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Observational Assessment of Engagement Strategies to Promote Parent Homework Planning in Community-Based Child Mental Health Treatment: A Pilot Study

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Abstract

Therapy homework includes tasks given to clients to complete outside of session to facilitate new knowledge/skills or to advance treatment goals. Homework completion, an important element of parent engagement in child mental health (MH) treatment, has been associated with improved child outcomes. The current pilot study assessed the design/assign phase of the therapy homework process to examine a) the extent to which therapists implemented engagement strategies with parents and b) whether therapist deployment of engagement strategies in early treatment predicted subsequent parent participation in homework planning. We included an ethnically-diverse sample of 10 therapists and 11 parent/child dyads receiving community-based MH services who participated in a pilot intervention study. Two observational coding systems were developed to code treatment session recordings for the extent to which a) therapists implemented engagement strategies with parents and b) parents contributed to therapy homework planning. Findings revealed low extensiveness of therapist implementation of engagement strategies with parents. As hypothesized, therapist use of engagement strategies (*Collaboration*, *Empowerment*, and *Psychoeducation*) in early treatment significantly predicted subsequent parent homework planning (*sharing perspective on homework planning*). However, therapist use of *Alliance* was unrelated to parent homework planning. These preliminary results suggest that therapist implementation of engagement strategies in early treatment may promote parent participation in homework planning, which is an important precursor to homework completion. This pilot study suggests potential future directions for both research on and training for community-based therapists in implementing successful strategies to promote parent homework planning in child MH treatment.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval This article does not contain any studies with animals performed by any of the authors. All procedures performed in studies involving human participants were in accordance with the ethical standards of the Institutional Review Board at San Diego State University and Rady Children's Hospital-San Diego.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Keywords

Parent engagement; Therapy homework; Child psychotherapy; Community-based mental health services; Disruptive behavior problems; Process research

Introduction

In child psychotherapy, although children are the identified clients, parents' active participation in their child's mental health (MH) treatment is considered critical to achieving successful outcomes (Nock and Ferriter 2005), with children faring better when parents are actively involved relative to individual child treatment (Dowell and Ogles 2010; Karver et al. 2006). However, most families only attend three to four treatment sessions before dropping out prematurely (Armbruster and Fallon 1994; Harpaz-Rotem et al. 2004; Kazdin 1996; Pellerin et al. 2010), and parents are often not actively involved in community-based MH service settings (Baker-Ericzén et al. 2013; Garland et al. 2010; Martinez et al. 2015). Community-based MH settings are locations in which MH services, which may or may not be evidence-based, are delivered to children, families, and adults within a "usual care" context, versus settings such as university training clinics or for efficacy research that do not provide care as it is typically provided (Garland et al. 2013).

The observed challenges in parent engagement in community-based MH settings is problematic given that many evidence-based interventions for child MH disorders include a parent component and thus necessitate active parent engagement (Kaminski and Claussen 2017). Treatment focus on the parent is particularly needed for child disruptive behavior problems (e.g., parent management training; Garland et al. 2008), which are the most common presenting problems in community-based mental health settings (Garland et al. 2001). There is great variability in the amount and type of care received in community-based MH care for child disruptive behavior problems (Garland et al. 2010). While community-based therapists employ a wide-array of practices with both children and parents, some of which are evidence-based, they often do not execute these strategies with the sufficient intensity that would be expected from evidence-based treatments (Garland et al. 2010). Thus, efforts are needed to understand factors impacting therapist implementation of evidence-based practices in community-based MH settings, particularly when it impacts parent engagement in child MH treatment.

A rich literature has examined factors associated with poor child MH treatment engagement, mostly measured by service attendance, across multiple contextual levels, including child, parent/family, provider, service, and organizational/program levels (e.g., Brookman-Frazee et al. 2010; Garland et al. 2012; Gopalan et al. 2010; Haine-Schlagel and Walsh 2015; Miller et al. 2008; Nock and Ferriter 2005). For example, child gender, symptom severity, and racial/ethnic background are all child factors that have been associated with engagement, although inconsistencies have been identified regarding the direction of these associations (e.g., Gopalan et al. 2010; Ingoldsby 2010). For parent factors, there are complex interactions among factors that impact MH treatment engagement. For example, greater psychopathology and stress, single parent status, poorer parental discipline effectiveness,

lower motivation to participate, and low level of family interaction are associated with poorer engagement (e.g., Gopalan et al. 2010; Haine-Schlagel and Walsh 2015). Additionally, parents may have had prior negative experiences with the MH system and/or a lack of high quality, culturally responsive care that may lead to poorer engagement (Gopalan et al. 2010).

Less research has been conducted on provider (e.g., provider background and experience; Garland et al. 2012) or service characteristics (e.g., strategies provided in treatment sessions, Garland et al. 2012) associated with engagement in child and family MH treatment. While whether parent engagement is wanted or invited by the provider has not yet been fully examined, some studies suggest that providers value using active strategies with parents that would require active parent engagement in sessions (Brookman-Frazee et al. 2010). Additionally, the evidence base points towards the importance of having parents actively participate in their child's mental health treatment, given better outcomes when parents are involved relative to individual child treatment (Dowell and Ogles 2010; Karver et al. 2006). There has been limited attention on organizational-/program-level factors, such as an organization's culture, climate, or policies, which have been examined in the adult treatment literature (e.g., Landrum et al. 2012). A recent study that examined parent participation in community-based MH services found significant program-level intra-class correlations (ICCs; Haine-Schlagel et al. 2016), while another study found very small program-level ICCs for parent attendance (Israel et al. 2007), suggesting variability in program-level effects on parent engagement. To address these challenges to parent engagement in community-based care, attention to parent engagement processes has increased in recent years (Becker et al. 2015; Gopalan et al. 2010; Haine-Schlagel and Walsh 2015; Ingoldsby 2010; Martinez et al. 2015).

