treatment outcome studies through which the TSM was developed, improvements in parenting self-efficacy over the course of treatment were associated with improvements in child symptoms (Warren et al., 2008; 2011).

Parenting Self-Efficacy Subscale

Indications for Action

The parenting self-efficacy items (items 1-7) sum to a score between 7 and 35 with a high score indicating higher feeling of parenting self-efficacy. A score at or below 30 has been determined to indicate the need to further explore parenting self-efficacy and take steps for improving it. In addition, specific responses to specific items can guide the therapist to consider certain aspects of parenting self-efficacy that may be most problematic. Cut-off scores on each

item have been established so that therapists can view the items when responses fall below normal responding. The following page provides information about improving parenting self-efficacy.

Parenting Self-Efficacy Interventions

Bandura's (1977) original self-efficacy theory points to several important methods through which a person's self-efficacy may be enhanced. Three that are particularly relevant for a therapeutic setting include: 1) personal experience of successes and accomplishments, 2) vicarious experiences of similar others, and 3) verbal persuasion. The personal experience of successes in the parenting role is the most important source of parenting self-efficacy. As such, efforts should focus on helping parents develop a personal history of successes in parenting tasks. This can be done by reviewing and emphasizing past experiences in the parenting role that were positive, and through creating new successes in the therapeutic process. For example:

- Help the parent make a list of memorable positive parenting experiences, examining each event and positive outcome in detail. Highlight how the parent's specific actions or characteristics contributed to the positive experience or outcome.
- Every parent has individual strengths and weaknesses. Have the parent make a list of his/her own positive parenting skills and strengths.
- Have the child or adolescent make a list of memorable positive experiences with the parent, focusing on what the parent did to make them good experiences.
- Have the child or adolescent create a list of the parent's positive attributes and behaviors, and have the child share this list with the parent.
- As part of teaching and providing feedback on parenting skills, provide opportunities for supervised practice of these skills in the therapy session, and reinforce the parent for effective practice of these skills.
- After having provided the parent with direct instruction and feedback on a specific parenting skill, provide homework assignments that are within the parent's skill level and have a high likelihood of producing a successful outcome.
- At each session, help the parent identify and process successful parenting experiences from the previous week, emphasizing what the parent did right in each situation.
- Regularly highlight areas in which the parent has shown improvement, and use these successes as leverage to build confidence in other areas of parenting.

Self-efficacy can also be altered by the vicarious successes or failures of similar others. For example, if a parent perceives someone as similar to them and observes that person succeeding in a parenting task, that parent's may feel more capable of successfully completing that task as well. Consequently, it may be helpful if the parent has a friend or acquaintance who is easy to relate to and who is a good model for parenting skills. Observing other parents and evaluating

reasons for their success in parenting tasks may help the parent feel more confident in being able to achieve the same results. As such, therapists can explore whether the parent has a "similar other" through whom parenting self-efficacy may be strengthened vicariously.

Finally, verbal persuasion from the therapist is another hypothesized method for increasing parenting self-efficacy. When parents hear frequent expressions of confidence and encouragement from the therapist, parents generally put forth greater effort to improve their parenting behaviors and are more likely to set aside feelings of self-doubt. However, increased parenting self-efficacy due to verbal persuasion can quickly disappear if not supported by subsequent parenting successes. Consequently, emphasis should be placed on helping the parent generate consistent positive experiences and successes in the parenting role.

Parent Social Support Interventions Handout

Parents' perceptions of their social support network may influence youth treatment and outcomes in many ways, directly and indirectly. Low perceived support may negatively impact a parent's ability to successfully manage the many demands involved in the parenting role, to follow-through with therapist recommendations, or even to bring the child or adolescent to scheduled therapy appointments. Parent perceptions of social support are directly related to their own psychological distress as well as the severity of symptoms they report in their children.

Changes in parent social support have been shown to be related to changes in youth symptoms over the course of treatment (Warren et al., 2008); however, causal relationships between these and other associated variables are not yet clear. Although the relationship between these variables is likely reciprocal, it is reasonable to believe that improvements in parent social support facilitate positive youth outcomes in many ways; for example, through improved parent well-being, increased parenting self-efficacy, more consistent parenting practices, or through instrumental support that directly helps the child as well as the parent.

