

# Triadic Model for Working with Parents in Child Therapy Settings

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## Abstract

Child therapists face challenges regarding whether they should meet needs of not only their child-clients but needs of the parents of their clients. Their difficulties arise from the fact that although they are specialized in counseling children, the majority of them lack proper training in or education on working with parents (Lolan, 2011). Given parents are the immediate environment and significant figures in children's development, handling and guiding parents effectively through parent involvement is essential in promoting children's therapeutic processes. Unfortunately, child practitioners are left without clear articulation or guidance on how to manage parents (Nock & Ferriter, 2005). To fulfil this unmet need, this paper introduces a conceptual framework that maps out role-performances of child practitioners when engaging parents in child therapy processes by applying Bernard's Discrimination Model. Within this conceptualization, therapists fulfill roles as teachers, counselors, and consultants in accordance with those in the Discrimination Model. Considerations for parent involvement are discussed and recommendations for child practitioners using the Discrimination Model in parent involvement, particularly for beginning counselors, are highlighted.

**Keywords:** working with parents, parent involvement, parent engagement, parent consultation, play therapy, parent involvement model

## 1. Introduction

Many child practitioners in counseling encounter situations in which they interact with parents, even though their primary clients are the children. Many of those parents visiting child-psychotherapy institutions present with anxiety, being desperate to gain professional help for their troubled child. Parents may ask child therapists for practical advice on how to cope with difficulties brought about by their children, requesting consultation for their concerns (Dougherty, 2009; Keys et al., 2003). Because of the high level of apprehension that parents exhibit, it is often inevitable for therapists to take time to listen and respond to parents' needs, even though their primary clients are the children. In addition, child therapists may feel the need to provide specific guidelines for parents to prevent the children's symptoms from being exacerbated and to further support their children's recovery. Unfortunately, many play therapists have limited exposure to training in relation to working with parents (Lolan, 2011).

The inadequate training and education related to parent consultation may hinder children's therapeutic processes. Parents may doubt the adequacy of treatment for their child when they sense a lack of confidence from therapists in the course of communication with them. Considering approximately 21% of clients stopped attending the therapy sessions after the first visit (Carlstedt, 2010), play therapists' effort for confident and competent presentation at initial meetings with parents should be given more attention for the continuity of child sessions. Nock and Ferriter (2005) concluded that treatment attendance and adherence are the most fundamental factors for achieving effective outcomes in child and adolescent therapy and suggested that parents have determinant roles in this attendance and adherence.

Involving parents in child therapy is a core aspect to successful child therapy outcomes as demonstrated in meta-analyses exploring play therapy efficiency (e.g., Bratton et al., 2005; Dowell & Ogles, 2010; LeBlanc & Ritchie, 1999; Lin & Bratton, 2015; Ray, Bratton, Rhine, & Jones, 2001). Unfortunately, in spite of the necessity of guidance, practical tips on how to help parents during child therapy processes are lacking. The application of a theoretical model applying Bernard's (1997) Discrimination Model, frequently utilized in counseling supervision, is proposed here to help improve child practitioners' conceptual understanding of how to mentor parents in child therapy settings. The first author, in her experience as child practitioner and counseling supervisor, noted that the two roles resembled each other in that both fulfill multiple functions. For example, child practitioners frequently encounter cases in which they had not to only discuss children's progress with parents but also instruct them in regards to child development and parenting skills. In

addition, child therapists need to build relationships with parents through empathy and understanding while also providing emotional support to them. Similarly, supervisors deliver different types of assistance for supervisees, such as teaching counseling skills, emphasizing their struggles, and reviewing their cases through mutual insight while functioning within the Discrimination Model. As such, there are similarities in terms of the role-fulfillments between child practitioners and clinical supervisors.

I believe the theoretical guidelines of child practitioners' roles through the Discrimination Model will serve as a useful map for them by illuminating their expected job performances in working with parents. For this paper, working with parent is interchangeably used with parent involvement or parent engagement that includes comprehensive forms of parental participation in the overall process, ranging from intake parent meetings, to family therapy, to child-parent sessions, to separate parent training sessions. Also parents have the primary legal responsibility in the child-rearing process. Parental dimensions cited in this paper include biological parents, family members, relatives, or legally designated guardians.

This paper first presents Bernard's Discrimination Model and the feasibility of its application to settings in which child practitioners collaborate with parents in child therapy by reviewing literature. Then conceptualization of the Discrimination Model in parent engagement, which specifies roles and expected performances of child practitioners, follows. Finally, this paper addresses considerations for decision making regarding parental inclusion and therapists' role(s).