Therapy homework completion is one important element of parent engagement (Haine-Schlagel and Walsh 2015; Lindsey et al. 2014). Therapy homework includes therapeutic tasks given to clients to complete outside of treatment sessions to reinforce and facilitate new knowledge and skills or to further advance treatment goals (Becker et al. 2015; Kazantzis et al. 2005; Lindsey et al. 2014). It is less likely that therapeutic changes achieved in treatment sessions are generalized to the home setting without therapy homework completion (Karver et al. 2006). Therapy homework completion has been linked to positive treatment outcomes. In child psychotherapy, parent homework naturally lends itself to the goal of enhancing skill acquisition and generalization outside of treatment sessions (Becker et al. 2015; Nock and Kazdin 2005), and thus is a core practice in evidence-based interventions for children with disruptive behavior problems (Garland et al. 2008). Moreover, a meta-analysis evaluating the effect of homework completion on cognitive behavioral treatment outcomes for adults provides empirical support for the role of homework in effective psychotherapy (Kazantzis et al. 2010). In the child psychotherapy realm, several parent training studies have found that therapy homework completion is associated with improved outcomes for children with externalizing disorders (Baydar et al. 2003; Kling et al. 2010; Tynan et al. 2004). Thus, the available data indicate that homework completion is an important element of engagement that can promote positive treatment outcomes.

Several theoretical models have been proposed regarding factors impacting homework completion, including client characteristics (e.g., severity of symptoms, motivation, beliefs about task and ability, etc.), therapist characteristics and behaviors (e.g. competence, enthusiasm/persuasiveness, therapeutic relationship/empathy, etc.), characteristics of the homework task (e.g., difficulty, topic, reminders/details to carry out, etc.), and environmental characteristics (e.g., unsupportive home environment, low psychosocial support, etc.), as well the interactions among these factors (Detweiler and Whisman (1999); Kazantzis and Shinkfield 2007). To date, the literature is limited on empirical tests of these factors predicting homework completion. One study experimentally examined client ambivalence and readiness to change as factors that influence homework completion. Participants assigned to a pretreatment Motivational Interviewing group vs. no pretreatment prior to initiating anxiety treatment demonstrated greater homework completion, which in turn improved outcomes (Westra and Dozois 2006), and homework completion mediated the impact of the pre-treatment group on anxiety reduction (Westra et al. 2009). A mixed-method study of therapeutic strategies to enhance homework completion found that therapists endorsed a broad range of strategies, such as praise, providing rationale, working collaboratively, and engaging clients through the therapeutic relationship (Houlding et al. 2010).

Kazantzis et al. (2005) proposed a therapy homework process model to better understand the complex nature of the therapy homework process, which includes four phases: 1) *Designing homework* (therapist and client determining the content and form of homework), 2) *Assigning homework* (therapist and client collaborating on methods to facilitate and reduce barriers to homework), 3) *Doing homework* (client implementing homework), and 4) *Reviewing homework* (review of homework, barriers to implementation, and integration of skills). The DADR model highlights the complex process leading to homework completion, with potential problems arising at each phase, particularly in the early phases. The *Design/Assign* phases are often grouped together, and reflect the homework planning behaviors that lead to homework completion. Chacko et al. (2013) assessed reasons endorsed by parents participating in a parent training intervention for not completing homework in all phases of the DADR model. They found that in the *Design/Assign homework* phase (grouped together), several reasons leading to a lack of homework completion arose, such as not agreeing with the rationale for homework, not feeling comfortable implementing homework, perceiving homework to be too difficult and confusing, and believing that homework would increase difficulties and would not work. It is also important to note that most problems arose in the *Doing Homework* phase, such as forgetting to do homework, having no time for homework, and difficulties with implementing homework (Chacko et al. 2013). Although the *Design/Assign* phase were grouped together and assessed separately from the *Doing* phase, it appears that the reasons cited for not doing homework may be linked to challenges in the *Design/Assign* phase and preliminarily suggest that homework planning and homework completion may be linked. That is, it is possible that obstacles to completing homework may be remedied in the homework planning phase. Thus, attention on how to engage parents in the homework planning process may be an important target for efforts to promote homework completion and its associated positive outcomes.

Although no direct links between the homework planning process and homework completion have been found to date, homework planning has been found to impact treatment outcomes. For example, Detweiler-Bedell and Whisman (2005) examined how the manner in which homework was assigned impacted treatment outcomes for adults receiving treatment for depression. They found that better treatment outcome (reduction in depressive symptoms) was associated with client involvement in the assignment of homework, therapist behaviors (i.e., setting concrete goals, discussing barriers to homework completion), and homework task characteristics (i.e., providing written reminders). It is important to highlight that the degree to which clients were involved in early discussions of homework planning was associated with subsequent positive treatment outcomes (Detweiler-Bedell and Whisman 2005). Thus, the available data suggest that engaging parents in the homework planning process may have a positive impact on homework completion and ultimately treatment outcomes.

