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Conceptualizing Parent Involvement in Child Therapy: A Framework Roles Using Bernard's Discrimination Model

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Conceptualizing Parent Involvement in Child Therapy: A Framework Roles Using Bernard's Discrimination Model

Abstract

This paper introduces a theoretical map conceptualizing parent involvement in the child counseling process by applying the roles from Bernard's Discrimination Model (DM). Semi-structured interviews with experts in child counseling and copyrighted DVDs were collected as data. A framework approach through the DM is utilized to analyze data to offer the conceptual structure of parent involvement. As a result, the three different roles—counselor, teacher, and consultant—and tasks for each role when engaging parents for child counseling are identified. Discussions about the meaning and limitations of this study are included.

Keywords

parent involvement, parent participation, parent consultation, Discrimination Model

Even though their primary clients are children, many child practitioners in counseling encounter situations in which they deal with parents regardless of their preparation for guiding them. Dougherty (2009) supports the notion that as long as human service professionals are working with children, they will need to consult with the adults living with the children, although the engagement levels may vary. In that sense, child counseling is unique (Gvion & Bar, 2014). Unfortunately, including parents in child counseling is not a simple task. Many of parents visiting child-counseling institutions present anxiety for fear that therapists may find attributable parental failings in relation to their child's symptoms (Kottman, 2011). Also, they may present lack of parenting skills or being inundated with their own issues that may exacerbate their children's issues. Intervening in those parents and listening and responding to their needs while guiding them in a conducive way to benefit their children's sessions seem to necessitate a good amount of effort and expertise from child practitioners. Regrettably, many child clinicians are left without clear directions on how to effectively give assistance to those parents. Lolan (2011) pointed out how limited training has been provided for play therapists when it comes to including parents in child counseling processes. Even therapeutic work with parents has been considered secondary to child therapy (Sutton & Hughes, 2000). Lack of attention in parent involvement suggests how this topic has been neglected in the discussion of the critical elements involved for successful child counseling outcomes.

Parent involvement is key to successful child counseling outcomes. Parent engagement is one of the five key elements for best practice for the best mental health practice in child welfare, which includes screening and assessment, psychosocial interventions, psycho-pharmacologic treatment, parent engagement, and youth employment (Romanelli et al., 2009). In addition, meta-analyses on child therapy outcomes demonstrate the efficacy of child therapy when parents are

included. For example, engaging parents in play therapy had a greater effect than play therapy without parental involvement by 0.83 standard deviation (Bratton et al., 2005; LeBlanc & Ritchie, 1999). Similarly, Dowell and Ogles (2010) reporting on their reviews on 48 studies found that sessions including parents was deemed to have significantly better results than singular child therapy unit ($d = 0.27$).

Unfortunately, there exists a gap between the necessity of guidance and the practical tips on how to engage parents, as well as the efforts needed to facilitate their involvement. Kottman (2011) asserts that it is unfortunate to find many play therapists who decide not to include or to minimally interact with parents because they are not comfortable with dealing with parents. It is believed child practitioners would alleviate anxiety at meeting with parents if they obtain guidance on how to effectively engage them, which may lead to greater parental involvement. Another issue in discussing parent involvement in child therapy settings is a lack of consensus at illuminating the specific tasks of the therapists involved. This disagreement may be derived from the fact that different approaches in play therapy may vary on how parents are engaged in child therapy settings depending on the differences in their theoretical orientations. For example, Theraplay (see Booth, & Jernberg, 2010) therapists actively coach parents by watching recorded child-sessions, which portray the parents' interactional patterns with their child. It is not uncommon in Theraplay play that parents join their child's sessions as co-therapists and take charge in adult-directed sessions. After the sessions, they receive thorough feedback on their performance from therapists. Significant focus is given to behavioral modifications in interactional patterns between the parents and their child.

Filial therapy (See VanFleet 2009, 2014) is also a psychoeducational model through which parents learn how to communicate with their child and approach issues that their child

presents in such a way that strengthens the parent-child relationship. Parents, however, attain those skills by learning non-directive play therapy, in which their child will lead therapy sessions. Without the child's presence, therapists first teach parents basic skills and tenets of non-directive play therapy until the parents gain competence and confidence to the extent they can solely manage sessions with their child. Then the parents independently practice play sessions with their child in their homes while therapists monitor the sessions by having regular meeting with the parents.

As seen, goals of both Theraplay and Filial therapy are similar in that both approaches emphasize teaching and training parents to enhance appropriate parent-child interactional skills and developmental knowledge on children, which ultimately targets improved relationships between children and their parents. However, what each approach includes in teaching and training and how they reach their respective goals by engaging parents also differ depending on their underlying theories. This divergence in assisting parents causes child practitioners to feel confused, which strongly raises the need for over-arching illustrations on parent engagement during child therapy sessions. To answer the need for overarching ideas on parent engagement and to bridge the gap between the call for guidance and the lack of training, a theoretical framework through this paper is provided. This framework conceptualizes parent involvement in child counseling settings through framework analysis by applying Bernard's (1997) Discrimination Model (DM), which is frequently utilized in counseling supervision. The new model in working with parents is particularly compelling for beginning child practitioners as their experiences and training in relation to working parents are limited. Through this model, they may be able to map out a comprehensive framework in working with parents.

