Understanding Factors That Influence Black Caregivers' Ongoing Engagement in Behavioral Parent Training Programs

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UNDERSTANDING FACTORS THAT INFLUENCE BLACK CAREGIVERS’ ONGOING ENGAGEMENT IN BEHAVIORAL PARENT TRAINING PROGRAMS

by

Jennifer L. Tomlin, M.S.

A Dissertation submitted to the Faculty of the Graduate School, Marquette University, in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

Milwaukee, Wisconsin

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ABSTRACT

UNDERSTANDING FACTORS THAT INFLUENCE BLACK CAREGIVERS’ ONGOING ENGAGEMENT IN BEHAVIORAL PARENT TRAINING PROGRAMS

Jennifer L. Tomlin, M.S.
Marquette University, 2024

Despite the efficacy of behavioral parent training programs (BPTs) in reducing young children’s challenging behaviors, ongoing caregiver engagement in these skill-based programs is poor, particularly in low-income Black populations. The existing literature relied heavily on associating client demographic variables with treatment attendance and focused almost exclusively on BPTs with older children. Contemporary conceptualizations of engagement view it as a multidimensional construct comprised of cognitive, attitudinal, and behavioral components, and prior research has called for continued investigation into the caregiver-therapist alliance and cultural relevance of these treatment programs when looking at ways to increase Black caregiver engagement. The purpose of the present study was to qualitatively explore ways cognitive (e.g., expectations for treatment), attitudinal (e.g., readiness to change), relational (e.g., alliance), and cultural (e.g., mistrust, relevance) factors may have influenced Black caregivers’ experience and ongoing engagement at an urban Midwestern nonprofit agency focused on treating trauma in young children (i.e., ages 6 years and younger). Twelve Black caregivers who recently completed a home-based BPT for their child with a White therapist were interviewed regarding their expectations and feelings about treatment, their working alliance with and the cultural understanding of the therapist, and their within- and between-session engagement with the treatment strategies. Findings suggested most caregivers entered therapy expecting to learn more effective ways of managing their child’s behavior but were involved in the therapy to a greater degree than they originally expected. Most participants also described at least some degree of ambivalence when speaking about their hesitations about engagement in treatment. At the same time, participants described a positive working relationship with their therapist and reported they felt their therapist was able to understand the caregiver’s experience, particularly in helping the caregiver better manage behavioral concerns. Most participants described multiple ways they engaged with the therapist and their child during sessions and reported consistent use of strategies between sessions. Study findings also include meaningful suggestions from participants for improving Black caregiver engagement in this type of early childhood BPT therapy in the future. Limitations of this study and implications for both future research and clinical engagement interventions are also discussed.
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Jennifer L. Tomlin, M.S.

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CHAPTER 1: INTRODUCTION

Despite the efficacy of behavioral parent training programs (BPTs) in reducing young children’s challenging behaviors and emotional regulation difficulties, ongoing caregiver engagement in these skill-based programs is poor (Butler & Titus, 2015; Chacko et al., 2016; Dretzke et al., 2009; Gross et al., 2018; Lees et al., 2019; Nix et al., 2009), particularly among low-income Black populations (Bornheimer et al., 2018; Fox & Holtz, 2009; McKay & Bannon, 2004). Consequently, engagement is a critical topic of study in early childhood mental health care (i.e., treatment with children under the age of six and their caregivers) as treatment interventions can only be effective when families are consistently attending and participating in treatment sessions (Garland et al., 2012; Staudt, 2007; Staudt, 2012).

Behavior difficulties (e.g., aggressive tantrums, defiance) in children under six-years-old are increasing, both in frequency and intensity (Lees et al., 2019). Research suggests these behavioral challenges may develop into long-term difficulties (e.g., poor mental health, substance abuse, antisocial behavior) for the child and the family without early intervention (Gross et al., 2018; Lees et al., 2019). As BPT programs aim to improve skills for both the child (e.g., emotion regulation) and the caregiver (e.g., positive parenting strategies), these programs require the family to be engaged (i.e., attending and actively participating) within sessions and practicing the skills between sessions in order to improve treatment outcomes for both child and caregiver (Beauchaine et al., 2005; Clarke et al., 2015; Gross et al., 2018).

The study of engagement in early childhood mental health care is especially complex, as the young child fully depends on the caregiver to seek, attend, and
participate in services. In addition, childhood therapy involves multiple people in the treatment process (e.g., one or both biological or foster parents, extended family members, siblings), the need for the therapist to attend to multiple relationships (e.g., child-therapist alliance, caregiver-therapist alliance) within session, and the need to clarify the caregiver’s role in the treatment process (Garland et al., 2012). Unfortunately, the literature on engagement with this population has largely ignored these complexities. Research has instead focused on initial recruitment efforts and session attendance, which have less of an association with positive treatment outcomes than does active participation in treatment (Kazdin & Whitley, 2003; Staudt, 2007). Indeed, most engagement literature pays little attention to identifying factors that may improve the quality of participation in therapeutic tasks both within- and between- sessions (Staudt, 2007; Staudt et al., 2012). An additional concern is the lack of engagement research in general, and on BPTs specifically, that focus on low-income minority families (Fox & Holtz, 2009; Gresl, 2014; Harris et al., 2014). The current study, therefore, aimed to examine attitudinal and relational factors that may influence Black caregivers’ ongoing engagement in a home-based BPT program. This chapter will discuss the rationale and purpose of this study, present the research question, give a brief overview of study methods, and define salient terms.

**Rationale for the Current Study**

There is a high need to increase engagement in child therapy in urban areas, as 40% of children living in these areas have mental health needs, and yet only about 25% of children with mental health needs receive service sessions (McKay & Bannon, 2004). Of those who do begin services, an estimated 40 to 60% of families prematurely end
treatment before the clinician deems the treatment complete or successful (Garland et al., 2012; McKay & Bannon 2004; Pelerin et al., 2010). This attrition rate is especially significant in low-income, urban areas (Bornheimer et al., 2018; Fox & Holtz, 2009; McKay & Bannon, 2004).

Research has demonstrated families who end treatment services prematurely are more likely to be single-parent households, low income, from a minority group, and face higher levels of adversity (e.g., higher levels of stress, frequent changes in employment or living situation, less social supports) than families who persist in treatment (Bornheimer et al., 2018; Chacko et al., 2009; Garland et al., 2010b; Harris et al., 2015). These same factors put children in low-income urban areas at higher risk of developing disruptive behavior problems (Fox & Holtz, 2009; Harris et al., 2015; Ketch-Oliver & Smith, 2015). Home-based services are designed to increase engagement, especially in low-income populations, by reducing contextual barriers (e.g., lack of transportation, loss of phone service, frequent relocation) and yet many families still do not fully engage in the treatment process (Fung et al., 2014; Harris et al., 2015; Staudt, 2007). It appears there are additional factors that may hinder low-income minority families from fully engaging in BPTs with their young children.

Beyond these contextual and family characteristics, caretakers in urban areas report significant agency-level barriers to engaging in treatment such as service providers not contacting them following the initial referral, missed appointments by clinicians, inconvenient agency hours, and scheduling problems due to work or family commitments (Harrison et al., 2004; Lakind & Atkins, 2018). Given these experiences and the difficulties in participating in treatment, families may feel alienated by providers, which
could lead to mistrust and apprehension about further engaging with clinicians in counseling (Harrison et al., 2004; Lakind & Atkins, 2018). Furthermore, negative stigma around receiving mental health care, combined with mistrust of providers, is additionally identified as a factor in preventing engagement in services more often in low-income minority families in comparison to Caucasian families who seek BPT services (Lakind & Atkins, 2018; Santiago et al., 2013a).

Given the discrepancy between need and engagement with services in urban populations (Frazier et al., 2007), and given the potential alienation of this population from treatment, an exploration of engagement in early childhood therapy and the factors that might influence ongoing engagement is warranted (Chacko et al., 2016; Staudt, 2007, Staudt et al., 2012). However, the existing BPT engagement literature has focused almost exclusively on engagement as merely session attendance with little attention paid to psychological factors (e.g., caregiver-therapist alliance, cost/benefit ratio of therapy participation, attribution of behavior cause, cultural relevance of treatment) that might influence a caregiver’s decision to continue or stop attending treatment (Becker et al., 2015; Clarke et al., 2015; Ellis et al., 2013; Haine-Schlagel & Walsh, 2015; Mattek, 2014; Nock & Ferriter 2005; Stadnick et al., 2016; Staudt 2007). Additionally, low-income Black populations have only been addressed in the existing research in a limited way; that is, by using demographic variables (e.g., race and socioeconomic status [SES]) as quantitative predictors of session attendance (Kazdin & Whitley, 2003, Staudt et al., 2012). While these variables are convenient to collect, they are not likely to provide researchers with insight into reasons a particular caregiver may choose to participate
within therapy, adhere to treatment strategies outside of session, or drop out of treatment (Chacko et al., 2017; Kazdin et al., 1997a, Kazdin et al., 1997b).

Contemporary views on caregiver engagement (e.g., Becker et al., 2015; Lindsey et al, 2014; Stadnick et al., 2016) call for the consideration of cognitive, attitudinal, and relational factors as well as treatment adherence in order to better understand how caregivers engage throughout BPT treatment. This multidimensional conceptualization of engagement acknowledges that attitudinal factors (e.g., openness to change, commitment to treatment plan, belief in positive outcome) strongly influence the behavioral components (i.e., attendance, within-session participation, between-session adherence) of engagement (Haine-Schlagel & Walsh, 2015; Lewis et al., 2018; Miller, 2008; Nock & Ferriter, 2005; Stadnick et al., 2016; Staudt, 2007). Cognitive and attitudinal factors (e.g., caregiver perception of treatment’s relevance, efficacy, and cost/benefit ratio) and relational barriers (i.e., poor alliance with their child’s therapist; cultural differences) have been identified as critical to within- and between-session treatment engagement in adolescent and adult populations (Fernandez & Eyberg, 2009; Gresl, 2014; Kazdin et al., 1997a; Kazdin et al., 1997b; Snell-Johns et al., 2009), yet research on these aspects of caregiver engagement within early childhood BPTs is sparse.

Additionally, the majority of research on caregiver engagement has been conducted using the clinician or agency perspective (e.g., cancellation rates, therapist rating of caregiver’s participation within sessions; Nix et al., 2009), thus making the caregivers’ perspective on factors that influence their own ongoing engagement in services a critical gap in the literature. One notable exception is the work of Yatchmenoff (2005), who tried to understand the caregiver perspective by interviewing a larger sample.
of caregivers regarding their experiences of engagement. The results suggested four important aspects of caregiver engagement: receptivity (i.e., problem recognition, perceived need for and openness to outside help); buy-in (i.e., expectation of benefit, hope for positive change, goal ownership, and active participation); working relationship (i.e., interpersonal relationship marked by open communication and collaboration); and mistrust (i.e., an anti-engagement factor, the belief that the agency worker is not working for the benefit of the caregiver or family; Yatchmenoff, 2005). These results highlight the cognitive (e.g., receptivity), attitudinal (e.g., buy-in), and relational (e.g., working relationship, mistrust) components of caregiver engagement (Becker et al., 2015; Lindsey et al, 2014; Yatchmenoff, 2005). Unfortunately, the sample was mostly White caregivers who were mandated to complete treatment through the child welfare system (Yatchenoff, 2005), so it is unknown if Black caregivers who are voluntarily participating in BPTs would highlight the same components when describing their engagement.