One set of factors that may impact both homework planning and homework completion are therapists' deployment of client engagement strategies (*Alliance, Collaboration, Empowerment, and Psychoeducation*). For example, building a strong therapeutic alliance (i.e., establishing and maintaining a warm and open relationship as well as a sense of working together in therapy; Horvath et al. 2011), particularly in the context of developing a mutual understanding of homework, can enhance homework completion (Dozois 2010; Kazantzis and Shinkfield 2007). A poor alliance may result in low client involvement in initial discussions around homework planning (Detweiler-Bedell and Whisman 2005). It is also essential for therapists to focus on developing a collaborative relationship with parents, as a collaborative partnership motivates and engages the client (Wampold 2001). Developing homework in a collaborative manner is crucial to the homework process (Chacko et al. 2013), as a lack of collaboration during the homework planning process can be a significant barrier to homework completion (Dozois 2010; Kazantzis and Shinkfield 2007). Empowerment strategies, aimed at praising and helping parents develop skills and confidence in actively creating change in their family's lives (Olin et al. 2010; Scheel and Rieckmann 1998), is also an important component to attend to in the homework planning process. In fact, using praise was the most highly endorsed strategy among therapists to enhance client follow-through with homework completion (Houlding et al. 2010). Lastly, psychoeducation strategies, the practice of presenting factual information about MH problems and rationale for treatments (Lukens and McFarlane 2004), is important to orienting and preparing families for treatment, particularly in the initial phase of the homework planning process. As barriers to homework completion arise in not agreeing with the rationale for homework (Chacko et al. 2013), clarifying the rationale using psychoeducation is important (Dozois 2010), and is thus a highly endorsed strategy among therapists to enhance homework completion. (Houlding et al. 2010).

As evidenced, therapist engagement strategies are important to address challenges that may arise along the complex DADR homework process leading to homework completion. This is especially important in homework planning discussions in the *Design/Assign* phase, where both active therapist and parent participate in collaboratively determining the content of homework and addressing barriers to completion is needed (Chacko et al. 2013). The current pilot study, drawn from a larger pilot trial, examined the links between therapist engagement

strategies and parent contributions to homework planning in community-based child MH treatment. Specifically, the first aim of the current study was to examine the extensiveness of in-session therapist deployment of *Alliance*, *Collaboration*, *Empowerment*, and *Psychoeducation* engagement strategies to parents of children with disruptive behavior problems served in community-based MH settings. The second aim of the current study was to examine the effect of therapist deployment of these engagement strategies with parents on promoting in-session parent homework planning in the design/assign phase. To investigate these aims, two observational coding systems were developed to code treatment session recordings for a) therapist in-session use of engagement strategies and b) parent in-session homework planning. We hypothesized that therapist deployment of engagement strategies to parents in the initial phase of treatment would predict subsequent parent homework planning behaviors.

Method

Participants

Therapist participants—A subsample of 10 therapists providing publicly-funded MH treatment for 11 parent/child dyads from five outpatient community MH clinics were included from the larger pilot trial. Therapists were recruited and enrolled prior to parent-child dyads, and therapist eligibility criteria for the larger pilot trial were as follows: 1) employed at their agency for at least the next 5 months, 2) provided clinic-based psychotherapy to children and their families, and 3) able to start a new episode of care with an eligible parent/child dyad during the recruitment window. Therapists who consented were randomized to PACT plus SC or SC alone. The subsample of therapists (across both conditions) included in the current study ($N = 10$) was drawn from the larger pilot trial sample of therapists ($N = 19$) that had a parent/child dyad participate in the study. Subsample participants were eligible if they had complete data to investigate the aims of the current study (i.e., completed more than four treatment sessions with the participating parent/child dyad since the dyad entered the study with available recordings of the first four treatment sessions and at least one recording after the fourth treatment session since the dyad entered the study). For their completion of measures, therapists in the PACT condition received \$45 and therapists in the SC condition received \$30. In addition, therapists were entered into monthly opportunity drawings for \$10 across their participation in the study for completion of parent/child measures. See Table 1 for therapist demographics.

Parent/child dyad participants—A subsample of 11 parent/child dyads receiving treatment in community MH clinics was included from the larger pilot trial. Parents were approached by participating therapists early in the treatment episode for permission to be contacted by the research team, and parent eligibility criteria for the larger pilot trial was as follows: 1) parent was the child's legal guardian, 2) parent was English-speaking, 3) parent was at least 18 years old, 4) child was between 4–13 years old, 5) parent had identified disruptive behavior problems (e.g., aggression, noncompliance, delinquency) as a presenting problem for the child's treatment during the pre-screen interview, and 6) parent and child had attended four or fewer treatment sessions with the participating therapist at the time of recruitment. The subsample of parent/child dyads (across both conditions) included in the

current study ($N = 11$) was drawn from the larger pilot trial sample of parent/child dyads ($N = 20$). As indicated above, subsample participants were eligible if, since entering the study, they had completed more than four treatment sessions with the participating therapist with available recordings of the first four treatment sessions and at least one recording after the fourth treatment session since the dyad entered the study. Parents in the PACT condition received up to \$50 and parents in the SC condition received up to \$35 (given increased time commitment for the PACT condition). Parents were entered into monthly opportunity drawings that were each worth \$10 across their participation in the study for completion of ongoing study measures. See Table 2 for parent/child dyad demographics.