Similarly, the behavior of youth with severe psychological problems can have a negative impact on the support network of their parents. Some parents may limit their associations outside the home because of the child's difficult behavior around others or because they cannot leave the child with others or unsupervised. As a result, parents of referred children often have less extensive and supportive social networks, which may serve as a barrier to helping the family make needed progress.

Parent Social Support Subscale

Indications for Action

The Parent Social Support items (items 8–14) sum to a score between 7 and 35, with a high score indicating adequate social supports. A score at or below 22 has been determined to indicate the need to consider interventions that will strengthen the parent's perceived support from family, friends, and/or significant others and take steps to facilitate external informal networks of care. Accordingly, scores of 22 or less are signaled as "red." In addition, specific responses to specific items can guide the therapist to consider certain aspects of support that may be most problematic for the parent. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. The following is a list of suggestions for improving social support.

Parent Social Support Interventions

Consider the *types of social support* that may be most helpful for the parent (House, 1981; Cobb, 1983; Turner, 1976):

- *Instrumental aid.* Actions or materials provided by others that enable the fulfillment of ordinary role responsibilities.

- *Socio-emotional aid.* Assertions or demonstrations of love, caring, esteem, sympathy, and

group belonging coming from friends and family.

- *Informational aid.* Communications of opinion or fact relevant to current difficulties—such as advice, personal feedback, and information that might make an individual's life circumstances easier.

Consider how the following *Coping Assistance Techniques* could be fostered through the parent's social support network (Lazarus & Folkman, 1984; Perlin & Schooler, 1978; Thoits, 1986):

- *Problem-focused coping.* A supportive friend or significant other exerts situational control by intervening directly to remove or alter circumstances perceived as threatening, either temporarily (e.g., by going on an outing with the individual) or more permanently (e.g., by helping the individual find a new job).

- *Perception-focused coping.* A "significant other" aids in reinterpreting situations so they seem less stressful and reinforces less threatening perceptions (i.e. "Don't take it personally, he's just having a bad day"). A helper may also tell a distracting story to divert attention away from overwhelming emotions.

- *Emotion-focused coping.* Significant others help the individual alter his or her psychological sensations to counteract a current emotional state. (For example, therapists may help clients identify, experience, and understand emotions or coach the distressed individual in biofeedback, meditation, desensitization, or self-hypnosis techniques. Significant others can participate directly in these efforts, thereby facilitating an individual's own coping attempts).

Selection of Significant Others (Wortman & Lehman, 1985; Gotliebb, 1985; Gerard, 1963)

Not just any significant other will supply effective coping assistance. The following criteria may be considered when helping a client choose potential significant others:

Sociocultural similarity. Sociocultural similarity increases the likelihood that a significant other will suggest coping techniques viewed as acceptable by the individual. Imagine a highly religious person telling a distressed atheist, "It's God's will." Social and value similarities enhance individuals' confidence in their comparative self-evaluations, and such similarities increase the perceived applicability of others' experience and guidance.

Situational similarity. Situational similarity increases the probability of empathic understanding, the key element in effective coping assistance. Considerable experimental evidence supports the notion that "misery loves company." Distressed individuals feel that others who have experienced the same situation are more likely to relate and less likely to reject. Empathetic helpers can accept the feelings that others find aversive or inappropriate. Acceptance enables the individual to discuss feelings freely, a crucial step towards healing.

Caution: *Significant others who react more strongly to situational stressors than the distressed individuals themselves may need to be avoided in favor of those who are substantially calmer. This may enhance the chances of having a more healthy environment for self-evaluation.*

Additional Therapeutic interventions:

- Assess parent's social network
- Refer parent to a parent support group or group therapy
- Role play social situations to facilitate acquisition of social skills
- Bring parent's significant others to sessions
- Refer parent to specific anxiety reduction practices such as biofeedback, applied relaxation, meditation, mindfulness practice and the like if it appears that social anxiety is inhibiting quality and/or quantity of interpersonal relationships
- Utilize progressive desensitization to aid client in overcoming social anxieties
- Encourage pursuit of hobbies, participation in clubs, service projects
- Assign helpers
- Encourage activities that promote contact with people outside the home
- Process concerns related to trusting others
- Encourage parent to befriend others who may need a friend
- Encourage parent to speak with an ecclesiastical leader about ways to become more socially involved
- Encourage active involvement in self-help groups