Rationale of Applying the DM to Child Therapy Settings from Author's Perspective

In working as both a child practitioner and counseling supervisor, I found the distinct roles to resemble each other in that they both fulfill multiple functions in the cognitive, affective, and behavioral dimensions. For example, as a child therapist, I had frequently experienced situations where I had to provide care and guidance for parents even though my primary clients were children. Throughout consultation with parents, I not only taught effective parenting skills but offered guidance for parents. Offering parents emotional support and limited counseling at the position of counselor was a major role as a child practitioner. Similarly, in supervisory settings, I fulfilled the instructor's role when I taught or role-played counseling skills with supervisees. At the consultant position, I facilitated supervisees' understanding of their cases and discussed their treatment plans. When I sensed that they needed encouragement and affective support, I provided those comforts for the supervisees. As seen, there are practical commonalities between child practitioners and clinical supervisors in terms of their multiple-role functioning in which they teach skills, offer consultation, and provide a simple form of counseling to parents of their child clients or supervisees. I believe conceptualization of child practitioners' roles through the DM will serve as a useful map for child therapists in that it illuminates their expected role-performance in regard to parent engagement.

Definitions of Terms Used

For this paper, parent involvement is defined as comprehensive forms of parental participation in the overall process: ranging from intake parent meetings, to family therapy, to child-parent sessions, and lastly to separate parent training sessions. Also, parents have the primary legal responsibility for the child-rearing process. Parental dimensions in this paper include biological parents, family members, relatives, or legally designated guardians. Child

counseling equates with play therapy, and child practitioners refer to play therapists. Limited or low-key counseling to parents refers to counseling service for parents at a surface level that does not delve into their individual issues. If parents are deemed for more professional help, they may be recommended for separate individual counseling.

Reviews of Different Performances by Child Therapists

A body of literature supports the idea that child practitioners perform different roles in working with parents. Kottman (2011) listed play therapists' various agendas in working with parents: a) teaching parenting skills and discipline strategies; b) supporting parents through exploring personal issues to optimize the application of parenting skills; c) helping parents understand family dynamics, marital issues, and school issues, and their impact on their child; d) helping parents better understand child development and their child; and e) facilitating parents in gaining insight into themselves and their relationship with their child. Cates, Paone, Packman, and Margolis (2006) also outlined multiple tasks conducted by play therapists in parent involvement. These tasks include helping parents understand the nature of play therapy and explaining therapeutic processes, establishing rapport with them, gathering data for assessment, discussing children's issues, providing psycho-education, and coaching parents on how to advocate for their child at school.

Gil (2011) described diverse therapists' roles as facilitators, role models, cheerleaders, and dialogue coaches. As facilitators, play therapists create an atmosphere in which parents and their child, and sometimes all family members, have positive interactions. In addition, the therapists demonstrate healthy interaction and communication skills as well as how to provide positive feedback to parents. Therapists' modeling helps parents concretize and enact those communicational skills. As cheerleaders, therapists encourage, validate, and support any trials

attempted by the parents. Finally, as a dialogue coach, play therapists first observe conversational patterns between parents and their child. Then the therapists provide parents with feedback on their interactional patterns and suggestions for healthy and successful communication. Similarly, Guerney (2003) discerned different child-therapists' roles from instructors to supervisors, supporters, or co-service providers in the discourse of helping parents become therapeutic agents for their child. Sanders and Burke (2013) identified what therapists offer to parents based on the social learning theory. Primarily, therapists teach parents parenting skills through modeling, rehearsal, practice, feedback, and homework. However, at the same time, they found that therapists serve as encouragers and emotional supporters by employing interpersonal skills in building relationships with parents and in facilitating parents' reception to their suggestions.

Child practitioners implement different roles in parent involvement in which they offer didactic service, increase parents' understanding of their child, and emotionally support the parents. Unfortunately, even though various tasks and role-performances have been identified through studies on child counseling, there has been no systemic conceptual model mapping out the different role-performances of the clinicians.