To date, early childhood mental health research is devoid of investigations into how Black caregivers experience their own treatment engagement in BPTs. A comprehensive literature review revealed multiple calls from researchers (e.g., Acri et al., 2016; Damashek et al., 2012; Gross et al., 2018) for examinations into how attitudes toward mental health care (e.g., attribution of cause, stigma), caregiver-therapist alliance, and cultural factors (e.g., parenting values, cultural relevance of treatment) may be particularly important influences on this population’s engagement decision-making process. To date, this gap still exists. Given this lack of understanding, as well as the lack of established theories or measures of caregiver engagement, it appeared a qualitative
investigation that would seek to deeply understand the factors influencing Black caregivers’ ongoing engagement in early childhood BPTs was warranted.

**Purpose of the Current Study**

The current study is grounded in the work of a urban Midwestern non-profit agency that provides home-based family behavior and trauma therapy to children under the age of six and their caregivers. The clinic’s evidence-based *Early Pathways* (EP; formerly called *Parenting Young Children* (PYC); Fox et al., 2013; Fox & Nicholson, 2003) is a BPT comprised of eight parenting strategies aimed at modifying caregiver responses to children’s challenging behaviors (i.e., aggressive tantrums, oppositional behavior) and provides emotional regulation strategies for both the parent and child (i.e., modeling feeling identification, using adaptive coping skills). The average length of treatment necessary to complete the program is 8 to 12 treatment sessions. Families frequently drop out of treatment before receiving all strategies, typically before the fourth treatment session (Fox & Holtz, 2009). In 2018, the clinic had a 43% attrition (i.e., disengagement) rate from services (Tomlin et al., 2019). While families report a high number of logistical stressors (e.g., lack of childcare, transportation), EP was specifically designed to increase accessibility to low-income minority families by holding treatment sessions within the family home (Fox & Holtz, 2009; Fox et al., 2013; Fox & Nicholson, 2003; Fung et al., 2014; Harris et al., 2015). Thus it appears, and prior research supports, external barriers do not fully account for the lack of ongoing engagement (Fung et al., 2014; Harris et al., 2015). Given the high caregiver/client dropout rates, it seems reasonable to wonder about other factors that influence caregiver engagement before and during therapy. The clinic is continually looking for ways to improve the quality of
families’ ongoing engagement (i.e., participation and adherence) with the treatment program.

Black families comprise the largest percentage of clients (i.e., 47%) seen at the clinic and 90% of all families served receive public assistance (Tomlin et al., 2019). At the time of study recruitment, and in the three years prior to study recruitment, the clinic employed only White or Latina clinicians. Latina clinicians’ caseloads were primarily Spanish-speaking families. As all Black caregivers receive services from a clinician of a different race, and this Midwestern city has consistently been rated as one of the most racially segregated and poorest cities in America (Loyd & Bonds, 2018), it appeared there may be value in examining any potential connection between attitudinal, relational, and cultural factors and ongoing engagement (i.e., treatment preparation, participation, and adherence) in the EP treatment program, particularly for Black caregivers. Therefore, the purpose of the present study was to qualitatively explore ways attitudinal, relational, and cultural factors may have influenced Black caregivers’ experience and ongoing engagement with this BPT.

It was the hope that this study would amplify caregiver voices and provide data on how Black caregivers make decisions regarding their within- and between- session engagement based on cognitive, attitudinal, and relational factors. Answers to these questions may better inform future engagement interventions and foster successful treatment outcomes for this population as the current study will allow Black caregivers the opportunity to offer direct feedback on factors that influence their engagement in a home-based BPT. Additionally, this study may help fill a gap in the literature on
engagement in child therapy by examining how Black caregivers’ ongoing engagement may by uniquely influenced by attitudinal, relational, or cultural factors.

**Research Question**

Recognizing that the process of engagement is multifactorial and dynamic over time, this study sought to explore and better understand the factors that influence Black caregivers’ ongoing engagement in their young child’s BPT therapy through the use of qualitative inquiry. As such, this study asked the broad question, “What influences Black caregivers’ ongoing engagement in early childhood BPT programs?” The study asked participants to explore their engagement before, during, and after the treatment experience. Additionally, participants were asked to reflect on how attitudinal, relational, and cultural factors may have influenced their within-session participation, alliance with the therapist, and between-session strategy adherence. This inquiry was intended to provide a rich and deep understanding of multiple factors may influence Black caregivers’ ongoing engagement in BPTs with their young child, with the hope of informing effective engagement interventions with this population.

**Overview of Study Methods**

Given the aim to understand the experience and engagement of low-income Black caregivers participating in a home-based BPT program, this study used the Consensual Qualitative Research method (CQR; Hill, 2012; Hill & Knox, 2021; Hill et al., 2005; Hill et al., 1997). CQR was selected as it was designed to facilitate deep understanding of participant attitudes, beliefs, and experiences (Hill & Knox, 2021). CQR uses open-ended questions within a semi-structured interview protocol to examine the individual experience of each participant while also exploring commonalities of the experience.
across participants (Hill & Knox, 2021; Hill et al., 2005). Participants’ own words served as data, reflecting the method’s constructivist stance. In addition to the semi-structured protocol, CQR contains other post-positive elements, including a clear procedure for data analysis, the use of a research team that works together at all stages of the data analysis to ensure multiple perspectives, required consensus among all team members about the meaning of the data, and the use of an external auditor to examine the team’s work and provide feedback (Hill & Knox, 2021; Hill et al., 2005; Hill et al., 1997). The method has been found to be useful in investigating topics not previously well-explored in the literature, in conducting collaborative research with underserved populations, and can inform both clinical practice and future research (Hill et al., 1997).

In the current study, participant interviews were conducted via telephone, audio recorded, and transcribed for analysis. CQR recommends a sample of 8 to 15 participants (Hill et al., 2005) with data saturation (i.e., the point when adding additional participants no longer adds new or meaningful knowledge to the study) more likely to occur the closer the sample size is to 15 participants, given a relatively homogenous sample (Hill & Knox, 2021). Recruitment took place using convenience sampling through the Behavior Clinic; participant inclusion criteria include Black caregivers who have completed treatment at the Behavior Clinic within six months of study onset. A full list of participant criteria, data collection, and data analysis procedures can be found in Chapter 3.

**Definition of Terms**

This study contains terminology related to caregiver engagement, many of which are often confused or conflated in the literature. Further, this study is centered around a
specific type of therapeutic intervention (i.e., BPTs) simultaneously aimed at both young children and their caregivers. Terms central to the reader’s understanding of the current study are briefly defined here, with further critical discussion of these terms to follow in the literature review found in Chapter 2.

**Caregiver.** This study defines caregiver as the adult who is participating in treatment with the child. This adult may be a biological parent, a foster or adoptive parent, a kinship placement (i.e., grandparent or other blood relative), or another adult who has been granted legal guardianship of the child. In any therapy involving a young child, caregivers are highly influential in treatment as they must seek it out, provide consent, attend the therapy with the child, participate within treatment sessions, and adhere to treatment interventions between sessions (D’Arrigo et al., 2017; Nock & Ferriter, 2005; Nock & Kazdin, 2005). Though the child is technically the identified client in BPT programs, this study solely examined caregiver engagement in BPT therapy.

**Behavioral Parent Training Program (BPT).** BPTs are evidence-based treatment programs grounded in the belief that all child behavior takes place within an environment of interpersonal interactions which the caregiver can change to better shape the child’s behavior (Prinz, 2019). BPT programs acknowledge the child’s dependency on the adult to effectively cope with feelings and manage their behavior, and as such, aim to equip caregivers with knowledge and skills that will help them manage their child’s disruptive behaviors (e.g., aggressive tantrums) while simultaneously fostering prosocial behaviors (e.g., listening and following directions) through a more positive caregiver-child relationship (Butler & Titus, 2015; Gross et al., 2018; van Mourik et al., 2017).
Though there are many individual examples of BPTs that work exclusively with young children (e.g., Parent-Child Interaction Therapy [PCIT; Eyberg et al., 1995]; the Chicago Parent Program [Gross et al., 2009], and EP [Fox et al., 2013; Fox & Nicholson, 2003]), this type of treatment has two main components: cognitive-behavioral approaches aimed at improving the child’s coping skills, emotion regulation, and problem-solving skills; and simultaneous interventions to improve caregiver-child attachment and increase the caregiver’s positive parenting practices (e.g., consistent limit setting, positive reinforcement for desired behaviors; Beauchaine et al., 2005; Dretzke et al., 2009; Garland et al., 2010b; Gross et al., 2018; Ketch-Oliver & Smith, 2015; Prinz, 2019; van Mourik et al, 2017). All BPTs typically include homework as way for caregivers and children to practice newly learned skills between sessions (Gross et al., 2018.) EP is an example of an evidence-based BPT for caregivers and young children ages six years and younger.

**Engagement.** Engagement is a complex, multidimensional construct that is used to describe several individual components occurring over time during an episode of mental health service use: contacting a provider; attending an intake evaluation; attending subsequent treatment sessions; forming a working alliance with the therapist; actively and consistently participating in the sessions with the therapist and the child; following recommended interventions between treatment sessions; and treatment completion (Garland et al., 2012; McKay & Bannon, 2004; Staudt et al., 2012). At any one of these time points or components, the caregiver may choose to disengage (i.e., stop attending or participating in sessions, stop adhering to recommendations; Byrd et al., 2017) from therapy. Given the multitude of components and opportunities for disengagement (i.e.,
attrition), the literature generally divides engagement into two phases: initial engagement (i.e., recognizing a need for treatment, contacting a provider, scheduling an intake assessment, and attending that intake with the child) and ongoing engagement. Ongoing engagement was the focus of the current study.

**Ongoing engagement.** Ongoing engagement is a term used to describe a caregiver’s continued involvement with the therapeutic process after the intake evaluation is completed. In the literature, ongoing engagement in BPTs involves four main caregiver behaviors (i.e., behavioral engagement): consistent attendance at treatment sessions; session participation; adherence to treatment strategies and recommendations; and completion of the treatment program (Becker et al., 2015; Lindsay et al., 2014; McKay and Bannon, 2004). Each behavior is now defined separately.

**Attendance.** Attendance is defined as the arrival of all agreed-upon people (e.g., parent/caregiver, child, family) to the treatment setting (e.g., clinic, school, home) for treatment sessions at a mutually agreed-upon appointment time (Nock & Ferriter, 2005). In BPTs with young children, arrival at sessions is considered the sole responsibility of the caregiver (Garland et al., 2012; Nock & Ferriter, 2005).

