

Family Matters: Engaging Parents in Youth Treatment

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Abstract

One of the keys to successful adolescent development is a healthy family dynamic. It is thus beneficial for adolescent treatment agencies to recognize, address, and foster family health such that the home system can support and sustain treatment gains made by the adolescent. In this paper, we describe how one residential program defines and facilitates the family work that happens in conjunction with youth therapy, called the Parallel Process. We also detail how parental skills learned during therapy are quantitatively associated with youth length of stay and post-treatment youth substance use and internalizing and externalizing problems.

Keywords: adolescent therapy, residential treatment for youth, family work for youth in therapy, family therapy, adolescent substance abuse, adolescent mental health, Satir family model, Parallel Process.

Family Matters: Engaging Parents in Youth Treatment

Family health is one of the keys to the success and emotional growth of an adolescent. All too often it seems that therapeutic adolescent programs pay lip service to working with families, without actually challenging the whole family system to change. In our clinical work, we have found that it is vital to recognize, address, and foster the maturity of the family in order to impart sustainable change in the adolescent. Family work is hard work, especially if families are far away, if therapists lack experience and confidence in doing family therapy, and if families themselves are ambivalent or outright resistant to change. Haine-Schlagel and Walsh (2015) note that there is very little information about how to optimize parental engagement with therapy and that more information is needed to flush out whether different types of parental engagement lead to different youth outcomes. In this paper, we describe how one residential program defines and facilitates the family work that happens in conjunction with youth therapy, called the Parallel Process. We will discuss typical barriers and solutions to engaging parents and also provide evaluation results that suggest that skills fostered through the Parallel Process are associated with youth substance use and internalizing and externalizing problems.

What is the Parallel Process?

As articulated by Kristy Pozatek, the Parallel Process is when parents engage in the therapeutic process and grow alongside their adolescent by looking at themselves for ways that they may be inadvertently interfering with their teen's maturity and/or lack their own emotional maturity (Pozatek, 2008). It requires that parents gain self-awareness about their part in their adolescent's difficulties and then find the courage to make the necessary changes. The Parallel Process is an opportunity for parents to work with therapists and their child to repair damaged relationships, establish healthy boundaries, and improve family communication. The goals of the Parallel Process are for parents to behave in new ways based on a higher self-awareness and self-responsibility and ultimately, to facilitate, support, and sustain their youth's treatment gains.

Two cornerstone skills that can be cultivated during the Parallel Process are accurate attunement and attuned limit-setting. We define attunement as a parent's ability to deeply see and understand their child. In other words, attuned parents understand the heart and situation of their child and communicate this understanding to their child. McKinnon (2011) refers to this attunement as 'recognition' of a child's strengths and vulnerabilities and the capacity to foster maturity in the context of that recognition. Limit-setting incorporates the knowledge of healthy boundary establishment and appropriate consequences for behavior.

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Benefits of the Parallel Process

There is some literature exploring the benefits of parental involvement with their child's therapy, but much of what does exist involves children in less intensive therapeutic settings, aged seven and older, whose young age more naturally incorporates parental involvement as a part of the child's therapeutic plan. However, within these contexts, there is some evidence that parental engagement improves youth outcomes. For example, Dowell and Ogles (2010) conducted a review of 48 psychotherapy outcome studies and found that parent-involved therapy was associated with improved youth outcomes over and above non-parent involved therapy, with a moderate effect size of $d = 0.27$. The authors note the need for more research to explore parent engagement factors and look at how therapists might optimize youth outcomes by considering parents as co-clients. Another review of nine CBT outcome trials for anxious youths aged 7-18 could not definitively conclude that parental involvement led to better youth outcomes, however, despite citing myriad methodological limitations and variability in research methods, the authors offer that the results could be viewed as '*favoured evidence appears real*' (p.578), suggesting that there are likely benefits of involving parents in youth therapy (Barmish & Kendall, 2005). It's clear that more information is needed, particularly in the area of parental involvement with their teenager's therapy, and especially as it pertains to residential or wilderness therapy.