Parenting Skills Interventions Handout

The literature on parenting practices is vast and multifaceted. Undoubtedly, parenting skills are a vital contributor to children's development and behavior, and are the primary emphasis of many interventions for addressing child and adolescent behavior problems. Although numerous parent-focused approaches have been developed and tested for addressing problem behavior in children (see below for clinician and parent resources), several parenting skills and behaviors emerge as core components across these programs. Examples include effective communication practices, attending to and reinforcing appropriate behavior, problem solving skills, monitoring youth behavior and activities, and the effective use of rules and consequences. Items from the parenting skills subscale were drawn from these domains, with the final group of items being selected based on the strength of their association with positive child outcomes (Henderson, Salisbury, Herzog, & Warren, 2012; Warren et al., 2008).

Parenting Skills Subscale

Indications for Action

The parenting skills items (items 15–26) sum to a score between 12 and 60 (items 15 and 23 are reverse-scored) with a high score indicating that the parent reports using more effective parenting skills. A score at or below 39 has been determined to indicate the need to further explore this area and take steps to improve foundational parenting skills. In addition, specific responses to specific items can guide the therapist to consider certain areas of parenting that may require particular emphasis. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. The following page provides information about improving basic parenting skills.

Parenting Skills Interventions

Numerous treatment approaches have been devised for child and adolescent behavior problems that employ a strong parent-training emphasis. The following clinician and parent resources are representative of the many programs and protocols that have been effectively used to improve core parenting skills and thereby improve child and adolescent behavior:

- *Helping the Noncompliant Child: Family-based Treatment for Oppositional Behavior*, Robert J. McMahon and Rex L. Forehand
- *Defiant Children (2nd Ed.): A Clinician's Manual for Assessment and Parent Training*, Russell A. Barkley
- *Parent-Child Interaction Therapy*, Sheila M. Eyberg (see http://pcit.phhp.ufl.edu/)
- *Multisystemic Treatment of Antisocial Behavior in Children and Adolescents*, Scott W. Henggeler et al.

- *Parents and Adolescents Living Together (Parts 1 and 2)*, Gerald R. Patterson and Marion S. Forgatch

- *How To Talk So Kids Will Listen & Listen So Kids Will Talk*, Adele Faber and Elaine Mazlish

Parent Distress Interventions Handout

In examining important variables related to child and adolescent psychotherapy, those related to parent functioning may be among the most important factors to consider in promoting good child outcomes. Children's dependence on their parents makes them particularly vulnerable to influences largely outside of their control such as the parent's psychological functioning. (Kazdin, 2003; Kazdin, 2004). Compelling evidence supports a significant relationship between parental distress and the development of psychosocial problems in children (e.g., Crnic, Gaze & Hoffman, 2005; Cummings & Davies, 2002; Deater & Decker, 1998). Further, emerging evidence indicates that parent distress and interpersonal relationships also impact psychotherapy outcomes for children (e.g. Kazdin, 2004; Kazdin & Wassel, 2000; Packard & Warren, 2012; Reyno & McGrath, 2006; Warren et al., 2008).

Many factors can contribute to parent distress. Of particular relevance in a child/adolescent treatment context is parenting-related stress (challenges with managing the parenting role), and the parent's own psychological symptoms (e.g., depression, social problems, deficits in adaptive functioning). Clearly, problem behavior in children and adolescents can be a major source of distress for parents, but in many cases parent psychopathology and difficulties in managing parental responsibilities can significantly impede a child's progress in treatment. Consequently, when parent distress is high, additional assessment and subsequent referral for individual or group treatment for the parent may be warranted.

Parent Distress Subscale

Indications for Action

The parent distress items (items 27–36) sum to a score between 10 and 50 (items 29, 30, 31, 32, 34, and 36 are reverse-scored) with a low score indicating that the parent reports high personal distress. A score at or below 25 has been determined to indicate the need to further explore this area and take steps to improve parent functioning. In addition, specific responses to specific items can guide the therapist to consider certain areas of parent distress that may require particular emphasis. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. Depending on the parent's responses, it may be useful to conduct further assessment of parent symptoms to determine if a separate referral for treatment should be made.