**Participation.** This study adopted the Stadnick et al. (2016) definition of caregiver participation: “active, independent, and responsive contributions from the parent during therapy sessions, including sharing opinions, asking questions, participating in session activities, and following through on parent- or child-directed between-session activities” (p.746).

**Adherence.** Adherence broadly refers to the completion of therapeutic tasks (i.e., active session participation, use of treatment strategies both within- and between-
sessions, completing between-session homework assignments, and following general therapeutic recommendations) by the caregiver in order to reach treatment goals (Becker et al., 2015; Nock & Ferrier, 2005; Ros et al., 2016).

**Completion.** Individual treatment programs define program completion differently. In EP, treatment completion has two components: caregiver attendance at the intake assessment and at least five additional treatment sessions; and at least two behavioral or trauma interventions being implemented (Fung et al., 2014; Love & Fox, 2019)

**Attitudinal engagement.** Separate from behavioral engagement, attitudinal engagement refers to the individual’s emotional investment in therapy (Becker et al., 2014; Becker et al., 2015; King et al., 2014; Lindsay et al., 2014). Attitudinal engagement is made up of cognitive preparation for treatment, commitment to treatment plan and goals, expectation of positive outcome, emotional bond and collaboration with therapist (i.e., alliance), and perceived cost/benefit ratio of participating in therapy (Becker et al., 2014; Becker et al., 2015; Lindsay et al., 2014; Haine-Schlagel & Walsh, 2015; King et al., 2014; Stadnick et al., 2016; Staudt, 2007). Though harder to operationalize than behavioral engagement components such as attendance, contemporary views on engagement acknowledge these attitudinal components strongly influence a caregiver’s behavioral engagement and are influenced by factors both internal (e.g., type of therapy, alliance) and external (e.g., logistical barriers, life stressors) to the therapy itself (Becker et al., 2014; Staudt et al., 2007; Staudt et al., 2012).

**Cognitive Preparation.** Cognitive preparation, one aspect of attitudinal engagement, refers to caregiver readiness and motivation for treatment. Cognitive
preparation involves beliefs about mental health care, motivation to change, attribution of cause for their child’s challenging behaviors, knowledge about type of therapy, role expectations for therapist and self during therapy, positive outcomes, and caregiver perception of own parenting efficacy and ability to change (Becker et al., 2015; Chacko et al., 2017).

**Alliance.** This study adopted Bordin’s (1979) conceptualization of adult alliance with a therapist; that is, alliance is a therapeutic relationship comprised of three separate domains (i.e., bond, tasks, and goals; Horvath & Greenberg, 1989). The bond domain speaks to the emotional aspect of alliance such as warmth, caring, and respect within the therapeutic relationship (Bordin, 1979; Horvath & Greenberg, 1989; Johnson et al., 2002). The task domain involves collaboration on therapeutic activities and the overall belief the therapist can help with one’s problems (Bordin, 1979; Horvath & Greenberg, 1989; Johnson et al., 2002). The goal domain consists of agreement about therapeutic goals and the commitment to actively working together toward achieving them (Bordin, 1979; Horvath & Greenberg, 1989; Johnson et al., 2002). As such, the construct of alliance overlaps with current conceptualizations of engagement which stress both attitudinal (e.g., affective bond, client beliefs and perceptions about therapy, therapist, and outcomes) and behavioral components (e.g., task adherence for the purpose of achieving therapeutic goals; Becker et al., 2015; King et al., 2014; Lindsey et al., 2014).
CHAPTER 2: REVIEW OF THE LITERATURE

To inform the current research question, “What influences Black caregivers’ ongoing engagement in early childhood BPT programs?”, this chapter begins with a discussion of how caregiver engagement has historically been operationalized and studied within the general child therapy literature. Recent multidimensional conceptualizations of caregiver engagement are highlighted as they appear key to better understanding how multiple psychological factors (e.g., cognitive preparation, attitudes toward treatment, therapeutic alliance, cultural relevance) may influence a caregiver’s level and length of engagement in their child’s mental health care. The existing BPT engagement literature is then reviewed in detail, emphasizing early childhood BPT programs and critically examining how diverse populations are represented in that literature. Finally, the existing research on factors influencing caregiver engagement, including barriers to treatment, treatment location and format, alliance, and cultural issues, are discussed as this literature and its implications directly informed the current study’s interview protocol.

**Definition and Operationalization of Engagement**

Despite the recognition of the importance of engagement, factors that influence engagement and the mechanisms needed to improve it remain poorly understood. This lack of understanding is due to inconsistent use of terms and operational definitions in the literature (Littell et al., 2001; Staudt, 2007; Staudt et al., 2012). At its most basic level, the term *engagement* is used to describe service use (i.e., enrollment, attendance, completion, retention or attrition; Butler & Titus, 2015; McKay & Bannon, 2004; Morawska & Sanders, 2006). Empirically, however, the term engagement is often used interchangeably with participation, involvement, collaboration, alliance, adherence,
retention, and compliance (Littell et al., 2001; Staudt, 2007; Staudt et al., 2012), which creates confusion about the operational definition of engagement. For example, _alliance_ is often a measure of the perceived quality of the relationship between the client and the therapist (Horvath & Bedi, 2002) while _adherence_ typically refers to the client’s completion of therapeutic tasks (Becker et al., 2015). Both alliance and adherence appear to overlap with engagement, but neither concept fully reflects the concept of engagement in therapy. This overlap of separate but related constructs makes interpretation and comparison of the literature on engagement difficult.

As a result, the terms _engagement_ and _treatment engagement_ do not have a common operational definition in the empirical mental health literature (Frazier et al., 2007; King et al., 2014; McKay & Bannon, 2004; Staudt et al., 2012). In their review of literature on client participation, another concept that appears to significantly overlap with engagement, Littell et al. (2001) discussed challenges that occur when definitions are not consistent within the literature. For example, it is difficult to compare results from studies in this area due to their differing definitions, as some studies define participation as attendance (i.e., a behavioral phenomenon), some studies equate participation with engagement (i.e., a cognitive-behavioral phenomenon), and still other studies discuss participation as a working alliance with the therapist (i.e., a relational phenomenon; Littell et al., 2001). Similarly, the term engagement also has various definitions within the literature and carries with it some of the same empirical challenges.

**Definitional Variations**

King and colleagues (2014) outlined four major definitional variations which make interpretation of empirical studies on engagement difficult. First, studies vary in
defining the object of engagement (e.g., engaging with interventions vs. engaging with the therapist; King et al., 2014). This creates conceptual confusion about what engagement truly entails. Second, the description of the engagement variable is different across studies. Some research treats engagement as a single event (i.e., attendance at intake appointment), as an outcome (i.e., program completion) or as a process (i.e., ongoing participation), adding to the conceptual confusion (King et al, 2014; Yatchmenoff, 2005). Third, studies differ in which aspect of engagement is measured (e.g., attendance, adherence to interventions, participation in session, or alliance; King et al., 2014; Nock et al., 2007). Differing operationalizations make comparing empirical results challenging as different variables are being measured in multiple ways across studies. Fourth, the research varies in perspective, as both therapist and client perspectives on client engagement have been studied (King et al., 2014), with heavy emphasis on therapist views. Together, these definitional variations highlight the complexity of engagement and have driven recent researchers to work to more clearly outline the construct of engagement in therapy.

Thus, engagement is an construct that appears to include a number of individual components that occur over the course of treatment: initial contact with a mental health provider; treatment attendance (e.g., individual session attendance, total number of sessions attended, program completion); therapeutic alliance; active participation within treatment sessions; adherence to recommended interventions between treatment sessions; and overall satisfaction with treatment (Garland et al., 2012; McKay & Bannon, 2004; Staudt et al., 2012). There are examples of individual engagement definitions within the
child therapy literature that point to these multiple components of caregiver engagement in services.

Prinz and Miller (1991) initially defined engagement as the quantity and quality of client involvement necessary to obtain benefits from treatment, citing regular attendance, participating in sessions, and demonstrated effort between sessions as the primary markers of engagement. Similarly, Cunningham and Henggeler (1999) defined engagement as a high rate of session attendance, homework completion between sessions, emotional involvement within the session, and progress toward treatment goals. Specific to child therapy, *parent participation engagement* has been defined as “active, independent, and responsive contributions from the parent during therapy sessions, including sharing opinions, asking questions, participating in session activities, and following through on parent- or child- directed between-session activities” (Stadnick et al., 2016, p. 746). King et al. (2014) recently extended the construct of caregiver engagement to include a motivational state that occurs when clinicians implement strategies to increase client willingness to take part, receptivity to proposed interventions, and parental self-efficacy beliefs.

**Attitudinal and Behavioral Engagement**

Based on these definitions, it appears there are both behavioral and attitudinal facets of engagement (Becker et al., 2014; Ellis et al., 2013; Haine-Schlagel & Walsh, 2015; Lewis et al., 2018; Morissey-Kane & Prinz, 1999; Stadnick et al., 2016; Staudt, 2007; Staudt et al., 2012). Attitudinal engagement is thought to be influenced by external barriers to treatment, life stressors, expectations and beliefs about treatment efficacy, and the strength of the therapeutic alliance (Becker et al., 2014; Staudt et al., 2007; Staudt et
al., 2012). The most essential aspect of attitudinal engagement is the client must expect the benefits of treatment will outweigh any costs associated with the treatment (Haine-Schlagel & Walsh, 2015; Stadnick et al., 2016; Staudt, 2007). Attitudinal engagement, therefore, effects behavioral engagement, which is comprised of four separate action elements: initial help seeking; session attendance; active participation within session; and adherence to recommendations between sessions (Haine-Schlagel & Walsh, 2015; Lewis et al., 2018; Miller, 2008; Nock & Ferriter, 2005; Stadnick et al., 2016; Staudt, 2007). Distinguishing between the attitudinal and behavioral components of engagement has important clinical implications, as many clients attend treatment (i.e., fulfill some behavioral components) without emotional investment (i.e., attitudinal engagement) in the therapeutic process (Gopalan et al., 2010; Haine-Schlagel & Walsh, 2015). Alternatively, increased attitudinal engagement (e.g., positive rapport with therapist) could lead to increased behavior engagement (e.g., skill practice, adherence), allowing clinicians to provide additional feedback which may continue to bolster both attitudinal and behavioral engagement in treatment (Lewis et al., 2018).

In the existing engagement literature, treatment attendance (i.e., behavioral engagement) is the most studied outcome variable (Ellis et al., 2013; Garland et al, 2012; Lindsey et al., 2013), likely because it is the most easily measured component of engagement (i.e., the presence or absence at a therapy session or the calculation of overall retention and attrition rates; Becker et al., 2015; Lindsey et al., 2014). Current researchers seem to agree that while parent attendance is a necessary component of engagement in their young child’s mental health treatment (Haine-Schlagel & Walsh, 2015; Stadnick et al., 2016), the measurement of attendance alone is not enough to fully represent the
complexities (i.e., both the behavioral and attitudinal components) of within- and between-session treatment engagement and provides little information about the psychological aspects of client engagement in treatment (Becker et al., 2015; Clarke et al., 2015; Ellis et al., 2013; Haine-Schlagel & Walsh, 2015; Nock & Ferriter 2005; Stadnick et al., 2016; Staudt 2007). The attitudes and behaviors necessary for engagement also vary depending on the stage of treatment. As such, researchers have divided the larger construct of engagement into two phases to better understand these behavioral and attitudinal components within each phase.