Some benefits that the Parallel Process may foster are youth treatment completion, parental emotional growth, improved family communication, and sustained treatment gains. First, earnest involvement of the family may be a catalyst that increases the adolescent's own motivation and commitment to stay the course in treatment. Second, parents may feel more a part of the process and less out of control when they, too, are engaged in the self-growth that mirrors that of their adolescent. Third, by working in parallel, both the youth and their family can learn and share a new vocabulary, which should foster improved communication. Finally, the Parallel Process may sustain the emotional growth work the adolescent completes during therapy, and promote lasting change for the entire family.

Obstacles to the Parallel Process

There are several factors that may interfere with the Parallel Process that can stem from the therapist or the parents. It may be too easy for therapists to fall into the trap of aligning with the adolescent, opposing the parents, and "divorcing" the parents from the therapeutic process.

Therapist-based barriers to successful family work can be addressed in several ways. First, inexperienced therapists could shadow more experienced therapists in family sessions. Indeed, in one study it was found that therapists with more experience were more likely to engage parents in the therapeutic process than therapists with less experience (Haïne-Schlagel, Brookman-Fraze, Fettes, Baker-Ericzen, & Garland, 2012). This suggests that shadowing may benefit less experienced therapists as they witness more experienced therapist's comfort with outlining expectations, ongoing communication, and engagement in therapeutic activities.

Second, therapists may gain skills through family-specific therapeutic training and ongoing supervision. One type of training that may be effective in increasing family skills is the Satir family approach (Satir, 1988). This approach includes many experiential activities to ground skills and build growth. The Satir approach encourages self-responsibility through individuation (awareness the inner self) and differentiation (identity and emotional separation within the context of the family) for all members of the family.

Therapist's personal family history naturally surfaces over the course of working with other families and this may interfere with therapeutic progression. Indeed, Minuchin (1998) comments on the need for therapists to avoid the trap of imposing his or her historical or current barriers to growth, and rather, to be closely attuned to the family narrative. Given this, a way therapists can overcome this barrier to engaging parents is to engage in their own process of increased self-awareness and self-confidence via therapy, group consultations, supervision, and continued education on family therapy.

Just as therapists can interfere with the parallel process, so the family can interfere with the adolescent's process, particularly by their own resistance to change. There are several reasons this might occur. First, it's common that parents deny their role in their adolescent's difficulties. It's important that parents are made to recognize, without assigning blame, that they are 'too important *not* to have an impact on their teenager's development'. Second, parents may focus only on their child's concerning behavior; progression (or lack of) through the therapeutic program, "flaws" of the program; their child's

academic or vocational future (Potazek, 2010). When parents are engrossed in these areas of focus, there remains little room to recognize the family dynamics that may contribute to the problematic health and behavior of their teenager.

There are a number of ways to overcome these parent-derived obstacles to youth therapeutic progression. Parent engagement needs to be more than just attendance at learning or therapeutic opportunities. For example, Haine-Schlagel and Walsh (2015) remind us that attendance is not a representative proxy of behavioral engagement with the process. Parents need explicit information about what is involved with a Parallel Process and they need to commit to approaching youth therapy in collaboration with the provider. Agencies can provide the environment and tools for parents to begin the change process and in doing so, parents may form their own support network with other parents that can foster a culture of authentic connections, recognition of each other's vulnerability, and challenge toward learning and growth.

Research Questions:

We explored the following questions:

1. What is the relationship between parent skills and post treatment youth substance use and internalizing and externalizing problems?
2. What is the relationship between parent skills and youth treatment duration?

Method

Pine River Institute (PRI) is a 36-bed residential treatment and wilderness leadership experience for youths aged 13-19. It places a high priority on family growth and maturity and has structured the program to cultivate transformative change in families through systemic adoption of the Parallel Process model. PRI is located in rural Ontario, Canada. Youths who attend PRI struggle with addiction issues and often mental health, behavioral, and relationship problems. Before PRI, youths experience compromised health, impaired development, and chaotic relationships. The treatment approach focuses on helping adolescents mature, using a developmental and relational model. Youths are placed in one of four gender-based teams, each of which is associated with a core group of staff including a therapist as the clinical supervisor and leader of the team and three front-line team leaders. Treatment duration varies by individual need, but is typically two months in an Outdoor Leadership Experience (OLE Phase), twelve months at the residential campus (Residence Phase) eventually with shared time between home and the campus (Transition Phase), and up to a year engaged with an aftercare specialist.