## **2. Bernard's Discrimination Model**

The Discrimination Model was originally suggested by Bernard in the mid-1970s to offer a theoretical framework for clinical supervision (Bernard & Goodyear, 2014). Through this model, Bernard conceptualized what assistance clinical supervisors should deliver to promote supervisees' professional development by providing a tangible structure of a 3 by 3 matrix. The matrix explicates nine supervisory approaches conjoining three supervisory roles and three foci (Luke, Ellis, & Bernard, 2011). Three different roles—teacher, counselor, and consultant—that supervisors could implement are explained with three separate foci for supervision: intervention skills, conceptualization skills, and personalization skills. As teachers, supervisors provide modeling, instruction, feedback, and evaluation for supervisees (Luke & Bernard, 2006). For example, supervisors may role play specific counseling skills with their supervisees to teach them proper intervention skills. As counselors, supervisors help their supervisees reflect on how their personal issues may interface with the therapy process so they are mindful that their personal matters do not effect clients' sessions. In addition, supervisors encourage that supervisees incorporate supervisees' personal styles in their counseling modality. Finally, in the consultant position, supervisors assist supervisees' conceptualization skill development. Through this support, supervisees advance their understanding of cases and discern distinct patterns from their clients. Throughout the process, supervisors instill trust in the supervisees' conceptualization skills (Luke & Bernard, 2006).

Through the Discrimination Model (Bernard, 1997), counselor supervisors perform three different roles—teachers, counselors, and consultants—at behavioral, affective, and cognitive dimensions to optimize supervisees' professional development. In supervised practices, counselor supervisors make professional judgments about which role(s) to play and which skills to target by considering the supervisees' needs, their developmental capabilities, and the counseling stages of their clients. Interestingly, the methods used by play therapists to assist parents during parent involvement are similar to those of supervisors in Bernard's model. Like supervisors, play therapists also take holistic approaches in working with parents to facilitate children's therapeutic processes by exercising different roles. For example, when play therapists sense parents need to learn skills and knowledge pertinent to their child's therapeutic processes, such as parenting, interactive, and communication skills, they take on teacher role in helping parents attain those skills and developmental insight for their child's progress. In addition, play therapists demonstrate the deepest levels of empathy towards parents' difficulties derived from their child's issues while supporting and encouraging them, which conceptualizes the supervisor's role as counselor. Like consultants, play therapists encourage parents to grasp what might be happening to their child, what might be contributing to problems their child undergoes, and what roles they can play in assisting their child's recovery. The Discrimination Model could feasibly be translated into settings with child therapists working with parents because of the performance similarities between clinical supervisors and child practitioners in their respective settings.

## **3. Application of the Discrimination Model to Parent Involvement**

Comprehensive role performances of play therapists at different positions have been studied. A body of literature suggests that working with parents is a multifaceted task at affective, behavioral, and cognitive levels (see Booth, & Jernberg, 2010; Gil, 2011; Kottman, 2011; McGuire & McGuire, 2001; Sanders & Burke, 2013; VanFleet, 2011, 2014). Booth and Jernberg discussed didactic components on the part of therapists through which they not only teach parents developmental knowledge pertinent to their child's difficulties but coach them to obtain proper parenting, interactional, and coping skills. They also suggested that the process of guiding parents to

attain Theraplay skills will allow them to gain insight into their own feelings at the cognitive dimension. Filial therapy (Landreth, 2012; VanFleet, 2011, 2014; Wilson & Ryan, 2006) and Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2011) also emphasize experiential learning for parents, which involves teaching components and emotional support for them. Seemingly those play therapy approaches focus on instructional aspects, but in fact they highlight attention to being affectively attuned to parents to provide empathy and encouragement for them. Jeon (2014) also classified various tasks fulfilled by play therapists: a) providing emotional support through warmth, caring, understanding, and acceptance; b) demonstrating the parental therapeutic components of play therapy and helping parents obtain play therapy skills; and c) discussing how to continue improvement made in therapy at home. Those tasks coincide with those that play therapists perform in the positions of teacher, counselor, and consultant based on the Discrimination Model. Kottman (2011) illustrated how Adlerian play therapists guide parents to learn skills and gain insight into themselves and their child through parent consultation, which follows four phases. In the early stage of parent consultation, the therapist mainly serves as an information collector while building relationships with the parents. As the stage proceeds, the therapist helps parents encounter themselves through experiential activities, such as family drawing, sandtray, and family games, through which parents realize inter- and intrapersonal dynamics that occur around their child's issues. Toward the later phase of reeducation, the therapist actively brings his/her teaching techniques through discussion, modeling, and behavioral rehearsal. As seen, different play therapy approaches embody different role-playing on the part of the therapists.