**Phases of Engagement**

*Initial Engagement*

The literature on engagement in child mental health services has been divided into two distinct phases: initial engagement (i.e., recognition of problem, referral for services, contact with provider, and attendance at intake) and ongoing engagement (i.e., consistent attendance at treatment sessions, session participation, adherence, and treatment completion; Becker et al., 2015; McKay and Bannon, 2004). Initial engagement in services is generally considered to encompasses everything that takes place before treatment itself begins. The family must first acknowledge the child has a problem which requires help, seek out a provider or mental health referral, and contact the provider to inquire about and schedule services (Byrd et al., 2017; McKay and Bannon, 2004). The child and caregivers must then attend and complete an intake evaluation with the provider (Byrd et al., 2017; McKay and Bannon, 2004). This operationalization provides distinct opportunities to collect quantitative data; if any of the above steps do not occur, the child and caregiver have disengaged from services (Byrd et al., 2017). However, this
operationalization reflects initial engagement only and focuses heavily on behavioral components of engagement without enough emphasis on the attitudinal components that determine whether families will remain in treatment and benefit from services. Therefore, this study focuses on ongoing engagement in order to explore factors that might better inform interventions to improve ongoing engagement throughout treatment, which in turn may lead to improved treatment outcomes (Clarke et al., 2015). Ongoing engagement is typically operationalized in the literature by two main categories: attendance and adherence.

**Ongoing Engagement**

**Attendance.** *Treatment attendance* is defined as the arrival of all agreed-upon people (e.g., parent/caregiver, child, family) to the treatment setting (e.g., clinic, school, home) for treatment sessions at a mutually agreed-upon appointment time (Nock & Ferriter, 2005). In child therapy, the caregiver is responsible for arrival at sessions (Garland et al., 2012; Nock & Ferriter, 2005). There are three constructs related to treatment attendance that are often the focus of empirical studies: continuation in treatment (i.e., the number of sessions attended); premature termination; and attrition (Nock & Ferriter, 2005). The terms *premature termination* and *attrition* appear to overlap and also have a variety of definitions: missing scheduled sessions, not attending a certain number of sessions, or dropping out of therapy before the treatment program has been completed or the therapist deems termination is appropriate (Miller et al., 2008). The majority of empirical literature is dedicated to the study of treatment attendance as evidence of ongoing engagement in services.
Caregiver Engagement as Attendance. Historically, the earliest literature on ongoing engagement in child therapy focused on solely on the behaviors of remaining in treatment or premature termination (Ellis et al., 2013; Garland et al., 2012; Lindsey et al., 2013; Nock & Ferriter, 2005; Yatchmenoff, 2005). Many of these studies aimed only to identify demographic differences between those who attended treatment and those who did not, often with inconsistent results. For example, Kazdin (1990) investigated the differences between families that completed treatment and those who terminated early in a program for children ($n = 81$, ages 7-13 years) referred for antisocial behavior. The author defined completion of the program as attendance at more than 75% of treatment sessions and premature termination as attendance at less than 25% of treatment sessions (Kazdin, 1990). Though caregivers who terminated early attended far fewer sessions (i.e., an average of 2.2 out of 16 sessions) than did caregivers who completed the program (i.e., an average of 15.6 out of 16), the study determined the two groups differed only on parental stress level, child symptom severity, and socioeconomic status (SES); the groups did not differ on other demographic factors such as race, age, type of caregiver (e.g., biological or foster parent) or number of caregivers in the home (Kazdin, 1990).

However, in a study using the same protocol and operational definitions but involving a larger sample and slightly younger children ($n = 160$, ages 5-13 years), Kazdin and colleagues (1993) found caregivers who terminated prematurely not only differed from those who completed in SES, parental stress, level of child symptom severity, but also in minority status, age, and single parent status even though participant demographics (i.e., race, SES, type of caregiver) were similar across the two studies. This study added an additional hypothesis that the risk of premature termination would
increase as the number of the family’s risk factors (e.g., poverty, symptom severity, parental stress, development delays, harsh parenting practices) increased; results confirmed this hypothesis (Kazdin et al., 1993).

Two other early ongoing engagement studies focused on demographic risk factors for attrition from services with inconsistent results. First, Armbruster & Fallon (1994) studied drop-out and continuance in child (ages 1-18 years) therapy and initially found caregivers who dropped out early were more likely have lower SES ($p < .01$), minority status ($p < .05$), or single parent status ($p < .05$) than were caregivers who continued in treatment for one year or completed the treatment program. Once SES was controlled for in the analysis, however, minority status and single parent status were no longer significant risk factors for early drop-out (Armbruster & Fallon, 1994). In a study ($n = 279$) explicitly comparing racial differences between treatment completers and those who terminate early, Kazdin et al. (1995) found a significantly higher rate of dropout for Black families (59.6%, $X^2 (1, N = 279) = 8.29, p < .01$) than for White families (41.7%). At the same time, the authors admit this difference cannot be exclusively attributed to race alone, but rather also to numerous confounding factors which relate to race, such as SES, single parent status, and parental stress level (Kazdin et al., 1995).

Indeed, while all four of these studies identified, albeit with some inconsistency in results, SES, minority status, single parenthood, child symptom severity, and caregiver stress level as risk factors for premature termination (i.e., ending ongoing engagement in services; Armbruster & Fallon, 1994; Kazdin, 1990; Kazdin et al., 1994, Kazdin et al., 1995), none of these research teams truly examined the interaction between these risk factors as they related to a family’s decision to continue or end services. This points to a
significant limitation of basing engagement studies on attendance data only; namely, the identification of risk factors for ending engagement with little information on how to design interventions to increase engagement. Using only demographic variables to determine risk factors is seen by many as a matter of ease as these variables are easily attainable and easily measurable (Chacko et al., 2017; Kazdin et al., 1997a, Kazdin et al., 1997b). As these variables (e.g., race or SES) are not going to change throughout the course of therapy, researchers need to examine engagement variables (e.g., attitudinal factors) that are more malleable to therapeutic intervention.

Nock and Ferriter (2005) point out another flaw in attendance as the sole measure of engagement; namely, merely calculating the number of sessions attended does not quantify the consistency of attendance or indicate the number of sessions a particular family needed in order to achieve therapeutic outcomes (i.e., some families may only need a few sessions in order to see positive change). Indeed, an earlier study demonstrated that one-third of participants who prematurely terminated treatment reported significant improvement in their child’s behavioral and emotional symptoms which suggests some families (i.e., those with less severe problems or fewer barriers to treatment) may only need a few treatment sessions in order to attain goals (Kazdin & Wassell, 1998; Nock & Ferriter, 2005). It appears child and caregiver factors may affect a family’s treatment attendance without being able to predict it (Nock & Ferriter, 2005).

Another critique of this literature is that, while some studies did include early childhood therapy (i.e., with children under the age of 6), studies often included a wide age range of children (e.g., 1-18 years old, Armbruster & Fallon, 1994; 3-13 years old, Kazdin et al., 1995), failing to account for the difference in caregiver engagement needed
depending on child developmental level. By only looking at attendance, researchers ignored these developmental differences and equated caregiver involvement in their child’s therapy as the same for all youth 18 years old and younger, which does not accurately reflect the amount of appropriate caregiver engagement based on the child’s age or developmental level (MacDonald et al., 2007). As such, there was a shift toward examining adherence as a measure of engagement both more malleable to intervention and more developmentally focused.

**Adherence.** Treatment adherence, the completion of tasks within therapy in order to produce the desired therapeutic outcome (Becker et al., 2015; Nock & Ferrier, 2005; Ros et al., 2016), is another important aspect of engagement in early childhood therapy. BPTs require a high level of adherence as these programs are skill-based for both caregiver and child (Beauchaine et al., 2005; Dretzke et al., 2009; Kaminski et al., 2008). Adherence has not been as thoroughly examined in the child therapy literature as has attendance, likely due to the number of ways adherence can be operationalized. Adherence can be measured by looking at both the quantity and quality of caregiver behaviors (i.e., participation) during treatment sessions (e.g., asking questions, making collaborative statements, participating in session activities) or between sessions (e.g., skill implementation; Clarke et al., 2015; Nock & Ferriter, 2005; Ros et al., 2016). For participation in therapy to enact change, caregivers must be open to new ideas, attentively listen in session, desire a change in interaction with their child, and honestly discuss problems with the therapist; they must also be willing to try new strategies within session while being coached by the therapist, and implement strategies outside of session consistently (Baydar et al., 2003; Dumas et al., 2007; Littell et al., 2001; Nix et al., 2009).
Participation can then be viewed as having multiple aspects related to both within- and between-session adherence to treatment. Again, terminology matters here. Participation is often used interchangeably with both adherence and engagement in the literature without being equivalent to either term.

The term *homework completion* is also sometimes used to describe adherence (Clarke et al., 2015), though this term speaks more to between-session participation than within-session participation in therapeutic tasks (Ros et al., 2016). Homework assignments are typically used in therapies with both cognitive and behavioral components, including BPTs, and are meant to give caregivers an opportunity to improve newly learned skills by practicing them in the natural environments in which they typically occur (Garland et al., 2010a; Kazantzis et al., 2010). Homework completion is positively correlated with improved therapeutic outcomes (Ros et al., 2016), and therefore seen as a marker of the quality of a caregiver’s adherence (Baydar et al., 2003; Nix et al., 2009; Ros et al., 2016), but the degree of the association is directly dependent on the client’s level of between-session adherence (Kazantzis et al., 2010).

Unfortunately, research indicates most clients do not attempt or complete homework assignments (Kazantzis & Shinkfield, 2007; Chacko et al., 2016) and therapists may, in fact, be reluctant to assign or review homework in session with caregivers (Garland et al., 2010a). In a study examining routine child therapy practices, researchers coded techniques observed in 1215 taped sessions and found homework assignment and review (i.e., between-session engagement) was only included in 13% of sessions (Garland et al., 2010b). Additionally, within-session participation in the form of strategy practice, coaching, and role-plays were only observed in 8% of cases (Garland et
al., 2010a; Garland et al., 2010b). A relationship between caregiver nonadherence with homework and therapists’ reluctance to assign and review homework appears to exist, but the nature and direction of this relationship remains unclear, as do other aspects of caregiver engagement such as consistency of participation.