The program implements Parallel Process via a multitude of events and interventions: Three-Day Parent Retreats, Semi-Annual Two-Day Parent Learning Workshops, Weekly Multi-Family Groups, Bi-weekly Parent Groups, Sunday Brunches and Satir Informed Family Therapy. During these opportunities, parents partake in learning activities, such as charting their family map, understanding family rules, and sculpting the coping stances within their family (Satir). Parents also engage in learning sessions related to developmental-relational approaches to understand their teenager. These opportunities help parents grow together and create a community culture of openness, learning, and support. Within this culture, mentorship naturally emerges from families whose youths are further along in the program and this mentorship provides hope and guidance for newer families, while strengthening the mentor's own increased awareness and self-responsibility.

Participants in this study were 70 families whose youths had attended PRI between 2010 and 2014. Youths in these families had an average age of 16.9 years at admission, 14% were adopted (not by a step-parent), and 68% were male. In 58% of the families, the biological parents lived together. These families, before treatment, were typically mired in ongoing crises related to their teenager's substance use, mental health, relationship, and behavioral problems. Specifically, about two-thirds of youths had experience with running away or contact with police, at least a third had visited a hospital for substance use or mental health reasons, academic careers were stalled or abandoned, and most of their relationships were fleeting or in turmoil.

Length of stay at the program is variable, dependent upon the youth's growth and maturity. Youths in this study stayed in the program an average of 376 days. In terms of therapeutic progression, 62% completed the residential phase of the program (29% departed during Residence and 9% during Transition phases).

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Post-treatment information is collected at one, three, six, and twelve months after the youth left the program, and then annually, after a youth has departed the program. For post-treatment time-point for this study, we collapsed the three- and six-month post-PRI data (using the three-month scores if there were duplicates). Post-treatment response rate for all parents is 67% (82% for families whose youth complete the program).

Measures

Youth age at admission, sex (*female* = 0, *male* = 1), phase of departure (POD; *OLE* = 1, *Residence* = 2, *Transition* = 3, *Completion of Residence* = 4), and duration of treatment are all collected as part of our ongoing records, via BestNotes client record management software (BestNotes, LLC.).

We measured clinician-rated attunement (ATTUNE) and limit setting (LIMITS). Attunement was defined as the capacity of the parent to deeply understand the needs and behaviors of their child and limit-setting was defined as appropriate boundaries and consequences for behavior. For each maternal and paternal caregiver, clinicians rated ATTUNE and LIMITS on a scale from 0 (*very low*) to 10 (*very high*) near the end of the youth's stay in the program. For this study, we took the average of the paternal and maternal caregiver ATTUNE and LIMITS.

Parent reported post-treatment information includes youth mental health and youth substance use. Youth mental health was measured with the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). This 112-item measure has impressive content, criterion, and content validity with the sub-factor reliability alpha ranging from .78 to .97. The CBCL instructs parents to describe their child over the past six months for questions such as '*too fearful or anxious*' with response options of '*Not True*' (0), '*Sometimes or Sometimes True*' (1), and '*Very or Often True*' (2). Scores are summed for each of eight subscales. Three of those subscales (Withdrawn / Depressed, Anxious / Depressed, and Somatic Complaints) combine to form the Internalizing Problem composite scale. Two sub-scales form the Externalizing Problems composite scale (rule-breaking behavior and aggression). We adopted the general Externalizing and Internalizing scales for our purposes. Youth substance use is measured with one question asking parents about the youth's substance use behavior over the previous three months, with response options of *Abstinent* (1), *Social / Occasional* (2), *Periodic Slips* (3), and *Consistent & Problematic* (4).