Parent Distress Interventions

Distress related specifically to the parenting role may be effectively addressed though interventions discussed in the sections for parenting self-efficacy, parent social support, and parenting skills, as well as through child-focused interventions. If assessment indicates high levels of personal distress (i.e., parent psychopathology, social dysfunction, occupational dysfunction), arrangements should be made for the parent to receive individual or group treatment to address these issues.

Parent Therapeutic Alliance Interventions Handout

Among the many differences between adult and youth treatment is the involvement of parents in therapeutic process. Children and adolescents are rarely self-referred; most often, treatment is sought when their behavior becomes a concern for someone else, usually a parent. If children and adolescents are brought to treatment against their will, the parent becomes a particularly important ally for the therapist. The therapist must maintain a positive working relationship with both the referred child and the referring parent to maximize the chance of a positive outcome.

The therapeutic alliance has been defined as the quality of the helping relationship between the client and therapist (Bickman et al., 2004). This relationship is considered to include a positive bond between the client and therapist, and agreement on therapeutic tasks and goals. Although most research attention has focused on the child/adolescent–therapist alliance, evidence supports the assertion that a positive parent–therapist alliance is also predictive of better child treatment outcomes (Kazdin & Whitley, 2006). Not surprisingly, if the therapist neglects the parent–therapist alliance, the child may be withdrawn from treatment even if the child–therapist alliance is strong. Also, because the time children spend with their parents is considerably greater than the time they spend with the therapist, a strong parent–therapist alliance maximizes the chance that parents will be motivated to internalize and apply the therapeutic principles promoted by the therapist. Research consistently demonstrates that the accuracy and predictive utility of therapeutic alliance ratings is higher coming from the client (either the parent or the child) than from the therapist. As such, it is most useful to use parent ratings when evaluating the quality of the parent–therapist alliance.

Parent Therapeutic Alliance Subscale

Indications for Action

The parent alliance items (items 37–40) sum to a score between 4 and 20 (item 38 is reversed scored), with a high score indicating a more positive parent–therapist alliance. A score at or below 13 has been determined to indicate the need to further explore the parent–therapist alliance and take steps for improving it. Accordingly, scores of 13 or less are given a warning signal. In addition, specific responses to specific items can guide the therapist to consider certain aspects of the alliance that may be most problematic. Cut-off scores on each item have been established so that therapists can view the items when responses fall below normal responding. The following page provides information about improving the parent–therapist alliance.

Parent Therapeutic Alliance Interventions

The key principle in promoting a strong parent–therapist alliance is to approach the treatment of their child as a partnership (Alexander & Dore, 1999). As such, treatment is approached as a collaborative process in which the parents are acknowledged as the primary "authorities" on their children. In contrast to traditional approaches in which the therapist assumes a position of unquestioned provider of services, parents should be encouraged and enabled to respond more as equals in making decisions and in implementing their child's

treatment. In addition, the therapist should not assume that the parents have played a central role in creating the child's problems, but should view parents as valued allies who must be included in the treatment process.

Excellent suggestions from the adult psychotherapy literature can also be applied to working with parents. Here we have borrowed extensively from the work of Muran, Safran, and colleagues regarding techniques that can be used to repair a ruptured alliance. A general principle applies: If there is a problem with the alliance then it will be most likely repaired if the therapist can elicit, from the client, negative affect, listen to it carefully, and call for elaboration. Above all, do not respond by explaining, justifying, or disagreeing (being defensive) if the patient expresses negative affect-- empathize and apologize.

Therapeutic interventions. (see Safran et al., 2002 for a more in-depth discussion of many of these suggestions)

- Pay careful attention to the amount of agreement between you and the parent concerning the overall goals of treatment and the tasks necessary to achieve those goals
- Reframe the meaning of tasks or goals and/or modify tasks and goals
- Work with resistance by retreating when necessary and being supportive
- Provide a therapeutic rationale for your techniques, actions, and/or behaviors
- Discuss the here-and-now therapeutic relationship with the parent
- Give and ask for feedback on the therapeutic relationship
- Spend more time exploring the parent's experiences
- Pay attention to subtle cues that there may be a problem with the alliance
- Allow the parent to assert their negative feelings about the relationship
- Accept responsibility for your part in alliance ruptures
- Explore with the parent their fears about asserting their negative feelings about the relationship
- Give more positive feedback
- Process transference and be aware of counter transference
- Discuss therapist and therapeutic style match
- Discuss shared experiences