Bernard's Discrimination Model

The Discrimination Model (DM), the original conceptual structure for framing child practitioners' tasks in parent involvement, was initially suggested by Bernard in the mid-1970s to provide a teaching tool for clinical supervision for counselor-trainees (Bernard & Goodyear, 2014). Through this model Bernard (1997) conceptualized what roles clinical supervisors perform to attend to supervisees' needs and further deliver supervisory services tailored to the supervisees' needs and developmental stages. This model addresses three different roles—teacher,

consultant, and counselor—that would be implemented by supervisors. For a simple example, in the position of teacher, supervisors focus on teaching supervisees proper intervention skills for their clients. In the consultant position, supervisors guide their supervisees to develop conceptualization skills through which the supervisees increase their understanding of what is occurring in sessions and discern patterns from them. Finally, the purpose of supervisors as counselors is to help supervisees increase their awareness of how their personal issues may interfere with the counseling process so their sessions are not contaminated by personal matters. At the same time, supervisors help the supervisees integrate their personal styles of counseling. While targeting those three dimensions during supervision, supervisors make a judgment about which role(s) to play considering the supervisees' developmental capacity and the counseling stages of the supervisees and their clients.

Contextualizing the DM to parent involvement, the child practitioners are juxtaposed with the position of the supervisors and the parents to those of the supervisees to develop a theoretical framework of parent involvement for child practitioners. Research questions to explore child practitioners' performances at meetings with parents are:

1. How do play therapists practice parental involvement in the child's therapeutic context?
2. How do play therapists facilitate parental involvement for the therapy processes?
3. How do play therapists handle challenges in the process of parental involvement?

Methods

Participants

This study began with the approval from the institutional review board (IRB) and followed ethical standards according to the American Counseling Association (ACA) Code of

Ethics (2005). To recruit participants, the author referred to a professional network such as the Association for Play Therapy and the official website for each play therapy modality. In addition, her personal networks built through play therapy conferences and trainings were utilized. Emails requesting for research participation were sent to qualified participants. Once first contact was made through these emails, snowball sampling, in which one participant recommended other potential participants, was employed.

The total of 10 participants were recruited through purposeful sampling. Purposeful sampling was pursued to find participants to which research questions were significant and who had expertise in being researched (Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2015). To ensure that participants have expertise in parent-involved child therapy settings, two criteria for purposeful sampling were employed. The first was the theoretical orientations of the participants. The 10 participants were intentionally chosen from five different approaches in play therapy depending on the degree to which play therapists of each model take the lead during sessions: Child-centered play therapy, Gestalt play therapy, Jungian analytical play therapy, Adlerian play therapy, and Theraplay. Child-centered play therapy, a non-directive approach, is one extreme of the spectrum, and Theraplay is the other. Gestalt play therapy and Jungian analytical play therapy are in the middle of the spectrum between directive and non-directive play therapy approaches. Adlerian play therapy was selected as Adler himself championed the significant role of parents in their child's developmental process. As such, Adlerian play therapists take an active stance to involve parents in the therapeutic process, separating sessions between play therapy with children and consultation with parents (Kottman, 2011). As the second criterion, to include participants with rich knowledge of and experience in their practice, at least one participant was

assured to be in a trainer position for each play therapy modality. Also, all participants were required to have a play therapist license and at least 7 years' experience with their approach.

Among the 10 participants, two were male, and the others were female. Their years in practice varied ranging from 9 to 55 years. The average of their years in practice was approximately 27 years. Six of them had a doctorate degree and the other four had a master's. Eight of them were Registered Play Therapists & Supervisors (RPT-S); one was a Registered Play Therapist (RPT); and one was practicing play therapy without play therapy credentials. However, she was trained by a prominent play therapist.

Table 1 identifies the demographic and background information of participants. Pseudonyms were introduced to protect identities of the participants except for copyrighted videos.

Table 1. Professional Background Information of the Participants

Pseudonym	Gender	Orientation	Position	Practice Years	Degree	PT Credentials
Peter	Male	Child-centered	Trainer	50	Ed.D.	RPT-S
Theresa	Female	Child-centered	Trainer	33	Ph.D.	RPT-S
Carly	Female	Gestalt	Trainer	30	M.Ed.	RPT-S
Lisa	Female	Gestalt	Trainer	20	M.A.	N/A
Thomas	Male	Jungian	Trainer	10	Ph.D.	RPT-S
Jeannie	Female	Alderian	Trainer	29	Ph.D.	RPT-S
Rachael	Female	Adlerian	Practitioner	9	Ph.D.	RPT-S
Amy	Female	Adlerian	Practitioner	16	M.S.	RPT
Grace	Female	Theraplay	Trainer	55	M.A.	RPT-S
Ashley	Female	Theraplay	Trainer	17	Ph.D.	RPT-S
Sandra (Video)	Female	Theraplay	Trainer			RPT-S
Rise (Video)	Female	Child-centered	Trainer			RPT-S

Data Collection

Interviews with the participants were the primary source of data. Upon the agreement of participants for the research, face-to-face interviews with seven of them were conducted. For the remaining three participants, phone interviews were proceeded because the physical distance hindered face-to-face interviews. Upon the agreement by interviewees, all interviews were recorded.