Procedure

The current study drew data from a pilot randomized intervention study that examined the preliminary effectiveness of a toolkit (the Parent And Caregiver Active Participation Toolkit or PACT; Haine-Schlagel et al. 2017) to promote parent participation engagement (PPE) in community-based child MH services. This randomized pilot of PACT plus standard care (SC) vs. SC alone was conducted in community-based MH clinics in San Diego, CA. Data collection was approved by the San Diego State University and Rady Children's Hospital Institutional Review Boards. See Haine-Schlagel et al. (2017) for a complete description of the larger pilot trial's study design.

Measures

Sociodemographics—At baseline, therapists reported on sociodemographics including gender, age, race/ethnicity, education level, as well as background and training (e.g., theoretical orientation, training in evidence-based practices, experience providing MH services, etc.). Parents reported on sociodemographics about themselves and their participating child.

Therapist Alliance, Collaboration, and Empowerment Strategies (ACEs) Observational Coding System (Haine-Schlagel and Martinez 2014b)—A 12-item observational coding system was developed for the current study to measure therapists' in-session use of engagement strategies directed at parents in child/family treatment session recordings. The engagement strategies in the coding system were based on (a) a training manual developed by the second author on treatment engagement strategies, (b) a review of the literature, (c) review of treatment session recordings, and (d) clinical experience. The coding system was developed to align with the structure of an existing observational coding system for capturing therapists' delivery of therapeutic strategies from a large-scale study of psychotherapy for children presenting with disruptive behavior problems (*Scoring Manual for the PRAC Study Therapy Process Observational Coding System for Child Psychotherapy: Strategies Scale*; Garland et al. 2008; Garland et al. 2010). The coding system captures extensiveness, which reflects both frequency and thoroughness of use of each strategy. Each code is rated on a seven-point Likert scale (0–6), with higher numbers indicating greater extensiveness (*0 = Therapist did not implement strategy; 1–2 = Therapist implemented strategy with low extensiveness; 3–4 = Therapist implemented strategy with moderate extensiveness; 5–6 = Therapist implemented strategy with high extensiveness*).

The therapist engagement strategies measured in the coding manual included *Alliance* (3 items: active listening, conveying parent-therapist partnership, communicating positive regard), *Collaboration* (5 items: offering suggestions, seeking parent input, incorporating parent input, involving parent in therapeutic activities, and working with the parent on plans for parent-focused homework), *Empowerment* (2 items: recognizing parent strengths and effort, addressing barriers to parent participation), and *Psychoeducation* (2 items: providing information about child problems, providing information about child MH treatments). Extensiveness ratings (0–6 Likert Scale) are based on the presence/frequency of the strategy as well as the thoroughness of use of the strategy. Therapists receive an extensiveness rating = 0 when they do not make any attempt to deliver the strategy to parents and receive a rating = 5–6 range when they consistently and/or very thoroughly deliver the engagement strategy. These statements are not rated in isolation, but rather in the context of the entire treatment session. The following are examples of therapist statements that can reflect high extensiveness (either delivered with high frequency and/or thoroughness throughout a treatment session) for each engagement strategy delivered to parents. *Alliance* - “Let me make sure that I’m understanding where you’re coming from. It sounds like the main area of concern for practicing this is...(summarizes concern). You’re right, it can be challenging to pay attention to and give praise for positive behaviors when you feel that your child is mostly doing negative things.” *Collaboration* - “What do you think about practicing praise? We can use some of our time today to come up with a list of behaviors that you can praise Johnny for, if you’d like? Let’s write down some things you can praise Johnny for, and how you will praise him when he does them.” *Empowerment* - “I really appreciate how open-minded you are about trying out this new strategy you’ve never practiced before. I’m only with Edgar for an hour a week, so you’re the person that knows best about positive behaviors to praise him for. I’m so glad you found time in your schedule for this.” *Psychoeducation* - “Lots of what children do happens for a reason. Usually that reason has to do with what the child does or does not get after he or she does something. Praise is useful because it helps us consider what is happening right in the moment to influence Johnny’s positive behavior.”

The coding team consisted of five undergraduate research assistants under the supervision of a postdoctoral research fellow (first author) and the principal investigator, who is also a licensed clinical psychologist (second author). Coders were trained for eight consecutive weeks before coding independently. Training included didactic training on the coding manual, practice scoring of treatment session recordings, review of specific treatment session segments, and weekly coding meetings to clarify codes and arrive at consensus. Codes were refined during the training process. The first and second authors produced seven gold-standard expert-rated recordings by coding treatment session recordings independently and having subsequent consensus meetings to address any discrepancies in codes. Coders were approved for coding independently after their ratings achieved an acceptable level of agreement with gold-standard expert-rated recordings (an average of 80% agreement within ± 1 point on a Likert scale from gold standard ratings across six practice recordings).