The means, standard deviations, and medians for all relevant variables are given below (Table 1)

Table 1. *Descriptive Statistics for Predictors and Outcomes*

	Mean	SD	Median
ATTUNE	4.9	2.4	4.8
LIMITS	3.3	1.3	4
Substance Use 3-6 Months Post-PRI	1.9	1.1	1
Internalizing Problems 3-6 Months Post-PRI	9	7.1	8
Externalizing Problems 3-6 Months Post-PRI	7.7	7.4	6
Length of Stay	375.8	158.8	367.5

Analyses

We used multiple regression for all of our analyses. Although we were not primarily interested in sex, age, or POD for this particular study, these factors are known to predict treatment outcomes. For example, females tend to experience success more than males (Cady, Winters, Jordan, Solberg, & Shindfield, 1996; Harrison & Hoffman, 1987). Richter, Brown, and Mott (1991) found that age was associated with youth outcomes. Finally, longer stays have been associated with more positive treatment outcomes (Latimer, Newcomb, Winters, & Stinchfield, 2000), and likewise, treatment completion was found to predict better outcomes (for example, see Gorske, Srebalus, & Walls, 2003; Winters, Stinchfield, Opland, Weller, & Latimer, 2000). So, we know that age, sex, and treatment completion

predict outcomes for youth. With this in mind, we wanted to control (statistically) for these factors. If we did not control for these factors, the variability in our outcomes might possibly be unaccounted for or possibly misallocated.

Our first investigation explored predictors of post treatment youth substance use and internalizing and externalizing problems.

Substance Use

The overall model predicting post-treatment substance use was significant ($F_{(5,49)} = 2.60, p = .037, R^2 = .21$). In other words, youths vary on their substance use after PRI and the combination of sex, age, POD, ATTUNE, and LIMITS accounted for 21% of that variability. In particular, POD was a significant predictor of substance use, as seen below (Table 1); for every one phase further a youth progresses in the program, we can estimate a decrease in substance use by .39 of a standard deviation (SD). The other variables were not significant predictors of post-treatment substance use (as noted by p -values greater than .05).

Table 2. Predictors of Post-Treatment Substance Use at 3-6 Months

	β	SE(β)	β (ST)	t	p
(Constant)	2.67	1.64		1.62	0.11
SEX	0.34	0.31	0.15	1.09	0.28
AGE	0.03	0.10	0.04	0.33	0.74
POD	-0.45	0.19	-0.38	-2.40	0.02
LIMITS	0.04	0.13	0.05	0.29	0.77
ATTUNE	-0.04	0.07	-0.09	-0.56	0.58

Internalizing Problems

The overall model predicting internalizing problems was significant ($F_{(5,48)} = 3.49, p = .009, R^2 = .27$). Here, 27% of the variability in internalizing scores was attributed to our combination of variables. LIMITS and ATTUNE significantly predicted internalizing problem scores. Specifically, controlling for other variables, as ATTUNE increased by one unit, internalizing problems decreased by almost half (.46) of a standard deviation. For every one unit increase in LIMITS, internalizing problems scores increased by .39 SD.

Table 3. Predictors of Post-Treatment Internalizing Problems

	β	SE(β)	β (ST)	t	p
(Constant)	-6.23	11.44		-0.54	0.59
SEX	-1.40	2.06	-0.09	-0.68	0.50
AGE	1.07	0.67	0.20	1.60	0.12
POD	-0.46	1.28	-0.05	-0.36	0.72
LIMITS	2.02	0.77	0.39	2.60	0.01
ATTUNE	-1.44	0.44	-0.46	-3.25	0.00

Externalizing Problems

The overall model predicting externalizing problems was not significant ($F_{(5,48)} = 1.60, p = .18, R^2 = .14$). In other words, this combination of variables did not predict scores on externalizing problems.

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Table 4. Predictors of Post-Treatment Externalizing Problems

	β	SE(β)	β (ST)	<i>t</i>	<i>p</i>
(Constant)	15.83	12.12		1.31	0.20
SEX	0.27	2.18	0.02	0.13	0.90
AGE	0.01	0.71	0.00	0.01	0.99
POD	-2.39	1.35	-0.29	-1.77	0.08
LIMITS	0.93	0.82	0.18	1.13	0.26
ATTUNE	-0.72	0.47	-0.24	-1.53	0.13

Length of Stay

The overall model predicting length of stay was significant ($F_{(5,120)} = 22.16, p < .001, R^2 = .48$). So, 48% of the variability in length of stay can be attributed to this combination of variables. Sex, POD, and parent factors were all significant predictors of treatment duration. Girls stayed longer than boys (57 days), those who progressed further in the program stayed longer (for each stage progressed, estimate 120 days longer), and as parental limit setting increased, so did the length of stay (19 days for each one unit increase in limit-setting). Finally, higher parental attunement was related to shorter treatment duration (13 days for every one unit increase in ATTUNE). For example, youths whose parents have an average score of five on attunement near the end of treatment can be estimated to stay an additional 39 days compared to those whose parents average 8 or an additional 65 for those whose parents average 10.