Semi-structured interviews lasted 45 to 90 minutes, respectively to obtain in-depth and comprehensive data by interviewing the participants' perceptions and experiences. Interview questions were constructed around the child practitioners' tasks, strategies, and experiences in relation to parent involvement for the child counseling process. In addition, sessions (e.g., video-recorded sessions) from different schools of play therapy were also a part of data collection. Two video sessions from Child-centered play therapy and Theraplay were included to review segments involving parents engaged with their child counseling practice. Analyses on copyrighted video tapes for the other three approaches were not included as the videos from these three play therapy branches only portrayed child sessions without parents.

Data Analysis

With the intention of demystifying tasks by child practitioners during parent involvement within the frame of the DM, Framework Analysis (FA) was employed. FA is an approach in qualitative data analysis rather than “a research paradigm such as ethnography, phenomenology, or grounded theory” (Ward, Furber, Tierney, & Swallow, 2013, p. 2425). This way of data analysis is different from inductive methods that are general in qualitative data analysis (Smith & Firth, 2011). FA has many overlaps with other qualitative data analyses in that it also undertakes data immersion, reduction, and theme development. However, FA usually identifies themes in

the early state of data analysis or themes are outlined by existing ideas (Ward et al., 2013). Theme development first necessitates researchers to become familiarized with all of the data. Then researchers classify and organize data in line with identified key themes, concepts, and emergent categories of the cross-sectional descriptive data. This process simultaneously involves the evolving development of sub-themes comprising the main themes (Ritchie, Spencer, O'Connor, & Barnard, 2014). The processes of moving across data lead to refinement of themes, which may eventually result in developing a conceptual framework (Smith & Firth, 2011). FA allows in-depth exploration of data to developing themes while presenting transparency in the data analysis procedures and credibility of findings (Ritchie et al., 2014).

The rationale for choosing FA for data analysis can be traced back to the data collection and early data analysis stages. While being immersed in the data through transcribing interviews and observational DVDs, reading through them, and writing researcher memos to screen the researcher's bias, the author found that the multiple role-performances by the child practitioners during parent involvement at cognitive, affective, and behavioral dimensions coincides with those of supervisors during clinical supervision. Particularly, researcher memos played a significant role because these memos enabled the researcher to find provoking ideas or concepts relevant to this research through a ruminating thought process. Having a background as a counselor educator, she discerned the major commonalities in tasks between child practitioners and clinical supervisors, from which she recoded all data based on the DM framework. Finally, constant refinement and synthesis of themes allowed the author to generate a parent involvement model for child practitioners.

For the systematic management of data coding and analysis, NVivo was employed. Particularly, NVivo is useful for developing a "bottom up" approach, whereby categories are

drawn from the content of the data (Strauss, 1987). NVivo has functions to develop codes of single cases and categories of cross-cases. Simultaneously drawing data from transcripts, to pictures, video-recorded materials, and textual resources enabled the author to visualize codes and categories and examine relationships between data and the participants. Table 2 illustrates the major themes and sub-themes identified in relation to child practitioners' role-performance based on the DM.

Effort for Validity

To minimize the researcher's bias for results, she wrote a researcher identity memo suggested by Maxwell (2005, 2012). The researcher identity memo asks researchers to write about a researcher's goals, background, experiences, and feelings, reflecting how they inform and influence the research. The purpose of this practice is to help researchers doing qualitative research to "examine your [their] goals, experiences, assumptions, feelings, and values as they relate to your [their] research and to discover what resources and potential concerns your [their] identity and experience may create" (Maxwell, 2005, p. 27). Whenever data were analyzed, the researcher mostly left small or long memos to screen and minimize her bias, resulting in over 23 memos. To increase reliability, the primary researcher acquired the assistance of one peer debriefer in a counseling program who has knowledge of qualitative research. By discussing pre-assumptions from the researcher's previous work experience and their potential impact on the findings and sharing processes of data collection, coding, and analysis of this study with this debriefer, she was able to check herself. In addition, this debriefing process prevented the researcher from being overly occupied by data. This assistance by the peer debriefer took place four times during data collection and analysis.

Results

Three roles—counselor, teacher, and consultant—and distinctive performances related to each role were identified according to the DM. Table 2 exhibits the major categories, listing general themes, sources, and references. Sources provide the total number of resources that were referred to each category from the interview and the observation transcripts. References mean the total number of quotations for each category.

Table 2. Three Roles of Child Practitioners and Corresponding Sub-Themes

Categories	Sources	References
What the play therapist does in parental involvement	12	204
Counselor’s Role	11	65
Emotional Support	9	35
Helping Parents Gain insight	4	10
Providing Mild Counseling	4	8
Teacher’s Role	12	59
Providing Psycho-Education	11	33
Offering Experiential Learning	7	19
Modeling for Parents	4	6
Consultant’s Role	12	45
Assessing Child’s Problems, Family Functioning and Parents’ resources	9	16
Facilitating Family Communications and Process	5	10
Information and Counseling Process Sharing with Parents	4	6
Discussing Alternative Ways of Interactions	4	5

Counselor’s Role

Child practitioners’ performance as counselor was characterized by emotional support and care for parents, helping the parents gain insight into themselves, and providing mild counseling services. Through these supports, the participants offered comfort and experiences of being heard for parents while promoting their awareness of themselves and of the dynamic between their issues and those of their child.