### *3.1 The Discrimination Model in Parent Involvement*

To contextualize the Discrimination Model to parent involvement, the juxtaposition of child practitioners with the position of the supervisors and parents to those of the supervisees is proposed. The proposed objective of the child therapist's three roles—teacher, counselor, consultant—and tasks corresponding to each role are as follows. Interchanging their roles, child therapists approach parents with three foci:

- Intervention skills to help parents obtain technical aspects such as coping and intervention strategies to their child's symptoms and difficulties
- Conceptualization skills to help parents clearly comprehend their child's case, identify what may contribute to their child's issues, and understand therapeutic aspects that are occurring in child therapy sessions
- Personalization skills to help parents gain insight into how their personal or couple issues may interface with their child's symptomatic presentation

When simplifying those roles, in the position of a teacher, child practitioners teach parents coping techniques and interventions, provide psycho-education to increase parents' awareness of child development, and help to improve their parenting skills. In the consultant position, therapists help parents conceptualize their child's case through a wider perspective by considering holistic aspects from both the child and parents. Finally, as a counselor, child practitioners support parents in gaining insight into the dynamics between their child's existing problems and their individual or couple issues.

Child practitioners can make professional judgments about which roles they will function as at involvement meetings to facilitate the children's therapeutic processes. When determining the type(s) of role to play, there are dimensions that they should take into consideration on the parts of both parents and child practitioners. These aspects will be discussed following Table 1, illustrating how each role intersects with the three different foci in parent involvement.

Table 1 Discrimination Model in Parent Involvement

<b>CHILD THERAPIST'S ROLE</b>			
<b>Focus of Intervention</b>	<b>Teacher</b>	<b>Counselor</b>	<b>Consultant</b>
Intervention	<ul style="list-style-type: none"> <li>· Therapist teaches parents coping techniques and interventions to child's internal or external issues through role-play, demonstration, or observation of child-therapist sessions.</li> <li>· Therapist provides education on parenting skills and effective communication skills</li> </ul>	<ul style="list-style-type: none"> <li>Therapist helps parents understand how implementing interventions may affect them and finds limitations that they may have in utilizing the interventions</li> <li>· Therapist emotionally encourages parents throughout the intervention-implementation.</li> </ul>	<ul style="list-style-type: none"> <li>· Therapist brainstorms with parents to help them come up with their own ideas for coping strategies.</li> <li>· Therapist helps parents expand learned techniques or develop different coping strategies</li> </ul>
Conceptualization	<ul style="list-style-type: none"> <li>· Therapist helps parents recognize themes and patterns of the child's problems and identify thematic statements the child uses (e.g., blaming, passive aggression) through parents' close observation of the child or by looking at session tapes together (with child's consent)</li> <li>· Therapist helps parents gain developmental knowledge about their child through psycho-education, through which they can better conceptualize their child's symptoms distinct from developmental features</li> </ul>	<ul style="list-style-type: none"> <li>· Therapist helps parents become aware of their willingness/reluctance to set realistic goals for the child.</li> <li>· Therapist helps parents gain insight into how their levels of discomfort related to goals may affect their inability to help the child.</li> </ul>	<ul style="list-style-type: none"> <li>· Therapist discusses potential conceptualization for the child's case through more shared stories and by looking at different models for case conceptualization</li> <li>· Therapist helps parents gain comprehensive understanding of where their child's symptoms are problematic and how the symptoms may have derived by mutually sharing each other's understanding and information of the child</li> </ul>
Personalization	<ul style="list-style-type: none"> <li>· Therapist assigns parents books or reading materials pertinent to the parents' parenting style and the child's issues.</li> <li>· Therapist discusses parents' learning from the readings by helping the parents relate the books to them.</li> </ul>	<ul style="list-style-type: none"> <li>· Therapist discusses what parents' personal or couple issues may relate to their concerns about the child.</li> <li>· Therapist helps parents gain insight into how their personal or couple issues may affect their child's difficulties.</li> <li>· Therapist provides low-keyed counseling for parents</li> </ul>	<ul style="list-style-type: none"> <li>· Therapist addresses how their comfort or discomfort zone affects identification of their child issues.</li> <li>· Therapist gently confronts parents' issues that may relate to the child's symptoms.</li> </ul>