In addition, caregivers may engage within-session but not between-sessions, or vice versa (Kazantzis & Shinkfield, 2007; Kazantzis et al., 2010; Garland et al., 2010a; Garland et al., 2010b). Participation may also significantly change across the course of treatment (Bamberger et al., 2014; Becker et al., 2014; Ellis et al., 2013; Lindsey et al., 2019; Littell et al., 2001; Staudt, 2007). These discrepancies are thought to reflect the caregiver’s attitudinal engagement (Becker et al., 2014), namely the perceived relevance, perceived benefits, and perceived demands of the homework activity as well as the caregiver’s confidence and perceived self-efficacy related to their ability to successfully complete the homework (Kazantzis & Shinkfield, 2007; Kazantzis et al., 2010; Garland et al., 2010b). Addressing caregivers’ attitudes toward homework appears to be an important area of research in child therapy, though adherence literature has historically focused on the quantity of homework completion (i.e., behavioral engagement) rather than the quality of homework completion and the attitudinal factors that affect it.

**Caregiver Engagement as Adherence.** In the early literature, attendance data was also used to study adherence, mostly in terms of complying with the recommendation to attend intake appointments (i.e., initial engagement) and later, additional therapy sessions (i.e., ongoing engagement). For example, McKay and colleagues (1996a) conducted a study aiming to increase attendance at intake appointments for low-income minority families by implementing a targeted telephone intervention. While results showed the
intervention did increase initial engagement, the researchers explicitly discuss how this type of adherence research does nothing to inform adherence in ongoing engagement (McKay et al., 1996a). When the same researchers later studied the impact of an intervention at intake designed to improve treatment retention (i.e., adherence with the continuation of recommended services), they again found, despite improved ongoing attendance, they had no insight into why clients continued or into the barriers that might interfere with ongoing participation in services (McKay et al., 1996).

Patterson and colleagues are well-known for their seminal studies on caregiver treatment adherence, initially tying adherence to attendance data but later moving to examine the associations between adherence and outcomes or adherence and alliance (Nock & Ferriter, 2005). Chamberlain et al. (1984) found 54% caregivers who did not adhere to treatment strategies prematurely ended treatment while only 14% of caregivers who did adhere to recommendations left treatment early. Patterson and Chamberlain (1994) defined adherence as the inverse of the amount of parent resistance to treatment (i.e., high resistance equaled low adherence to treatment recommendations, low resistance equaled high adherence). In a study of low-income families of children with behavior problems \((n = 70, M_{age} = 9\) years old), these authors found increasing caregiver adherence explained nearly 40% of caregiver change in parenting behaviors, which subsequently reduced challenging child behaviors (Nock & Ferriter, 2005; Patterson & Chamberlain, 1994).

The same research team identified several factors affecting resistance to treatment strategies: personal history of discipline efficacy; caregiver traits such as depression or behavior difficulties; contextual variables such as SES or caregiver stress level; and the
therapist’s skill and determination to engage caregivers within sessions (Patterson & Chamberlain, 1994). The fourth factor, therapist skill and commitment, is an important one as it again suggests adherence appears to influence alliance, perhaps bidirectionally (Garland et al., 2010a; Garland et al., 2010b; Nock & Ferriter, 2005; Patterson & Chamberlain, 1994). Nonadherence, both within- and between- sessions, was associated with lower therapist ratings of alliance and less time dedicated to teaching caregivers parenting strategies (Nock & Ferriter, 2005; Patterson & Chamberlain, 1994), again speaking to the therapist’s role in engaging the client. Based on these findings, other researchers moved to combining attendance data with additional measures of adherence to better understand ongoing engagement in child therapy and the effects of adherence on outcomes.

For example, Nix et al. (2009) investigated whether attendance and the quality of caregiver participation (i.e., adherence) predicted treatment outcome in the group-based Fast Track BPT program, which is built around four parenting domains: parental warmth; parent perception of the child; discipline practices; and involvement in their child’s education. Using a sample of 445 caregivers of first grade children (\(M_{age} = 6.47\) years, \(SD = .48\); 45% Caucasian, 53% African American, and 2% Latino, Asian American, or Native American), the authors not only calculated rates of caregiver attendance at parenting groups but also rated the quality of caregiver participation (Nix et al, 2009). Several aspects of participation were rated (e.g., amount and quality of participation in both group and caregiver-child sharing time; homework completion; comprehension of parenting concepts, and the implementation of skills (Nix et al., 2009). This rating system
allowed researchers to gauge both within- and between-session adherence, reflecting both the attitudinal and behavioral components of adherence.

Hierarchical linear regression models revealed that while attendance at parenting groups was related to increased caregiver school involvement, attendance alone did not uniquely predict change in any of the other parenting domains (Nix et al., 2009). However, the quality of caregiver participation was related to changes in all four parenting domains (i.e., increased warmth, $\beta = .14, p < .01, 95\% \text{ CI} = .04-.25$; improved perception of child, $\beta = .14, p < .01, 95\% \text{ CI} = .03-.24$; reduction of harsh discipline, $\beta = .16; p < .01, 95\% \text{ CI} = -.27$ to $-.06$; and increased school involvement, $\beta = .23, p < .001, 95\% \text{ CI} = .13-.34$), even when family characteristics, baseline measures, and attendance were controlled (Nix et al., 2009). This finding stresses the importance of the quality of ongoing engagement (i.e., adherence) over the quantity of ongoing engagement (i.e., attendance), especially when using a diverse sample of caregivers of young children.

At the same time, limitations exist. Quality of caregiver participation was rated exclusively by facilitators and was done after sessions; the sessions were not videotaped and thus there was no measure of interrater reliability (Nix et al., 2009). Finally, the authors did not examine which features of quality participation (e.g., participation in parenting group or participation in child-caregiver sharing time) were more impactful on parenting domains (Nix et al., 2009).

In the end, attendance and adherence are separate constructs that appear to significantly interact with each other to contribute to engagement in child therapy (Nock & Ferriter, 2005). For example, attendance is a prerequisite for adherence, as one cannot adhere to treatment if treatment is never attended. At the same time, a client can attend
many sessions but not learn or adhere to any treatment strategies (Bamberger et al., 2014; Israel, 2007; Haine-Schlagel & Walsh, 2015; Nock & Ferriter, 2005). Conversely, a client could cease attending sessions yet still adhere to the treatment regimen as they feel further attendance is no longer necessary for strategy implementation (Bamberger et al., 2014; Becker et al., 2015; Nock & Ferriter, 2005).

**Summary.** Despite the lack of a commonly accepted definition of engagement within the child therapy literature, early researchers focused on two main aspects of ongoing engagement to study: attendance and adherence. Early attendance research (e.g., Armbruster & Fallon, 1994; Kazdin, 1990) focused on identifying demographic variables which may predict early termination (i.e., a lack of engagement). These studies have failed to consistently and commonly identify demographic variables that could both predict attendance and inform intervention research as demographic variables (e.g., minority status) are not likely to change over the course of treatment and as the variables themselves (e.g., race and SES) often interact in confounding ways (Kazdin et al., 1995). Attendance studies have also historically included large age ranges of children, ignoring the developmental differences of early childhood clients and the associated need for high caregiver involvement among this population (MacDonald et al., 2007). Attendance studies also focus entirely on one type of behavioral engagement without acknowledging the attitudinal factors that may impact caregiver engagement behaviors.

Adherence research has reflected the lack of a common operationalization of adherence, measuring it as attendance (e.g., McKay & Bannon, 1996) the inverse of resistance (e.g., Patterson & Chamberlain, 1994), the quality of participation (e.g., Nix et al., 2009), and as homework completion or lack thereof (e.g., Chacko et al., 2016;
Garland et al., 2010b). Researchers have found a difference between within-session engagement (i.e., active participation) and between-session engagement (i.e., implementation of strategies, homework completion; Ingoldsby, 2010; Kazantzis & Shinkfield, 2007; Kazantzis et al., 2010) but have not fully explored the reasons behind this difference, particularly in early childhood BPTs. A caregiver’s participation in their child’s therapy may also change over the course of treatment (Bamberger et al., 2014; Becker et al., 2014; Ellis et al., 2013; Lindsey et al., 2019; Littell et al., 2001). While some of this change may be developmental (MacDonald et al., 2007), it is largely believed to be a reflection of a caregivers’ attitudinal engagement (i.e., perceived relevance, self-efficacy, belief in outcomes, alliance; Kazantzis & Shinkfield, 2007; Kazantzis et al., 2010).

Most research to date has focused on either on attendance or adherence as related to ongoing engagement but has provided little insight into the interaction between the two. Similarly, while researchers agree engagement has both behavioral and attitudinal components (Becker et al., 2014; Haine-Schlagel & Walsh, 2015; Lewis et al., 2018; Morissey-Kane & Prinz, 1999; Stadnick et al., 2016; Staudt, 2007; Staudt et al., 2012), the nature and the direction of the relationship between these components within early childhood engagement literature remains poorly understood. The role of the therapist and working alliance has also been acknowledged as important to caregiver engagement (Garland et al., 2010a, Garland et al., 2010b), though the nature and direction of this association also needs further exploration.

As such, recent research suggests moving beyond the broad components of attendance and adherence to describe ongoing engagement in child therapy and instead
move toward viewing engagement as a complex, multidimensional construct (e.g., comprised of attitudinal, behavioral, and cognitive involvement; King et al., 2014), with each dimension having multiple components. It is believed that the attitudinal components of engagement (e.g., adherence and cognitive preparation) may have most potential to both influence treatment outcomes and to create effective clinical interventions (Becker et al., 2015; Ingoldsby, 2010). Three recent multidimensional conceptualizations of ongoing caregiver engagement will now be discussed.

**Multidimensional Conceptualizations of Engagement**

**Three Domains of Engagement: Attendance, Adherence, and Cognitive Preparation**

Becker et al. (2015) have described three primary domains of treatment engagement: attending sessions, treatment adherence, and cognitive preparation. As mentioned, attendance can be measured in multiple ways (e.g., the number of sessions attended or whether the family completed the treatment program; Chacko et al., 2016). The two latter domains, treatment adherence and cognitive preparation, may be the most malleable and have increased potential to inform engagement interventions as these domains likely influence client attendance.

Adherence is defined here as active participation in sessions and consistent practice of treatment strategies outside of session (i.e., skill utilization and homework completion; Becker et. al., 2015; Chacko et al., 2016). High caregiver adherence is associated with higher levels of positive treatment outcomes, such as increased caregiver and child skill acquisition, change in parenting behaviors, increased prosocial behaviors (i.e., listening and following directions), and reduced challenging behaviors (i.e., aggressive tantrums; Nock & Ferriter, 2005; Patterson & Chamberlain, 1994). This
association is important in BPTs, which are heavily focused on caregiver skill building and practice (Beauchaine et al., 2005; Gross et al., 2018). It is logical to assert that most caregivers will need practice within and between sessions to become competent at using treatment strategies with their children independently in their homes.

The third component of Becker et al.’s (2015) conceptualization, cognitive preparation, encompasses the client’s overall readiness and motivation for treatment. Cognitive preparation for therapy addresses the caregiver’s attitude about mental health care, expected treatment outcomes, level of motivation for change, possible causes of their child’s problem behaviors, and perceptions of personal strengths and adversities (Becker et al., 2015). This cognitive component of ongoing engagement has been understudied despite its association with therapeutic alliance, treatment expectations and outcomes, and overall treatment satisfaction (Becker et al., 2014; Chacko et al., 2016).