Therapists were asked to submit treatment session recordings with their parent/child dyads for up to four months. A total of 126 treatment session recordings were received. Only recordings that had the parent present for at least 10 min were included in the pool of

eligible recordings (two recordings were excluded). Treatment session recordings were then selected for coding from the (a) first four early treatment sessions after parent/child dyad enrollment, (b) three middle treatment sessions spaced approximately 1 month apart, and (c) the final treatment session. This yielded 93 treatment session recordings (approximately 50 min in length), with a per case average of 4.65 recordings. Of these 93 recordings, 28 (30.1%) were double-coded by a second coder to assess inter-rater reliability using intraclass correlations (ICCs). Only ACEs engagement strategies observed in treatment session recordings from the first four treatment sessions were included as predictor variables in analyses for the current study, as we were interested in measuring therapist use of engagement strategies in the early phase of treatment. This focus on the initial phase of treatment was driven by the consistent finding that most families only attend a handful of treatment sessions (Armbruster and Fallon 1994; Harpaz-Rotem et al. 2004; Kazdin 1996; Pellerin et al. 2010), which suggests that an intensive dose of engagement strategies early in treatment is critical for successful engagement.

Two codes were dropped from analyses due to low interrater reliability (*Empowerment: Addressed barriers to parent participation*) or extremely low rate of occurrence (*Collaboration: Therapist involved parent in therapeutic activities*), and thus a total of 10 codes were used for the current study. Inter-rater reliability for the remaining codes was fair to excellent according to accepted standards (M of ICCs = .63; range = .44-.80) (Cicchetti 1994). To obtain one score for each major engagement strategy, composites of the *Alliance*, *Collaboration*, and *Psychoeducation* items were created by averaging the individual items (except for *Empowerment*, which only had 1 item). The internal consistency of the composites were in the acceptable range; three items for *Alliance composite* ($\alpha = 0.72$), four items for *Collaboration composite* ($\alpha = .72$), two items for *Psychoeducation composite* ($\alpha = .60$).

Parent Participation Engagement (PPE) in Child Psychotherapy Observational Coding System (Haine-Schlagel and Martinez 2014a)

An observational coding system was developed to measure parents' in-session homework planning. Measurement of homework planning in the coding system was based on (a) a review of the literature, (b) review of treatment session recordings, and (c) clinical experience. To capture parent homework planning, a code of *sharing perspective on homework planning* was developed, which included statements where the parent provided their point of view, opinions, and/or suggestions about recommended therapy homework (e.g., "*I think it's going to be hard for me to ignore her crying.*", "*I feel nervous about putting him in a time-out.*", "*I wonder if I can also include her grandmother in providing these rewards to her?*" etc.). *Sharing perspective on homework planning* was rated on a five-point Likert scale (1–5), with higher numbers indicating greater extensiveness of participation (*1 = Parent did not share perspective; 2–3 = Parent shared perspective with low extensiveness; 4–5 = Parent shared perspective with high extensiveness*).

The same coding team and overall coding process were utilized as described above, with the exception of different recordings being used to create the gold standard recordings. Of the 93 eligible recordings (see above for description of eligibility criteria), 27 (29.0%) were

double-coded by a second coder to assess inter-rater reliability using intraclass correlations (ICCs). Only parent homework planning observed in treatment session recordings beyond the first four treatment sessions (post treatment session four) were included as the outcome variable in the current study, as we were interested in measuring parent homework planning after the early phase of treatment and using the engagement strategies detailed above as predictors of this outcome. Inter-rater reliability for the parent homework planning code of *sharing perspective on homework planning* was in the acceptable range ($ICC = .61$) (Cicchetti 1994).

Data Analyses

The effect of therapists' use of engagement strategies in early treatment (first four treatment sessions) on subsequent parents' in-session homework planning (after the fourth treatment session) was examined. To establish a temporal link between therapist implementation of strategies and subsequent parent homework planning, the analyses required using a subsample of cases that had more than four treatment sessions with the participating parent/child dyad since the dyad entered the study with available recordings of the first four treatment sessions and at least one recording after the fourth treatment session since the dyad entered. This resulted in a reduced sample of therapists ($N = 10$) and parent/child dyads ($N = 11$) compared with the larger parent pilot trial ($N = 19$ therapists; $N = 20$ parent/child dyads). Importantly, no significant differences on participant demographics between those parent/child dyads that were not included in the current study ($n = 9$) compared with those that remained ($n = 11$) were detected, either overall or within condition.

Multiple regression analyses were conducted using SPSS (IBM SPSS Statistics for Windows, version 22.0; IBM Corporation, 2013). Since data were drawn from a parent pilot intervention study, study condition (PACT versus SC) was controlled for in all analyses. Results from four separate regression models are reported, where each therapist engagement strategy was entered as predictor variables (*Alliance* composite, *Collaboration* composite, *Empowerment* item, *Psychoeducation* composite) of parent homework planning (outcome variable of *sharing perspective on homework*). Cohen's f^2 (Cohen 1988), which is appropriate for estimating the effect size within regression analyses, was calculated for each regression model.

Results

To obtain scores for each therapist and parent/child dyad across treatment session recordings, extensiveness ratings for coded treatment sessions were averaged across each therapist or parent/child dyad participant. For therapist implementation of engagement strategies delivered to parents in treatment sessions, scores were averaged across the first four treatment sessions from available treatment recordings. On average, when engagement strategies (*Alliance*, *Collaboration*, *Empowerment*, and *Psychoeducation*) were deployed by therapists, they were delivered with low extensiveness ($M_{\text{Range}} = 1.16\text{--}1.93$, on a 0–6 Likert scale). For parent homework planning demonstrated by parents in treatment sessions, scores were averaged after the fourth treatment session from available treatment session recordings. On average, parents demonstrated *sharing perspective on homework planning*

with moderate extensiveness ($M = 3.04$, $SD = 0.77$, on a 1–5 Likert scale). Mean observational ratings of therapist engagement strategies and parent homework planning are presented in Table 3, and a correlation matrix of all study variables is presented in Table 4.