Table 5. Predictors of Treatment Duration

	β	SE(β)	β (ST)	<i>t</i>	<i>p</i>
(Constant)	76.90	139.25		0.55	0.58
SEX	-57.01	24.03	-0.16	-2.37	0.02
AGE	-3.45	7.88	-0.03	-0.44	0.66
POD	120.62	13.77	0.66	8.76	0.00
LIMITS	18.76	8.01	0.18	2.34	0.02
ATTUNE	-12.88	5.26	-0.20	-2.45	0.02

Note: There were 125 participants in this analysis as we could include families who had not yet contributed to post-treatment data.

Discussion

Our findings were interesting in several ways. First, we showed that POD is an important element for predicting reduced substance use. In other words, treatment completion is associated with reduced substance use three to six months after the program.

Parent skills had an impact on internalizing problems to the degree that they trumped the influence of POD. In other words, parental attunement was associated with reduced youth internalizing problems, even when we factored into the analysis the impact of therapeutic progression. This is intriguing, given the breadth of research that has found treatment completion to be such a strong predictor of post-treatment youth improvement. We think it is important to note, however, that we are not advocating that one need not complete treatment plans in order to reduce internalizing problems. Instead, we promote that good treatment that includes a structured and purposeful parental parallel process is likely to improve the outcomes of youths, even if the youth does not fully complete the program.

The increase in internalizing scores when parental limit-setting was higher merits some thought. In other words, the more strictly that parents set limits with their adolescent, the more problematic the youth's internalizing problems were scored. It's possible that high parental limit-setting enters the realm of rigidity, which may not resonate with a youth who feels that they have matured beyond the need for very strict limits. Further, it's possible that parents may utilize limit-setting without accurate attunement, perhaps based on their own anxiety and experience pre-treatment. This may overlook the

real needs of the child, and be a catalyst for unhealthy emotional reaction for the youth.

The non-significant findings about externalizing problems was not overly surprising. The CBCL includes a broad array of aggression and rule-breaking problems (one element of which is substance use). Thus, nonsignificant findings could easily be attributed to therapeutic or natural factors that were not included in this study.

The finding that parental skills predict therapy duration is compelling. Most importantly, reduced treatment duration means that youth may be treated more efficiently, with shorter treatment stays, when the Parallel Process model is used. It points to the potential value in investing in the Parallel Process as a cost-benefit strategy. Our findings suggest that, with dedicated family work to increase parent skills, the youth's treatment duration can be reduced by over one month.

In this paper, we defined and explained how one program employs the Parallel Process model. We provided early evaluation results that indicate that treatment completion is key to reducing youth substance use and that parental attunement is an important factor for improving the emotional health of their teenager. Finally, we found that parental attunement is associated with treatment duration. We consider this work a springboard for future exploration of the impact of parental engagement in the Parallel Process and the development of self-responsibility, awareness, and attunement.

Limitations

This study is not without its limitations. First, single site post-treatment only design does not allow us to claim that our results are caused by our treatment but rather can only explore the relationships between the two. Second, our substance use, ATTUNE, and LIMITS measures are not standardized; they were designed to be meaningful for treatment planning primarily, and used in this study to begin to explore and validate our work with families. Third, not all families who attended the program were included in the study. This could be due to lack of contribution or to the fact that the post-treatment time-points had not yet been reached at the time data were analysed. Finally, our use of simple multiple regression and post-treatment only data is not a limitation per-se, but we look forward to a few years in the future when we have enough pre-post data to look at changes over time and possibly developing models that explore parental skills as mediators or moderators of change.

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