Often, clients need psychoeducation about what services will entail, their role in their child’s therapy, and how to form realistic expectations for treatment outcomes (Becker et al., 2015; Chacko et al., 2017). At other times, the caregiver may hold beliefs about the cause or severity of their child’s problems which differ from the therapist’s assessment of the child (Corcoran & Ivery, 2004; Ellis et al., 2013; Kil et al., 2020; Mattek, 2014).

Caregiver attribution of cause for their child’s behavior has been shown to influence caregiver response to the behavior and caregiver treatment engagement (Corcoran & Ivery, 2004; Kil et al., 2020; Mattek, 2014). For example, one study found caregivers who attributed their child’s negative behaviors to an internal and stable characteristic of the child were more likely to disengage (i.e., drop out or reduce participation) than were caregivers who thought the child’s behaviors were temporary,
situation-driven, and influenced by external factors (e.g., parenting style; Corcoran & Ivery, 2004). More recently, Kil et al. (2020) found caregiver attribution of cause directly influenced their participation in the treatment of children with disruptive behavior disorders, as these treatments tend to be caregiver-directed (i.e., BPTs). If the caregiver believes the behavior is a problem the child needs to fix, it follows caregivers may be less willing to fully participate in modalities where interventions aim to modifying the caregiver’s behavior. Caregivers who acknowledged the child’s behavior may be influenced by parenting style were found to be more ready to change their own behavior (i.e., cognitively prepared; Becker et al. 2015) through participation in a caregiver-directed treatment program (Kil et al., 2020).

Discrepancies between caregiver and therapist explanations of child behavior have been shown to decrease adherence, which in turn decreases overall engagement and has been discussed in the literature as resistance to treatment (Patterson & Chamberlain, 1994). Engagement also decreases when differences between caregiver treatment expectations and the provided treatment and its outcomes are also present (DeCarlo Santiago et al., 2013; Ellis et al., 2013; McKay et al., 1996; Patterson & Chamberlin, 1994), such as when the caregiver enters a BPT program believing the child will be the only focus of treatment strategies. As such, Becker et al. (2015) noted that while adherence and cognitive preparation are important components to more fully understanding engagement, further research is needed on these components in children’s mental health care to understand the interaction between them.
Four Dimensions of Engagement: Attitudinal, Behavioral, Facilitative, and Socializing

As a second important conceptualization of engagement, Lindsey et al. (2014) described engagement as a multidimensional construct having attitudinal, behavioral, facilitative, and socializing dimensions. The attitudinal and behavior dimensions are focused on the client role in engagement while the facilitative and socializing dimensions focus on the clinician’s role in engaging the client, thus acknowledging that both there are both client and clinician factors which influence client engagement (Garland et al., 2010b; Lindsey et al., 2014). Attitudinal engagement involves a client’s commitment to and investment in the therapy (i.e., cognitive preparation; Becker et al., 2014; Becker et al., 2015), while behavioral engagement involves a client’s performance of therapeutic tasks to achieve positive treatment outcomes (i.e., treatment adherence; Becker et al., 2015; Nock & Ferriter, 2005), echoing earlier research.

The facilitative dimension of engagement involves clinician actions such as appointment reminders or attention paid to treatment barriers, formally acknowledging clinician and agency behaviors and policies impact caregiver engagement (Harrison et al., 2004; Garland et al., 2010b; Lindsey et al., 2014). The socializing dimension of engagement involves actions that build rapport (i.e., alliance), providing additional resources, or building client support systems (Lindsey et al., 2014), again pointing to the overlap between the therapeutic relationship and perceived helpfulness of the clinician as important influences on caregiver engagement (Acri et al., 2016; Kazdin et al., 2006). Like Becker et al. (2015), Lindsey et al. (2014) provides a more comprehensive definition of engagement that suggests it is a more complex concept than session attendance or
homework completion. It appears the behavioral component of engagement, attendance, does not ensure the attitudinal component (i.e., the client will participate in and commit to the therapeutic process; Staudt, 2007). Indeed, there seem to be psychological aspects of engagement which may be more responsive to intervention than session attendance.

**Three Types of Involvement: Affective, Cognitive, and Behavioral**

To better understand child and caregiver engagement in services, King and colleagues (2014) conducted a scoping literature review and produced an evidence-based conceptual framework of psychological engagement for children and caregivers that is focused on client motivation. After reviewing 58 relevant studies, the authors posited engagement is a process that has three distinct elements: *affective involvement* (e.g., emotional investment in the therapeutic relationship and commitment to the treatment plan); *cognitive involvement* (e.g., problem recognition, perceived need for outside help, belief in intervention effectiveness); and *behavioral involvement* (e.g., working together with the therapist on therapeutic tasks, within- and between- session implementation of intervention strategies outside of session; King et al., 2014).

In this framework, clinicians use three engagement strategies, or *client change processes*, to help the client reach an optimal state of engagement: *receptiveness* (e.g., openness to intervention, belief in therapist; King et al, 2014; Yatchmenoff, 2005); *willingness* (e.g., belief in need for intervention, perceived relevance of intervention; King et al., 2014; Nock et al., 2007); and *self-efficacy* (i.e., caregiver’s perception of competence to implement treatment interventions outside of session; King et al., 2014). The clinician instills hope, gives support, and designs practical interventions for the family in order to facilitate these change processes (King et al., 2014). Clinicians will
know a caregiver is in an optimal state of engagement when the caregiver demonstrates hope (e.g., optimistic attitude about positive change), conviction (e.g., commitment to treatment plan and goals), and confidence (i.e., believes in own ability to implement strategies; King et al., 2014). This conceptualization differs from Becker et al. (2015) and Lindsey et al. (2014) in that it gives distinct psychological markers rather than behavioral markers clinicians can use to measure ongoing engagement.

While these three multidimensional conceptualizations of caregiver engagement (Becker et al., 2015; King et al., 2014; Lindsey et al., 2014) are similar in terms of including attitudinal, behavioral, and cognitive components, they again differ in their definitions of these components and in the importance placed on each component. There is still no commonly accepted definition, conceptualization, or operationalization of engagement within the child therapy literature, though this does not mean these multidimensional conceptualizations are without merit. Based on these conceptualizations, strategies focused on improving adherence, assessing caregivers’ cognitive preparation for therapy, and other psychological factors such as hope for treatment efficacy and motivation to change appear to hold promise for increasing caregiver engagement in child therapy, particularly with young children. However, missing from these discussions are other possible important components of engagement such as attending to the child’s needs within session, inconsistent treatment participation from multiple caregivers, or a thorough understanding of the caregiver’s role in BPT prior to beginning treatment.
Role of Caregiver in Behavioral Parent Training Programs

No matter the type of treatment, parents or other caregivers (e.g., foster parents) typically determine the level of ongoing treatment engagement in early childhood therapy. This review adopts the use of the term caregiver to mean the adult who is participating in treatment with the child. The term caregiver acknowledges this adult may be a biological parent, a foster or adoptive parent, a kinship placement (i.e., grandparent or other relative), or another adult who has been granted legal guardianship of the child. Caregivers must not only seek out treatment for the child, provide consent, and present the child for treatment, but caregivers also significantly influence the child’s adherence both within- and between- sessions through their own level of adherence (D’Arrigo et al., 2017; Nock & Ferriter, 2005; Nock & Kazdin, 2005). In BPTs, caregiver engagement can also be tied to outcomes as caregivers are primarily responsible for transferring treatment gains to other settings, such as the family home (Stadnick et al., 2016). Ultimately, although the goal of child therapy is typically to alter the child’s externalizing behaviors (e.g., reduce aggression, tantrums, hyperactivity), the caregiver must demonstrate both attitudinal and behavioral engagement to do so (Nock & Ferriter, 2005; Nock & Kazdin, 2005).

Despite the distress associated with their young child’s challenging behaviors, many caregivers enter BPT treatment with the expectation that the child will be the sole focus of interventions (Corcoran & Ivery, 2004; Kil et al., 2020; Nock & Ferriter, 2005). However, BPTs are manualized, skills-based treatment protocols which rely on active participation from both the child and the caregiver, both within- and between- sessions, to achieve positive outcomes (e.g., reduced tantrums, increased listening; Beauchaine et al.,
Caregivers may enter these programs without fully understanding the importance of their role in treatment (i.e., modify current responses to child behavior, learn and implement positive parenting strategies) and may disengage if they are not cognitively prepared to take on that role or to change their parenting practices (Becker et al., 2014; Nock & Ferriter, 2005), pointing to the ethical obligation to fully inform caregivers of what treatment will entail.

Additionally, one major flaw of early BPT literature is that engagement has been treated as a fixed caregiver characteristic rather than a variable one (Bamberger et al., 2014; Becker et al., 2014; Ellis et al., 2013; Lindsey et al., 2019; Littell et al., 2001; Staudt, 2007), again due to the overreliance on attendance data as a measure of engagement. Researchers argue clients make decisions about the level of their participation in services based on values, external barriers, and previous mental health experiences; each of these factors can change over time based on family context and sociocultural influences (Harrison et al., 2004, Littell et al., 2001; Staudt, 2007). Littell and colleagues (2001) asserted participation in therapy varies on two continuums: level of activity (i.e., ranging from passive to active); and valence (i.e., ranging from negative attitudes and behaviors not consistent with treatment expectations and goals to positive attitudes and behaviors that do align with goals and expectations; Littell et al., 2001). Placement on these continuums is most often assigned by the clinician or researcher rather than by the caregiver, resulting in caregivers being labeled as either cooperative or resistant, two additional terms that have various definitions in the literature (Littell et al., 2001; Patterson & Chamberlain, 1994; Yatchmenoff, 2005). This perspective on caregiver engagement is problematic as does it little to acknowledge participation may
change over time or that the client’s perspective on their own participation may vary significantly from the therapist’s view (Littell et al., 2001; Yatchmenoff, 2005). It also provides little insight into the client’s experience of within-treatment factors that may be affecting their level of participation at any one point in time in the therapy.

Additional researchers have agreed that level of caregiver engagement justifiably changes over the course of therapy. Macdonald et al. (2007) created a developmental framework for participation in children's mental health services, asserting that while caregivers are the main consumer of treatment interventions with younger children, caregivers’ participation in treatment naturally declines as the child ages and as treatment goals are met and maintained. Similarly, in a study of African American and Latinx caregivers engaged in a preventive group intervention, Coatsworth et al. (2006) found several aspects of caregiver engagement, (e.g., quality of participation, alliance, affect during interventions, participant leadership, and relationships with other group members) changed over the course of the intervention, though this study only used facilitator ratings of these aspects of caregiver engagement. It appears it would be beneficial to explore caregivers’ perceptions of their own participation and alliance to get a direct view of how these aspects of engagement may fluctuate in BPTs with their young children.