Multiple regression analyses were run to determine the effect of therapist implementation of engagement strategies on promoting later in-session parent homework planning, controlling for study condition. As hypothesized, therapist use of engagement strategies in the early phase of treatment significantly predicted subsequent in-session parent homework planning after the early phase of treatment, controlling for study condition. Specifically, the *Collaboration composite* ($B = .81$, $p < .05$), *Psychoeducation composite* ($B = .49$, $p < .05$), and *Empowerment code (recognizing strengths and effort)* ($B = .53$, $p < .05$) significantly predicted parents' *sharing perspective on homework planning*, with Cohen's f^2 effect size estimates all in the large range. The *Alliance composite* was unrelated to parents' *sharing perspective on homework planning*. Results from these multiple regression analyses are displayed in Table 5.

Discussion

The central aim of the current study was to preliminarily examine the impact of therapist implementation of engagement strategies with parents on promoting parent homework planning behaviors, which is part of the *Design/Assign* phase of the DADR model (Kazantzis et al. 2005), in treatment for children with disruptive behavior problems served in community MH settings. While preliminary given the pilot nature of this study, the results provide data on the variability of the extensiveness of therapist deployment of engagement strategies and whether the extensiveness of engagement strategy deployment promotes parent homework planning for families receiving community-based child MH treatment.

Overall, when engagement strategies were deployed by community-based therapists, they were delivered with low extensiveness compared to what would be expected from evidence-based interventions that include a parent component (e.g., Brookman-Frazee et al. 2012). Although preliminary, the overall low extensiveness of delivery of therapist engagement strategies is somewhat expected given that community-based therapists frequently spend much time using eclectic strategies to engage clients, which may come at expense of delivering evidence-based strategies with high extensiveness (Garland et al. 2010; McLeod and Weisz 2005). For example, the strategy of assigning or reviewing homework is not commonly implemented by therapists in community-based child MH settings, and when it is observed, it occurs with low extensiveness of therapist delivery (Garland et al. 2010). It is important to note that the engagement strategies observationally coded in this study corresponded to practices found in interventions specifically designed to enhance treatment engagement (Becker et al. 2015; Lindsey et al. 2014), which may have contributed to lower extensiveness than coding for any type of engagement strategy. For example, engagement strategies that consist of directive treatment approaches (e.g., *Psychoeducation*) are not observed as frequently in community-based MH settings as in more structured treatment protocols (Malik et al. 2003). Further, although preliminary, the finding of overall low extensiveness of engagement strategies is consistent with larger scale studies (e.g., Garland et al. 2010) that have demonstrated that therapists rarely deliver these strategies with

sufficient extensiveness consistent with the expectations of evidence-based treatment models (Garland et al. 2010).

We hypothesized that therapist use of engagement strategies in the initial phase of treatment would predict subsequent parent homework planning in MH treatment for children with disruptive behavior problems. This hypothesis was mostly supported by these pilot study findings. Although therapists displayed overall low extensiveness of engagement strategies in early treatment, this was associated with overall moderate extensiveness of *sharing perspective on homework planning* from parents in later treatment, preliminarily suggesting that even low extensiveness of engagement strategies in early treatment impacts parent homework planning in later treatment. Although preliminary, therapist use of *Collaboration* strategies in the initial phase of treatment predicted subsequent parent homework planning is in line with previous literature. A collaborative therapeutic relationship has consistently been a robust predictor of treatment adherence and outcomes for individuals with a range of MH problems (Howego et al. 2003), and having ruptures in developing a collaborative relationship can be a barrier to homework completion (Dozois 2010; Kazantzis and Shinkfield 2007). Chacko et al. (2013) highlight that the *Design/Assign* phase of the DADR homework model is comprised of the therapist working collaboratively with the parent to develop feasible and effective therapy homework. They argue that designing/assigning homework in a collaborative manner is crucial to the homework planning process, as parents who do not believe homework is meaningful and feasible to implement will not complete homework. The preliminary results from this study support this argument.

The finding that therapist use of *Empowerment* in the initial phase of treatment predicted subsequent parent homework planning is consistent with previous studies that have found that empowering parents to help their child and family is linked to greater treatment benefits (Resendez et al. 2000; Taub et al. 2001). This preliminarily suggests that empowering families by offering praise on family strengths and effort may maximize the likelihood that family's attempt and complete homework. Praising any effort exhibited by the family, even if homework is not completed, may create honest and open discussions during the homework planning process about reasons for not completing homework, thereby keeping the momentum moving towards successful completion. A previous study found that of all therapist endorsed strategies for enhancing therapy homework completion, praising families to empower them to complete homework was the highest endorsed strategy (Houlding et al. 2010). The finding that therapist use of *Psychoeducation* strategies in the initial phase of treatment predicted subsequent parents' *sharing perspective on homework planning* aligns with studies of predictors of overall parent engagement in child psychotherapy (Martinez et al. 2015), and studies that have included psychoeducation strategies as a core component in successful parent engagement interventions (Becker et al. 2015). Preparing and orienting parents on the rationale of therapy homework completion using psychoeducation strategies can help address parent misconceptions and unrealistic expectations about therapy homework, thereby increasing the likelihood of active participation in therapy homework planning and completion (Chacko et al. 2013; Dozois 2010; Houlding et al. 2010). While preliminary, these results support this argument.