### 3.2 Role Expansion from the Discrimination Model

When applying the Discrimination Model in the supervision of parent involvement in child therapy, child practitioners should expand their roles beyond the three dimensions to facilitate the parents' relevant engagement levels. This additional demand is derived from the inherent difference between supervisees and parents. Supervisees in supervised settings are ready-recipient for feedback from their supervisors; they are willing to listen to suggestions or guidance offered by supervisors for their professional development. Unfortunately, this level of readiness does not occur for all parents. Parents often bring their children to therapy when they exhaust their other options, resulting in much self-doubt in the parenting ability. Some parents feel doubtful about their child's sessions; others may struggle from their own issues, which may hinder them from gaining critical insight through parent involvement. For both cases, parents' commitment to involvement could be minimal. Therefore, to encourage parents' engagement, child therapists need to take a more active, but gentler, stance in delivering appropriate feedback. Gil (2011) described one of the child practitioners' roles in working with parents as that of

cheerleaders, and Guerney (2003) identified the role as that of supporters. Because the quality of relationship between parent and therapist is critical, child practitioners will want to provide empathetic understanding of what the parents are going through relative to their child's symptoms. This connection with parents is a cornerstone to building trusting relationships with them, and without this type of relationship the effectiveness of parent involvement could be in doubt.

#### **4. Aspects to Consider for Parental Inclusion and Therapist's Role-Decision**

Unlike the Discrimination Model in which supervisors consider the supervisees' needs and developmental capacity when deciding their role(s), child practitioners conceptualizing the Discrimination Model for parent involvement should contemplate multiple facets for role selection. Special consideration should be given in respect to the role decisions because parents are easily inclined to self-blame and become skeptical about their adequacy as parents (Landreth, 2012). This section covers only variables on the part of parents when it comes to parental involvement in child therapy, excluding considerations on the part of children such as severely traumatized children, children with severe mental health disorders, and children who have been severely sexually abused (VanFleet, 2014).

##### *4. 1 Parent Readiness*

Not all parents are ready for or participate in parent involvement. Many of the parents visiting child therapists have the expectation that their child's practitioner will cure their child and that all the child therapeutic processes have to do with the therapist, rather than with them. When the parents are invited to a parent involvement meeting, they are likely to be bewildered. Considering the potential ill-preparation of the parents, in the beginning stage of parent involvement, child practitioners may want to employ the roles of consultant and/or counselor. Interplaying these positions, therapists should first offer the parents a rationale for the parent involvement. In addition, when mutually discussing the child's matters with their parents, the therapists should provide empathetic understanding of the parents' position. Then therapists can gradually transition to a counselor's role based on the degree of the parents' insight and readiness. Booth and Jernberg (2010) commented that parents should have an understanding of the nature of play therapy, its underlying assumptions, therapeutic playfulness, and the importance of their participation in the involvement process.

##### *4. 2 Parent Insight into Themselves, the Child's Issues, and the Dynamic of the Two*

Parents' attitude and perception of themselves when it comes to their locus of control related to their child's issues are critical factors in determining the dynamics of the relationship between the parents and their child (Landreth, 2012) and affecting their interaction with their child and their involvement in their child's therapy. To help parents develop better awareness of aspects that may affect their relational dynamics with their child, play therapists should consider the parents' cognitive styles. Some parents are concrete thinkers, meaning they have a better understanding with specific examples and explicit instructions in comprehending the origins of their child's presenting issues and coping strategies for the difficulties. Other parents have a high level of awareness of the dynamics occurring around their child's problems, thus abstractedly process the information that is given. For the former case, child practitioners want to be a teacher more than the other two roles; for the latter they can shift between consultant and counselor or combine the two.

##### *4. 3 Relationship with Therapist*

Play therapy sessions can reveal boundary issues between the therapist and parents (Booth & Jernberg, 2010). This is true particularly when children display significant affection toward the therapist rather than their parents. Parents may project their anger toward the therapist or their child's behavioral problems (McGuire & McGuire, 2001). Therapists easily become the targets of blame for resistant parents. Therefore, effort in developing a relationship should come before disseminating practical tips for the children's problems and encouraging parents to practice those tips at home. When a trusting relationship is not established, parents may not agree to suggestions by therapists or may present resistance toward the child's therapy processes. For this task, therapists can exercise the counselor role first. For example, McGuire and McGuire recommended that therapists be mindful of delivering consistent and persistent reflection of the parents' feelings, communicate with empathy, and avoid power struggles to reduce parental anger and resistance and eventually lead parents to develop rapport with and trust in the therapists. Booth and Jernberg asserted that parents need to feel supported and acknowledged before they can attend to their child's needs. Parents need to feel heard, understood, safe, and unthreatened.