Typically, engagement increases as caregivers form a strong therapeutic alliance with the provider and recognize the relevance and effectiveness of the intervention; alternatively, engagement may decline over time as the intervention is deemed irrelevant, too difficult, or repetitive (Bamberger et al., 2014; Becker et al., 2014). Perhaps most realistically, caregiver engagement may fluctuate throughout treatment depending on the personal circumstances of the caregiver and the perceived relevance of specific
interventions (Bamberger et al., 2014; Becker et al., 2014; Lindsey et al., 2019; Littell et al., 2001; Nock & Kazdin, 2005). Therefore, the consensus among recent researchers (e.g., Becker et al., 2014; Becker et al., 2015; Lindsey et al., 2014; Lindsey et al., 2019) is full caregiver participation (i.e., ongoing engagement) in their child’s therapy is a malleable characteristic and should be viewed as the general goal of any therapeutic intervention and as a specific goal of BPTs to better meet treatment goals.

**Engagement as Related to Treatment Outcomes in BPT**

A thorough understanding of engagement is important because successful outcomes are strongly associated with higher levels of treatment retention and engagement, regardless of the type of treatment (Miller & Prinz, 2003; Morawska & Sanders, 2006). Treatment efficacy for young children with behavior and emotional regulation difficulties is important because these early childhood difficulties put children at risk for continued behavior challenges and mental health issues into adolescence and adulthood (Garland et al., 2010b; Morawska & Sanders, 2006). Kazdin and Whitley (2003) reported BPT completion was tied to positive treatment outcomes for the child (i.e., reduction in challenging behaviors), the caregiver (i.e., reduced stress, increased parenting skills), and the family (i.e., improved overall functioning). However, this and other early studies (e.g., Morawska & Sanders, 2006) reporting this association were again relying on attendance data (i.e., treatment completion) as the sole measure of engagement.

BPTs are considered effective with young children (i.e., under the age of six years; Butler & Titus, 2015; Gross et al., 2018; Lees et al., 2019) but little early research investigated which components of BPT are the most effective at reducing challenging
behaviors, improving emotional regulation, increasing positive parenting strategies, and improving the caregiver-child relationship (Kaminski et al., 2008). As such, recent research has begun to look at mechanisms related to ongoing engagement, most specifically, active within-session participation and between-session adherence of treatment strategy practice, as important to BPT outcomes. For example, Kaminski and colleagues (2008) conducted a meta-analytic review of 77 studies to determine the most effective BPT components at reducing young children’s externalizing behaviors. Researchers examined the following BPT components: program content (e.g., behavior management and discipline, focus on prosocial behavior, positive caregiver-child interactions); program delivery (e.g., manual, modeling, homework, in-session rehearsal); location and frequency of sessions; and the classification as a prevention program or a treatment intervention program (Kaminski et al., 2008).

Results showed four elements of BPTs have the largest effects on treatment outcomes: increasing emotional communication and positive interactions between child and caregiver; teaching caregiver consistency in behavioral response; use of the time-out strategy; and in-session rehearsal of new parenting strategies with the child (Kaminski et al., 2008). Within-session rehearsal of treatment strategies with caregiver and child had a large effect size (.91) on parenting outcomes and a medium-to-large effect size (.69) on child externalizing behaviors (Kaminski et al., 2008). The effect sizes for between-session adherence were small-to-medium for parenting skills outcomes (.39) and small for child behavior outcomes (.20; Kaminski et al., 2008). Importantly, these effect sizes represent the difference in outcomes for programs that include these components versus programs that do not contain them; actual caregiver completion rates for the components
were not included in this analysis. As BPT programs are inherently skill-based, it follows that programs which include in-session rehearsal of skills (i.e., within-session engagement) would demonstrate improved outcomes.

Building on this work, recent studies have more closely examined the association involving between-session adherence (i.e., practice of treatment strategies at home) and treatment outcomes. Ros et al. (2016) conducted an examination of the additive effects of homework completion on parenting skills, parenting stress levels, and child behavioral outcomes when using Parent Child Interaction Therapy (PCIT, a BPT) with children with or at risk for developmental delays. Using a sample of 48 children (\(M_{\text{age}} = 44.70\) months, \(SD = 14.27\)) and their mothers (\(M_{\text{age}} = 35.11\) years, \(SD = 6.51\); 72% Caucasian), the authors measured homework completion using caregiver self-report of the number of days per week the homework (i.e., engaging in five minutes of child-led play with their child practicing “do” skills (e.g., praise, behavioral descriptions) and abstaining from “don’t” skills (e.g., commands, questions, negative comments) was completed (Ros et al., 2016).

Results demonstrated homework completion was a significant predictor of increased “do” skills (\(\beta = .39, p < .01\)) but did not significantly predict reduced “don’t” parenting skills (\(\beta = -.27, p > .05\)). Mothers with greater homework completion also reported greater reductions in overall parenting stress (\(\beta = -.36, p < .05\)) and reported greater reductions in their child’s externalizing behaviors post-treatment than did mothers with less homework completion (Ros et al., 2016). It appears that homework completion (i.e., between-session adherence) is tied to outcomes in BPTs, though this study has some notable limitations. Results may not be generalizable to all caregivers in BPTs as young
children with or at risk for developmental delays may inherently exhibit more challenging behaviors than the general population; mothers of these young children may also exhibit greater levels of stress due to their child’s delay (Ros et al., 2016). Additionally, as shown by the discrepancy in change between positive (i.e., “do” skills) and negative (“don’t” skills) parenting behaviors, caregiver self-report of homework completion in and of itself does not equal skill acquisition or competency (Ros et al., 2016).

Also drawing from Kaminski and colleagues’ (2008) findings, Berkel et al. (2018) examined the relevance of home-based practice of BPT skills in the New Beginnings Program, a 10-session prevention program that teaches positive parenting skills following parental divorce. This study is unique in that its sample (n=477 families of children ages 3 to 18 years) was not only considered culturally diverse (32% Latino, 61% Caucasian; 8% other ethnicities) but it included a substantial number of fathers (42%) as participants. This study conceptualized and measured four distinct components of homework completion as tied to positive parenting outcomes: attempts at practicing the skills; fidelity in skill practice (i.e., degree to which all components of the skill were completed); caregiver perception of skill efficacy within family setting; and demonstrated skill competence (Berkel et al., 2018). Caregivers rated themselves weekly on attempts, fidelity, and efficacy using checklists and Likert-type scales while clinicians rated caregiver competency using a 5-point Likert type scale (Berkel et al., 2018).

Regression analyses indicated efficacy in home-based practice of skills (i.e., adherence) significantly predicted improvements in the caregiver-child relationship (β = .24, p <.05 for caregiver report of relationship) while clinician-rated competence significantly predicted improvements in parent-reported discipline skills (β = .42, p
<.0001; Berkel et al., 2018). These results held constant when examining Latino caregivers and fathers as subgroups. Though the study included a wide age-range of children, these results speak to the need to assess homework practice quality over homework completion when associating between-session adherence with outcomes. Researchers in this area call for the need to continue this line of research involving other cultural subgroups (Berkel et al., 2018; Kaminski et al., 2008; Ros et al., 2016) to get a broader picture of how this aspect of engagement is tied to outcomes in BPTs.

**BPT Engagement Research**

BPTs, like most evidence-based treatment programs for children, were established on the belief that all child behavior takes place within an interpersonal context in which the caregiver can modify the child’s behavior by enacting changes within the environment and within the parent-child relationship (Prinz, 2019). In BPT programs, children’s externalizing behaviors (i.e., aggression, tantrums) have been shown to decrease as parenting practices become less harsh, less critical, and less coercive (Beauchaine et al., 2005; Cooper et al., 2018). Indeed, BPT programs are among the most effective evidence-based treatments for disorders such as attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) in older children and adolescents (Dretzke et al., 2009). At the same time, these types of treatments are only effective for approximately two-thirds of the children whose caregivers complete these programs, in part due to a lack of full participation from caregivers (Beauchaine et al., 2015; Garland et al., 2010b). This outcome data points to the need for caregivers to both actively participate in and complete treatment programs for treatment goals to be met.
There have been two recent large-scale reviews on caregiver engagement in BPTs. Chacko et al. (2016) reviewed 262 studies on engagement in BPTs, examining recruitment, attendance, attrition, and within-session engagement across all studies. The authors acknowledge that the review was challenging due to differing operational definitions between studies (Chacko et al., 2016). Using attendance data and combining attrition from initial recruitment and attrition from treatment, the authors found at 51% of identified families across all studies did not complete the treatment program (Chacko et al., 2016). However, most studies in the review \((n = 182)\) included only attrition data. Only 61 studies (i.e., 23% of the sample) included ongoing engagement attendance rates, with the mean percentage of scheduled sessions attended at 72% \((SD = 18\%; \text{range } 29\text{-}100\%\); Chacko et al., 2016). Across these studies, the only demographic variable that appeared to affect caregiver attendance was SES. In studies that included low-income samples, lower SES participants had a higher attrition rate (34%) than those participants with higher SES (24% attrition), with a moderate effect size \((d = .58; \text{Chacko et al., 2016})\).

As discussed, BPT is a skill-based intervention and its efficacy is believed to be dependent on within-session caregiver participation and the completion of homework between sessions (Chacko et al., 2016; Gross et al., 2018). However, only 27 studies reviewed (i.e., 10%) included data on within- or between-session engagement (Chacko et al., 2016). Fifteen studies included therapist-rated levels of caregiver participation in session while only one study included caregiver self-reported participation levels (Chacko et al., 2016), echoing Yatchmenoff’s (2005) argument that the lack of examining caregivers’ self-report of participation is a critical gap within this literature and may hold
the key to identifying factors that profoundly influence between- and within-session engagement. Homework completion (i.e., treatment adherence) data was only reported in eight studies and the reported homework completion rate was 48% (range 14-95%); the authors acknowledged an additional eight studies included information about homework completion but not in a way that allowed the authors to calculate overall completion rates (Chacko et al., 2016), again speaking to the importance of commonly operationalized variables. Still, results from the limited number of studies using non-attendance-based ways of measuring engagement suggest research on factors affecting caregivers’ within-session participation and their practice of treatment strategies between sessions is warranted to understand caregiver engagement more completely in BPTs (Chacko et al., 2016; Nix et al., 2009). In fact, the authors criticized researchers because 17% of all efficacy studies published between 2004 and 2016 do not mention engagement at all despite the call for further BPT engagement research for the last three decades (Chacko et al., 2016; Miller & Prinz, 1990).

As a result, the majority of engagement interventions and research continue to focus on increasing initial and ongoing attendance (e.g., telephone reminders, psychoeducation about services; Chacko et al., 2009; McKay & Bannon, 2004) instead of addressing the attitudinal factors related to within- and between- session engagement (e.g., discussing caregiver readiness to change, caregiver problem-solving and coping skills, explaining the purpose of homework; Chacko et al., 2009; Chacko et al., 2013; Chacko et al., 2016; Nock and Kazdin, 2005). One notable exception is Chacko and colleagues (2017), who examined caregiver-level factors (e.g., mental health, stress, parenting efficacy, attribution of child behavior, and barriers to treatment participation) in
a study of 40 single mothers (i.e., caregivers of 120 children ages 5 to 12 years with an ADHD diagnosis) who either never attended BPT after referral, dropped out of BPT prematurely, or completed BPT programs with their child. This was a secondary analysis on previously collected data (Chacko et al., 2009) to investigate which caregiver-level attitudinal factors, deemed more malleable than demographic characteristics, were associated with caregivers who dropped out or completed treatment for the purpose of designing interventions that are specifically targeted toward those factors (Becker et al., 2015; Chacko et al., 2017).