Therapist use of *Alliance* strategies in the initial phase of treatment was not significantly related to subsequent parent homework planning. The engagement literature has not yet fully examined links between alliance and parents' participation engagement, which includes their contributions to homework planning (Haine-Schlagel and Walsh 2015). It is important to note that given the small sample, it is conceivable that there was a power issue in detecting a significant effect of *Alliance* on parent homework planning. Although the *Alliance* effect size was in the small to medium range, it was not as strong as the other strategies effect sizes that were all in the large range, suggesting the potential that *Alliance* is not as strongly related to parent homework planning. This may be due to community-based therapists spending much time joining empathically with parents to engage and build rapport in ways that may not necessarily position the parent to be an active agent in completing therapy homework. Studies have suggested that having a strong alliance and mutual understanding of homework can enhance homework completion (Dozois 2010; Kazantzis and Shinkfield 2007), and that a poor alliance may result in low involvement in discussions around homework (Detweiler-Bedell and Whisman 2005). It should be noted that *Alliance* and *Collaboration* are often collapsed together to represent the "therapeutic relationship" in the homework literature (e.g., "collaborative therapeutic relationship"; Kazantzis et al. 2005), which may make it difficult to disentangle the effects of these two constructs. That is, the specific manner in which we coded for *Alliance* versus *Collaboration* may have contributed to finding varying effects on parent homework planning.

Limitations

The results of the current study should be interpreted with caution given several study limitations. First, the small sample size of this pilot study mitigated statistical power, the ability to examine multiple predictors in the same model, and the ability to control for child-, parent-, therapist-, and organizational-level variables that may be associated with parent homework planning and completion, such as child diagnosis, child age, parent mental health diagnoses, life stressors, type of homework assigned, therapist orientation, and agency/organizational support of therapist use of evidence-based treatment protocols and training. This small sample of both therapists and parents also limits the generalizability of findings, as only one therapist in the study was able to recruit more than one parent/child dyad (total of two). Although the results still hold without this additional parent matched to a therapist, the remaining therapists only had one parent/child dyad each, making it difficult to disentangle whether therapist and parent interactions were dependent on the nature of this specific one-on-one relationship dynamic.

Second, treatment session recordings were not available for all treatment sessions due to missing data. As the current study aimed to examine the temporal association between therapist implementation of engagement strategies in early treatment and subsequent parent homework planning in later treatment, we were limited in our sample due to only being able to include cases where treatment lasted beyond four treatment sessions, which resulted in a reduced sample from the larger intervention pilot trial. Relatedly, it is conceivable that some therapist engagement strategy deployment and parent contributions to homework planning occurred in sessions that were not recorded, and thus not captured in the treatment sessions that were coded. Third, although we assessed in-session behaviors indicative of therapy

homework planning from the DADR model that includes in the *Design/Assign* homework phase, we did not assess the *Doing* and *Reviewing* homework phases. Fourth, we did not specifically measure the nature of the homework being assigned or any guidelines therapists may have followed around assigning homework, such as from an evidence-based intervention. These factors may impact elements of the homework assignment such as the complexity of the assignment or the acceptability of the assignment to the parent, which may in turn impact parents' contributions to homework planning. Fifth, non-English speaking families were excluded from the current study, precluding generalizability to that segment of the treatment population.

Despite these limitations, the current pilot study, while preliminary, has important merits. First, the sample of therapists and parents were highly diverse and the care provided was highly eclectic, supporting potential generalizability of findings to diverse populations of therapists, families, and community-based MH services. Second, the development of two observational coding systems to capture multiple in-session therapist engagement strategies and parent homework planning is a notable strength. Third, the longitudinal design, which included examining therapist engagement strategies in the initial phase of treatment as predictors of subsequent parent homework planning in later treatment, allows for stronger confidence in the potential causal association between therapist engagement strategy deployment and parent involvement in homework planning than in a correlational design.

Future Directions

Future studies that include a larger sample may address power limitations and the ability to examine factors that may contribute to the relationship between therapist engagement strategies and parent homework planning. For example, cultural factors may impact parents sharing of perspective on homework planning with the therapist, which may also be impacted by language interactions (e.g., Spanish vs. English) between parent and therapist. We have found that Hispanic/Latino parents shared less of their perspective on homework compared with non-Hispanic/Non-Latino parents (Dickson et al. 2017), suggesting the influence of cultural factors in parent-therapist interactions. Also, future studies should examine whether therapists use engagement strategies more extensively with families that are more engaged in homework discussions, and how different types of homework may impact homework planning leading to completion. In addition, examining concurrent associations between therapist engagement strategy deployment and parent homework planning may elucidate whether therapists need to maintain their use of engagement strategies later in treatment to ensure ongoing parent engagement in homework planning. Future studies should also focus on observing therapists' use of engagement strategies to promote homework planning and other parent engagement behaviors in evidence-based structured treatment protocols. Furthermore, future studies should observationally measure how each phase of the DADR model impacts actual homework completion, and assess therapist and client factors that may moderate the relationship between therapist implementation of engagement strategies and homework completion (e.g., type of homework practice assigned, problem area being targeted based on child diagnosis, etc.).