Providing parents with emotional support. Emotional support and care for parents were the cornerstones of the counselor's role, which was emphasized by all interviewees. This emotional support and understanding of parents' positions is tremendously important given that parents decide to seek professional help when their tolerance for their emotional distress and frustration is too excessive to cope with (Landreth, 2012). Child therapists in the study delivered this emotional support through approaches of warmth, caring, understanding, and acceptance. They understood how hard it would be for parents to engage in their child counseling process and to put effort for change. Hill (2009) expresses this genuine and empathetic understanding of parents' positions by therapists as "holding" or "containing," through which child practitioners simultaneously feel the pain and experiences of the parents. Ashley mentioned her work starting from understanding parents; she shared, "I think that because the mom has a lot of knowledge, but for her important thing is nobody understands mom. So, being understood in a professional way, being supportive to mom, helped her really change her gear."

Lisa pointed out parents' experience of being guilty of and angry about their child's symptoms and shared that she understood their emotional hurt in a non-judgmental manner.

But the goal was to get her calm down enough, really I focused I think on her fear of not being a good mother and letting this happen to their child. So I kind of wanted her to get out of that anger and that seemed to work. You know, really focused on the fact that she was a really good mother and that it wasn't her fault. And that's beginning to come through her enough where she could start listening to what would really make sense for her daughter . . . So work on the relation with the parents and make sure you truly feel a sense of compassion for them and the connection that you really do; then you will find some compassion and connection there . . . Because they were children once too and they are hurting as well.

This excerpt exhibits how Lisa endeavored to understand and connect with the parents. Her effort started from learning about the source of the parents' distress and at the same time creating a safe, non-judgmental atmosphere for them.

Helping parents gain insight. Another role that the child practitioners performed as counselors was to help parents gain insight into their child and themselves and how their personal or marital issues may interface with those of their child. This type of assistance offered by child therapists has been supported by a significant body of literature (see Booth, & Jernberg, 2010; Gil, 2011; Guerney, 2003; Kottman, 2011; Kottman & Meany-Walen, 2016; McGuire & McGuire, 2001; VanFleet, 2009, 2014). Thomas believed child counseling would be fully effective only when parents looked at themselves. He shared one of his cases in which he helped the parents to confront themselves:

At first, there was lot of resistance to the sand part, not from the mother, but from the father . . . So, when I met him separately . . . The father was crying in the session and saying that any time he tries something new in front of his wife, he always felt less than . . . She had no idea, so she started crying, she is like, “I always thought you judge me because I always had to live with your standard.” So, I had them look at this and said. “Could you imagine what the child’s internalizing if you are having this, hyper competitive for each other? What is the child having to achieve? What does the child have to prove to you all?” . . . They were able to work out through some of their challenges.

Thomas created a moment in which the parents were able to look at their relationships and their experiences with each other. In addition, he facilitated how the couple's issues might affect their child's problematic symptom. Booth and Jernberg (2010) concur with Thomas, stressing that child practitioners should help parents become aware of their own needs while helping the parents understand experiences of their child.

Amy briefly described how parents’ insight-gaining through play activities comes naturally. She said, “Changes are being made, so I guess, a lot of having the parents in session, playing games or activities, which also gives parents insight into themselves without commenting on them.” Amy observed engaging parents in child counseling itself rendered opportunities for parents to obtain insight into themselves.

Providing brief mild counseling for parents and family. As counselors, child practitioners provided limited counseling for parents. This type of counseling during the parental involvement occurred naturally through deep understanding of and support for the parents.

Peter shared how his interview with parents could be perceived as a counseling session:

There is a time that you would check in my interview with parents [through microphone] and you would say, "Oh, that's not a parent interview, that's a counseling session." Because one of the parents is hurting, I wanna touch that hurt, I wanna respond to it. I wanna respond, provide understanding of that their hurt, their pain, their confusion. For sure their anger with their child would be in touch with that. So, my or few minutes would be exactly like what I would be doing in the therapy.

As such, Peter's intention for better understanding of and profound connection with the parents made his interview with the parents perceived as a counseling session for them. Even though this type of counseling is limited, it demonstrates that clinicians function like counselors during parent involvement.

Teacher's Role

All the participants performed as teachers by delivering psycho-education, experiential learning opportunities, and modeling for parents so that they better understand the concept of play therapy and the healing process of their child and learn specific skills to enhance their interactions with their child as well as their parenting. These teaching components offered by child practitioners have been not only constantly discussed (see Booth & Jernberg, 2010; Cates et al., 2006; Gil, 2011; Guerney, 2003; Kottman, 2011; Kottman & Meany-Walen, 2016; McGuire & McGuire, 2001; Sanders & Burke, 2013; VanFleet, 2009, 2014) but have been attributed to effective child counseling results (Thulin, Svirsky, Serlachius, Andersson, & Ost, 2014).