##### *4. 4 Parent-Child Relationship*

Consideration for the quality of the relationship between the parents and their child is critical when parents have histories of abusing or neglecting their child (VanFleet, 2014). In this case, parent involvement should be

deferred until professional judgment by play therapists guarantees the benefits of parent involvement in the child's therapeutic processes. According to Costas and Landreth (1999), parent engagement through filial therapy may not be successful for outcomes or for diminishing parental anxiety for sexually abused children.

Aside from the above scenario, the general suggestion (Booth & Jernberg, 2010; Kottman, 2011; Landreth, 2012; McGuire & McGuire, 2001; VanFleet, 2014) for therapists is to provide understanding to how tired parents may present difficulties originating from their child's symptom(s). When the parents' relationship with their child is strained, parents tend to become defensive about therapists' suggestions at home. Pointing out conflict(s) between child and parents and giving advice for improving the situation may not benefit the parents as parents may currently not be emotionally and mentally in a place to receive such information and suggestions. Careful approaches from the position of consultant or counselor are recommended to not trespass on the psychological territory of the parents and not cast them to a secondary position in their child's life (VanFleet et al., 2010), as they may feel inadequate as parents.

#### *4.5 External Issues Affecting Parents' Involvement*

Some parents may not be ready to take on parent involvement because they have other external issues, such as family or marital problems that may hinder their emotional involvement in their child's therapy process. Particularly, when parents are misusing drugs or are depressed, their engagement in the child's sessions should be placed on hold (Booth & Jernberg, 2010). Similarly, parents caught up in their own unresolved issues must first settle their matters before being able to meet their child's needs. In the position of counselor, child therapists may want to take a sympathetic posture toward the obstacles faced by the parents. Therapists should not blame parents for their limited, or total unavailability for their child's therapy. Parents may have legitimate reasons for not fully being present or not engaging in parent involvement. Under these circumstances, child therapists may want to deliver support and encouragement for parents. Some therapists provide low-key counseling for these parents. However, they should be careful about keeping a boundary as the child's therapist. If they sense parents need additional counseling, they should refer the parents to other counselors.

#### *4.6 Therapists' Theoretical Orientations*

Therapists' theoretical orientation is important in deciding the characteristic environment for parent involvement and the extent of parent involvement in children's therapeutic processes. For example, child-centered play therapists, whose theoretical concepts follow person-centered approach, trust in the children's healing and self-actualization capacity. They also believe that children are able to process their inner conflicts effectively through therapeutic play, thus engaging parents in their child's sessions may be less beneficial compared to their unaccompanied sessions. However, child-centered therapists may recommend a systemic approach to working with parents, inviting parents to learn basic play therapy skills to enhance their relationship with children through filial therapy (Landreth & Bratton, 2006, VanFleet, 2014). Theraplay (Booth & Jernberg, 2010) and Developmental play therapy (Brody, 1993) are other proactive approaches in encouraging parents to participate in their child's sessions. Theraplay therapists follow the attachment theory in which they posit therapy goals as building healthy bonds between children and their parents. They believe that parents' involvement is a key to successful child therapy results. The form and degree of parental engagement in parent involvement may vary depending on the practitioners' theoretical orientation and their belief in parent involvement.

### **5. Conclusion**

Incorporating the Discrimination Model in parent involvement is a pragmatic application for guiding parents through child therapy processes. Child practitioners will gain competence by having a theoretical framework to illuminate how to handle and guide parents in relation to their child clients. Three roles—teacher, counselor, and consultant—are conceptualized within the Discrimination Model during which the therapists navigate which role to perform contingent on the parents' readiness levels, the parents' insight into their child's issues, the therapists' relationship with the parents, the parents' relationship with their child, the parents' external issues, and the practitioners' theoretical orientation. The Discrimination Model in parent involvement allows even child therapists without training on parent involvement to grasp what performance is expected at the meeting with parents. Successful parent involvement provides the potential to elicit parents' cooperation and engagement in the children's therapy processes, which is crucial in maximizing the child's results. Regardless of the theoretical orientation child practitioners identify with, the Discrimination Model in parent involvement offers a valuable pathway for mapping out the performance of the therapists at parent involvement. Given the reality that the majority of child therapists should deal with parents, review of the application of the Discrimination Model in parent involvement is highly recommended for all child practitioners. Also, research examining the effect of application of the Discrimination Model in parent involvement on child practitioners' competency in working with parents is encouraged to provide empirical evidence for this model.

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