Another important future direction is to further develop the coding systems utilized in this study and to map the engagement strategies onto the delivery of specific evidence-based practices. One such effort is currently underway. We have adapted our ACEs coding system by decreasing the number of codes to reduce coder burden and enhancing the range of exemplars in the coding manual. This modified coding scheme has recently been applied to community MH treatment sessions for children with Autism Spectrum Disorder receiving an evidence-based package of strategies to target disruptive behavior problems (Haine-Schlagel et al. 2018). Preliminary results indicate greater observed variability in the strategy extensiveness.

There is a substantial amount of research on client characteristics that predict treatment engagement, particularly attendance in care, but not as much an understanding of specific in-session engagement strategies delivered by therapists that may promote parent homework planning that contributes to completion. Whether parent engagement is wanted or invited by therapists due to a host of factors, the current study's results suggest that providers can promote parent homework planning based on the extensiveness of engagement strategies deployed, which is an important foundational skill for implementing evidence-based practices in community-based MH settings. An understanding of how specific in-session engagement strategies implemented by therapists impacts the parent homework planning process further elucidates the therapist's role in promoting parent engagement and homework planning in child MH treatment.

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Table 1

Therapist demographics

	<i>N</i> = 10 <i>n</i> (%)
Gender	
Male	2 (20.0)
Female	8 (80.0)
Mean age (SD)	37.0 (11.0)
Ethnicity	
Latino/Hispanic	5 (50.0)
Non-Latino/Non-Hispanic	5 (50.0)
Race (may have selected more than 1)	
White/Caucasian	9 (90.0)
Other	1 (10.0)
Primary discipline	
Marriage family therapy	4 (40.0)
Psychology	2 (20.0)
Social work	4 (40.0)
Primary theoretical orientation	
Cognitive-behavioral	3 (30.0)
Family systems	3 (30.0)
Eclectic	1 (10.0)
Integrative	1 (10.0)
Other	2 (20.0)
Highest degree held	
Bachelor's	2 (20.0)
Master's	7 (70.0)
Doctorate	1 (10.0)
Licensure status	
Licensed	4 (40.0)
Unlicensed	6 (60.0)
Trainee	
Trainee	3 (30.0)
Non-trainee	7 (70.0)
Prior training in EBP	
Received prior training	9 (90.0)
Did not receive prior training	1 (10.0)
Mean years of experience (SD)	9.5 (11.3)
Mean # of clients per week (SD)	10.5 (6.0)

Table 2

Parent and child demographics

	<i>N = 11 n (%)</i>
Parent gender	
Male	1 (9.1)
Female	10 (90.9)
Parent mean age (SD)	37.3 (13.0)
Marital status	
Married	4 (36.4)
Not married	7 (63.7)
Ethnicity	
Latino/Hispanic	5 (45.5)
Non-Latino/Non-Hispanic	6 (54.5)
Race (may have selected more than 1)	
White/Caucasian	5 (45.5)
Black/African American	2 (18.2)
Asian	1 (9.1)
Other	4 (36.4)
Highest level of education	
Less than high school	2 (18.2)
High school graduate/GED	5 (45.5)
Some college	1 (9.1)
Bachelor's degree	3 (27.3)
Annual income	
\$35,000 or less	9 (81.8)
\$35,001 or more	2 (18.2)
Spoken language (other than english)	
Spanish	5 (45.5)
Other	2 (18.2)
Child gender	
Male	9 (81.8)
Female	2 (18.2)
Child mean age (SD)	8.9 (2.3)
Primary clinician-assigned diagnosis	
ADHD	5 (45.5)
Anxiety	3 (27.3)
Other (Disorder of Infancy, childhood or adolescence NOS; enuresis)	3 (27.3)

Table 3

Mean observational ratings of therapist engagement strategies and in-session parent homework planning

Variable	<i>M</i> (<i>SD</i>)
Therapist ACEs strategies (<i>n</i> = 44 treatment session recordings coded)	
Alliance composite	1.80 (.93)
Collaboration composite	1.35 (.51)
Empowerment–strengths and effort ^a	1.93 (1.07)
Psychoeducation composite	1.16 (.94)
Parent homework planning (<i>n</i> = 26 treatment session recordings coded)	
Share perspective about homework	3.04 (.77)

^aComposite was not computed due to being 1 item

ACEs = Alliance, Collaboration, and Empowerment: Range = 0–6; Parent Homework Planning: Range = 1–5

Table 4

Inter-item correlations of study variables

Variable	1	2	3	4	5
1. Alliance composite	–				
2. Collaboration composite	.69	–			
3. Empowerment–strengths and effort ^a	.29	.51	–		
4. Psychoeducation composite	.37	.30	.21	–	
5. Share perspective about homework	.34	.66	.84	.45	–

Correlations significant at $p < .05$ are in bold

The effect of therapist engagement strategies on in-session parent homework planning, controlling for intervention condition

Table 5

Variable	Share perspective on homework			
	B	p	R ²	F ²
Alliance composite	.30	.16	.57	.13
Collaboration composite	.81	.02	.73	.28
Empowerment code ^a	.53	.02	.72	.27
Psychoeducation composite	.49	.01	.79	.34

^aComposite was not computed due being to 1 item

Effects significant at $p < .05$ are in bold; f^2 0.02, f^2 0.15, and f^2 0.35 represent small, medium, and large effect sizes, respectively (Cohen 1988)