Providing psycho-education. The child practitioners of this study helped parents understand what play therapy may mean to their child. This orientation to child counseling is

essential because if parents do not understand child counseling processes, they may not have faith in the therapist (Landreth, 2012), which may link to the child's outcomes.

Theresa communicated a process of play therapy to facilitate parents' understanding of play therapy in the first meeting with them.

In the first case, I have to educate them a little bit about play, and so, I will try to do that in a way, I often talk about, you know, 'Play is language, play is how kids express what's really going on inside. And then we can understand more about that . . . Um, the play helps with emotional regulation, helps behavior, like self-control, and helps with that especially if it's done with the context of relationship. Play can assist, you know, how kids express everything about the world . . . You can understand what's really going on for your child's underneath of that might be anxiety instead of anger, or might be other things.

By explaining and educating parents to the meaning of play and play therapy and by highlighting what play therapy can bring for children's emotional and behavioral regulation and relationship improvement, Theresa not only helped parents better understand play therapy, but also instilled hope for them regarding her practice.

Instructing developmental information about children was another teaching component in psycho-education. The education on child development was aimed to improve the parents' ability to distinguish whether their child behaviors could be accepted or whether they are something that requires an intervention. Rachael emphasized,

Um, two would be education about, um, child-development, children's need...information about their specific child . . . just general child development, you know, what is normal, what you can expect from five years old, um, third would be specific information about their child, who their child is, how their child is once in a world and, how they are contributing, how the combination between them is contributing.

Rachael helped parents differentiate what they could expect from their child based on the child's developmental stage. This knowledge seemed to promote the parents' acceptance of their child's behaviors that once they perceived as abnormal or irritating.

Offering experiential learning. The participants coached parents to attain parenting and interactional skills through experiential learning. The clinicians actively invited parents to engage in mock play therapy sessions or demonstrated communication skills to the parents using play activities. Learning through experiential activities is powerful in that they enable parents to understand what is happening during child sessions while at the same time letting parents become aware of their own feelings and responses (Booth & Jernberg, 2010). In addition, parents learn how to apply behavioral techniques to modify behavioral issues their child presents (Wagner, 2008). Filial therapy (Guerney 2003; Landreth, 2012; VanFleet, 2009, 2014; Wilson & Ryan, 2005), Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2010), and Theraplay (Booth & Jernberg, 2010) are representative approaches that exhibit experiential learning for parents.

Grace's sharing was a good example of how the participants employed experiential activities for parents, which was similar to what Sandra explained in the DVD demonstration.

I think the first step is the session that they have [play activities] for themselves . . . I once did a kind of role play. I had a father whose son was just all over. He couldn't stop him [his son]. So I said, "O.k. You will be your son and I will try to help you." He [the father] just ran all over the room, climbing upon things, I finally got him and got him down, got him calm. And he went, "Hue [like deep breathing sound], I thought you would never stop me. Do you think that's how my son feels?"

It was clear that through role-play the parent realized how his son may have felt when he lost his control. Experiential learning enabled the parent to get in touch with his son's experience and response.

Rise introduced a parent training group and supervision in which she offered parents feedback on their interactions with their child.

We train parents to the play session; then we as we start doing the play session with their own children. We supervise those sessions. And eventually parents learn to do play session home without our supervision, and very end part of the process is actually very

important too, what the parents learn in terms of skills, um, interacting with their children, interaction patterns they learn. We've helped them delivery, help them generalize those new days in their life.

Rise had the parents conduct play sessions with their child at home and practice interaction and communication skills based on play therapy activities. Through this process, Rise facilitated the parents' learning of better parenting and coping skills and a generalization of learning in their life.

Modeling for parents. Modeling by the child practitioners facilitated the parents' concrete understanding of the skills in interactions and communication with their child. Ashley said,

It's difficult, because she was so negative to the child. So, I do a lot of modeling. I model mom that in a way she's gonna model the child. I keep emphasizing her positive impatience, even though it turns out something negative.

Through constant modeling in which she demonstrated how the mother's impatience could be understood positively, Ashley hoped the mother would do the same for her child. Modeling by the therapists was an intentional intervention so that the parent learned areas for improvement at behavioral and cognitive levels in an explicit way.

Consultant's Role

The consultant's role that the participants played was found in three activities. First, they assessed sources of difficulties with parents and their child by gathering information. Second, they attempted to promote understanding and communication between parents and their child by serving as mediators between the two parties. Finally, the participants had mutual conversations with the parents to provide feedback on their coping strategies, discuss alternative forms of interactions between the parents and their child, and review the counseling process with them. Child therapists fulfilling these functions at the position of consultant has frequently been noted in the literature (see Booth & Jernberg, 2010; Cates et al., 2006; Gil, 2011; Guerney, 2003;

Kottman, 2011; Kottman & Meany-Walen, 2016; McGuire & McGuire, 2001; Sanders & Burke, 2013; VanFleet, 2009, 2014).

Assessing children's problems and resources of parents. The participants collected information from both the parents and their child to understand the child's issues and to determine the sources of the problems. Jeannie's comment represented what the participants do to better understand the positions of parents and their child, respectively, and what information they assess. Jeannie shared:

I see the parents as a source of information in formulating my hypothesis about what's going on with the child. I'd also like to know what's been tried, what's worked, what hasn't worked, what's effective, um, in like parenting, kind of things I want to know, all that stuff . . . for example, I'd like to see how the parents talk about the child, but also how the parents talk about themselves, in terms of their attitude toward their kids, their attitude towards parenting. Um, sometimes marital stuff comes in, and I believe in many cases problems between the parents and the child, in terms of like personality not matching very well, um, maybe a source of the child's problem . . . So assessing that . . . I wanna explore kind of the root of the child's problem, and the root may be if their parenting issues.

Jeannie approached her cases holistically to figure out where the child's issues may come from.

For the assessment process, Lisa implemented an activity of family drawing, involving all family members in the activity and asking them to draw a picture together.

I wanna hear what's they're upset about . . . At that [second] session, I have everybody draw a picture of their family, each person in their family as an object or an animal including themselves. And I have everybody go around and talk about each person, you know, why they pick that. And [I say], "Tell me one thing they like and one thing they don't like about each person including themselves." And that starts to set the tone for discussion about, "What you are unhappy about?" The message is this is place we can talk about what you are unhappy about with the person you love. And they are saying things you are really angry about, things you don't like, things you're mad about. This is an open forum here.

Through family drawing, Lisa was able to hear the voices of all the family members and see their perceptions of themselves and other family members.

Facilitating family communication. Through the means of play or other experiential activities, the participants established an atmosphere in which parents and their child felt connected to each other. Theresa introduced one of her methods in which she utilized a dog.

One is I just include them [parents and their child] with some of the activities. So we might say, "O.K, today we're gonna try get the dog to do ZYX or the horse or whatever we are working with." So, we will say, "Here is your job as a family, is to get the dog to go from here, here without ever touching the dog." And then they have to figure out how to move dog without touching it. You know, by calling it, or enticing it, you know, whatever they gonna do. But, they have to work it out as a family, so that would be one way.

By employing an activity that required all family members' participation and cooperation, Theresa not only created a pleasant family time but also promoted family communication.

Jeannie also built moments in which parents had quality of interaction and pleasant time with their child through novel approaches.

I gave homework . . . highly encourage them [parents] to do special thing with their child when he behaves. I always say, "[. . .] Um, pick family game night. Have that family game night on Friday night that you never wanna make time for it. You're always busy doing some other time, doing some other things" . . . I have one little boy, he had some good week, where he gets up and gets ready for school. And they get there on time, Friday night, they do the Monopoly [name of a board game] night. So I always encourage parents to reward their child with some extra time, doing things better pleasurable that are not electronics.

By helping parents understand what might be better ways of rewarding their child and suggesting an alternative way of interacting with their child through a game, Jeannie played a role of facilitator in communication and interaction between parents and their children.

Information and counseling process sharing with parents. At the position of consultant, therapists shared how child counseling sessions went as well as changes or improvements that the child clients presented. Hill (2009) asserts parents need this information sharing and feedback from an expert's perspective because they lack confidence in their own tentative conclusions about the development of their child's issues. Carly's comment is an

exemplar segment as a therapist of consultant.

Well, in the consultation, I'm just getting information, like 'How are things going at home,' 'Are you seeing any changes at home?' Or 'If something has occurred?' Um, oftentimes, I may be sharing with them, with the permission usually of the child without breaking confidentiality, but, what I'm seeing happening in the therapy, themes that may be emerging, things that they might do at home, to support the work I'm doing.

Being aware of the scope within which the practitioners do not break confidentially, the therapists debriefed sessions with parents while helping them recognize changes in their child and themselves.

Discussing alternative ways of interactions with children. As consultants, child therapists discussed better ways of interaction between parents and their child, sometimes suggesting professional opinions to parents. Theresa explained how she implements this solution-finding conversation with parents.

I use a lot of examples in my filial therapy training. You kids come home from school every day and get into a big fight. What could you do parents, (chuckle) every day and second day they walk to the door that would keep them, prevent them getting into a fight. So, I will ask that question to parents and I hopefully parents would have some ideas . . . If the parents can come up with the solutions, it's more likely to set into their life style than if I say, "Could you do this? Could you do that? Could you do the other thing?" because I'm trying to get the parents to solve their problems as much as possible.

In the position of consultants, the participants offered a place where parents examined their own ideas on coping strategies to deal with their child's problems, which ultimately facilitated the parents' own problem-solving skills.

Discussions

The intent of this study was to conceptualize the multiple roles child practitioners perform during parent involvement in child counseling settings by employing the roles from Bernard's Discrimination Model (Bernard, 1997). Specifically, three different roles (counselor, teacher, and consultant) were identified through interview data with experts in child counseling

and through DVD observations of parent engaged child sessions. As a result, a conceptual map of parent involvement for child practitioners was generated. This conceptualization of the roles and tasks child practitioners fulfill in parent involvement is meaningful for three reasons. First, the theoretical scheme of parent involvement addressed in this study portrays a systematic and concrete role-performance that is expected of child therapists when mentoring parents. Such a framework on how to exercise parent involvement has been lacking in child counseling settings. Dowell and Ogles's (2010) meta-analytic review on child psychotherapy outcome demonstrates that in spite of the effectiveness of including parents in child counseling process, child practitioners are left without clear empirical evidence about how to guide parents into the treatment of children. Similarly, Nock and Ferriter (2005) assert there has been no articulation of how to manage parents for the duration of the child's treatment. The clinicians' three different roles in the parent involvement model answer the call for an explicative model for parent involvement for practitioners. Furthermore, by providing descriptions through empirical data of how and what to carry out in parent involvement, this study provides tangible understanding of child therapists in relation to enactment of their tasks.

Second, the conceptualization of parent involvement lays out a balanced framework in working with parents. Previous studies on parent engagement in child counseling have excessively emphasized behavioral elements through which therapists' performance is focused on the parents' education or training for skill acquisition, rather than combining all the emotional, cognitive, and behavioral aspects with interventions for the parents. Wagner (2008) asserts behavioral consultation is a pervasive modality in working with parents. Thulin et al. (2014) also point to the lopsided emphasis on the teaching component in parent involvement. They identify that the majority of meta-analyses on child counseling effectiveness were predominantly derived

from child cases with externalizing problems in which parent engagement methods included parent training components such as role-play, modeling, and homework assignments, which are heavily focused on behavioral modification of parents. The framework of parent involvement of the present study, however, suggests that child practitioners should take a holistic approach for parent advisement at affective, cognitive, and behavioral levels as counselor, teacher, and consultant.

Finally, clinicians' tasks identified during parent involvement through this study evoke the significance of support for parents at the affective dimension. As seen in Table 2, among the three roles, services offered at the counselor's position were most cited, and emotional support was the most dominant theme among the sub-themes of the three different roles. This finding indicates that the importance of warm and caring understanding and acceptance delivered by child clinicians toward parents brings attention to the quality of relationships with parents. In fact, valuing relationships with parents in child counseling settings has been stressed through extensive literature (see Booth & Jernberg, 2010; Cates et al., 2006; Gil, 2011; Guerney, 2003; Kottman, 2011; Kottman & Meany-Walen, 2016; Landreth, 2012; McGuire & McGuire, 2001; Sanders & Burke, 2013; VanFleet, 2009, 2014). These studies emphasize interpersonal processes, such as collaborative relationships, in addition to skills training that should not be neglected for effective parent interventions (Sanders & Burke, 2013). Without this type of relationship between parents and child practitioners, the effectiveness of parent involvement could be in doubt.

Limitations for the conceptualization of parent involvement based on the DM should be mentioned. First, a systemic perspective in understanding the performance of child practitioners is lacking. The concept of parent involvement is based on a psycho-social standpoint that

considers different systemic components in the child counseling process. That is, child counseling does not isolate the child unit from other systems, such as parents and siblings. Interventions that facilitate function and communication as a family, sibling, or parent-child dyad are based on this systemic view. So tasks, performance, and strategies based on a systemic approach should be incorporated into mapping out parents' involvement.

Second, cultural considerations should be addressed when applying the parent involvement conceptualization of this study to different groups in terms of ethnicity, race, and social and economic status. Dominant studies of parental involvement in child counseling have been performed with a Caucasian population. Dowell and Ogles (2010) confirm this through their meta-analytic review exploring the effects of parent participation on child psychotherapy that included 48 cases and 3,893 participants. Among the participants, 65% were Caucasian followed by 28% Hispanic, 19% African American, and 3% Asian participants. Not only is cultural sensitivity required for child practitioners, but they should present respect for cultural values and parents' roles across cultural groups.

Conclusion

The conceptual scheme of parent involvement applying the Discrimination Model to parent involvement is a pragmatic application for guiding parents through child counseling 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 through empirical data. The parent involvement conceptualization of this study 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 counseling processes, which is crucial in maximizing the child's results. Regardless of the theoretical orientation child practitioners identify with, results of this study offer a valuable pathway for mapping out the performance of the therapists for parent involvement. Given the reality that the majority of child therapists should deal with parents, review of the application of the parent involvement frame is highly recommended for all child practitioners.

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