Results demonstrated a significant difference in both parental cognitions (i.e., parenting efficacy and attribution of child behavior) and perceived treatment relevance between groups (Chacko et al., 2017). Caregivers who never attended BPT after referral had significantly lower parenting efficacy scores \( (F(2, 37) = 9.81, p < .0001, \eta^2 = .35) \) and behavior attribution scores \( (F(2, 37) = 22.10, p < .0001, \eta^2 = .54) \) than did caregivers who dropped out early or completed the BPT program, confirming the authors’ hypotheses that parental cognitions influence both initial and on-going engagement in BPTs (Chacko et al., 2017). Similarly, a hypothesis that caregivers who never attend or drop out prematurely would have significantly different ideas about treatment relevance than those who completed the program was also confirmed \( (F(2, 37) = 5.27, p = .01, \eta^2 = .21; \text{Chacko et al., 2017}) \). Interestingly, this study found no significant differences between groups on caregiver mental health or stress, perhaps due to the small sample size and relatively low power. Though this study again used attendance data to mark treatment completion and did not focus on within- or between-session participation (i.e., ongoing engagement), the results are relevant to informing
future research on caregiver-level attitudinal factors in BPT engagement, namely perceived treatment relevance.

To that end, Axford et al. (2012) also conducted a review of BPTs in the United Kingdom for the purpose of providing clinical and research recommendations regarding engagement in such programs. Like Chacko et al. (2016), Axford et al. (2012) found 40 to 60% of families prematurely dropped out of treatment despite financial incentives and provided childcare, refreshments, and transportation. These authors recommended BPT programs implement the following strategies to improve engagement: reduce logistical barriers to treatment to make programs more accessible; work collaboratively with parents; focus on building relationships with caregivers; address the caregivers’ specific concerns; and address the unique needs of each caregiver based on minority status, SES, education level, and relevant cultural norms (Axford et al., 2012). Unlike the previous review, however, the Axford et al. (2012) review defined engagement solely as session attendance or program retention and did not address the adherence component of engagement; they also supplied no information on the number or type of studies reviewed. The authors admit the above recommendations are offered exclusively to increase initial recruitment and ongoing retention in BPT programs and do not address whether participants truly engaged (i.e., between- and within-session participation) with the therapeutic process or material (Axford et al., 2012). They do argue that both types of participation contribute to program retention (Axford et al., 2012) despite assertions from other researchers that attendance and adherence overlap but one does not ensure the other (Bamberger et al., 2014; Israel, 2007; Haine-Schlagel & Walsh, 2015; Nock & Ferriter, 2005).
While, when taken together, both reviews looked at a large number of empirical studies on engagement with this type of treatment program, it is important to note that both reviews were comprised of BPT engagement and efficacy studies involving children with a diagnosed mental health disorder, most often ADHD and ODD. Both reviews also included studies of children ages 18 and under, which again ignores developmental differences in the appropriateness and necessity of caregiver involvement in treatment (MacDonald et al., 2007). There is a paucity of literature on engagement in BPTs with young children who do not yet meet diagnostic criteria for a specific disorder, and even less engagement research in this population that does not focus on attendance as the main indicator of engagement. Again, further study on increasing adherence in early childhood mental health care is important as early childhood behavior problems often persist if not effectively treated (Chacko et al., 2016; Morawska & Sanders, 2006).

**BPT for Young Children**

The five most widely studied BPT programs for young children and their caregivers are Parent-Child Interaction Therapy (PCIT; Eyberg et al., 1995); the Triple-P Positive Parenting Program (Sanders, 1999), the Incredible Years Parent Training Program (IY-PT; Webster-Stratton, 1992), the Chicago Parent Program (Gross et al., 2009), and Early Pathways (EP; Fox et al., 2013). All five programs use an evidence-based, manualized treatment approach to addressing behavioral and emotional difficulties in young children; all five programs have demonstrated positive outcomes for both the child (e.g., less aggression, fewer tantrums, improved compliance, improved emotional regulation, improved relationship with caregiver) and caregiver (reduced stress, increased use of positive parenting strategies, and improved relationship with child; Eyberg et al.,
2008; Gresl, 2014). A sixth program, Mom Power (MP; Muzik et al., 2010), is unique among BPTs in that the caregiver (i.e., the mother) is the identified client; MP has shown to be effective in improving parenting behaviors, improving the attachment between caregiver and child, and lowering caregiver stress (Mucka et al., 2017). However, like most BPTs, these six programs vary in attention paid to ethnic and socioeconomic diversity within their empirical research (Coard et al., 2004; Gresl et al., 2014). Each program is briefly described below. Relevant literature on ongoing engagement, with an emphasis on research investigating engagement with low-income minority families, is also presented for each program.

**Parent-Child Interaction Therapy (PCIT)**

PCIT (Eyberg et al., 1995) is an evidence-based BPT modality that targets the caregiver-child relationship and aims to change patterns of interactions between caregivers and their young children (ages 2 to 7 years) with externalizing behavior problems (Eyberg et al., 2008). The caregiver and child meet weekly with the therapist for an average of 12 to 16 treatment sessions consisting of play, modeling, and in vivo coaching (Eyberg et al., 2008). Treatment is divided into two phases, each targeting a specific type of interaction. The first phase, Child-Directed Interactions (CDI), aims to increase warmth and positivity in the relationship by teaching the caregiver specific verbal attending skills (i.e., behavioral descriptions, reflections, and praise) to use in response to prosocial behaviors and active ignoring skills to use in response to challenging behaviors (Agahi, 2016; Eyberg et al., 2008; Fernandez & Eyberg, 2005). The second phase, Parent-Directed Interactions (PDI), involves teaching the caregiver effective discipline skills (e.g., giving clear instructions, effective limit-setting, follow
through; Eyberg et al., 2008). Other PDI skills include setting family rules for behavior, praising compliance, and enforcing consequences (i.e., time-out) for non-compliance (Agahi, 2016; Fernandez & Eyberg, 2005).

The coaching element of treatment supplies immediate feedback on skill implementation, which allows parents to gain confidence using the skills in session; PCIT also requires caregivers to practice these skills between sessions as homework (Eyberg et al., 2008). As skill mastery, improved caregiver-child interactions, and reduced caregiver stress are all important components of PCIT, the course of treatment is flexible and often requires more than a brief course depending on individual family needs and responsiveness (Agahi, 2016; Fernandez & Eyberg, 2005; Gresl, 2014). As such, length and intensity of caregiver engagement demands also vary.

**PCIT Engagement Research.** The majority of PCIT research on engagement has focused on predicting treatment retention or attrition, often as part of larger studies focused on outcomes and often with a primarily Caucasian sample (Fernandez et al., 2011). For example, Werba et al. (2006) explored pretreatment predictors of outcomes in PCIT using a sample of 99 child (ages 3-6 years; 78% Caucasian; 80% boys) and mother dyads. All children had an ODD diagnosis and all families were considered low-to-middle class (Werba et al., 2006). To examine characteristics of treatment completers, the authors conducted multiple regression analyses comparing 26 demographic (e.g., minority status, maternal age), maternal (e.g., depression, parenting stress), child (e.g., symptom intensity, comorbid diagnosis), behavioral management skills (e.g., inappropriate parenting behaviors, direct commands), and accessibility (e.g., assignment to immediate treatment or waitlist group) variables (Werba et al., 2006).
Initial results demonstrated the only variable to differentiate treatment completers \((n = 50)\) from non-completers at the \(p < .05\) level was the caregiver’s ratio of using direct commands when interacting with their child (Werba et al., 2006). When combined with four other variables (i.e., comorbid diagnoses, maternal stress level, maternal depression, and inappropriate parenting behaviors) which were found to differentiate between completers and non-completers at \(p < .10\), the model including maternal stress and inappropriate parenting behaviors was found to have the best fit, \(\chi^2(2, N = 81) = 7.92, p = .02\), predicting 84% of treatment completers (Werba et al., 2006) and ultimately indicating the need for continued research on caregiver characteristics that may influence treatment completion. This study, however, did not examine participation or treatment adherence, but merely studied engagement as attendance and completion. Moreover, this study, like much PCIT research, was conducted with a primarily Caucasian sample.

Fernandez et al. (2011) recognized the need to research PCIT engagement and outcomes using an African American sample \((n = 18)\), citing the need to better understand reasons for attrition in minority populations given the association between treatment completion and improved behavioral outcomes. Data was taken from two different larger studies (e.g., Fernandez & Eyeberg, 2009) on PCIT outcomes and engagement to create a participant sample that identified solely as Black or African American; all families were also low-income. One study hypothesis was engagement (again, as defined as attrition or completion) would be poor due to earlier research demonstrating SES as a predictive factor in PCIT dropout (Fernandez et al., 2011). The children \((M_{\text{age}} = 53\) months, \(SD = 14\)) all had diagnoses of ODD, CD, or ADHD; most of the children \((n = 15)\) had more than one diagnosis (Fernandez et al., 2011).
As predicted, the overall attrition rate was high (56%, \(n = 10\)), though 70% of study dropouts occurred prior to the first treatment session (i.e., lack of initial engagement; Fernandez et al., 2011). While treatment was effective in reducing challenging behaviors, it was not effective in reducing caregiver depression or stress (Fernandez et al., 2011). The authors call for continued PCIT engagement research with diverse populations, and specifically question whether the PCIT approach is acceptable to African American parents, given the study’s small sample, attrition rate, and prior research citing treatment relevance and acceptability as factors in caregiver engagement (Fernandez et al., 2011; Kazdin, 1996). Again, this study did not examine factors related to participation or adherence, only attendance. In fact, no studies examining engagement as the primary outcome variable nor any studies examining ongoing engagement as defined as participation or adherence in PCIT were found in the scope of this review.

**Triple P-Positive Parenting Program**

Triple P (Sanders, 1999) is a five-level treatment program for caregivers and children (ages 0 to 12 years). Similar to PCIT, Triple P strives to improve the caregiver-child relationship while simultaneously teaching positive parenting skills to improve caregiver efficacy, child behavioral control, and emotional regulation for both caregiver and child (Eyberg et al., 2008; Gresl, 2014; Sanders, 1999). Specifically, the program has five core principles: creating a safe and engaging environment for the child; creating a positive learning environment for children by teaching problem-solving skills; modeling positive parenting strategies using assertive discipline; forming realistic caregiver expectations; and encouraging caregiver self-care (Prinz, 2019).
Treatment levels are based on problem severity. Levels 1, 2, and 3 include a universal prevention program (Universal Triple P), a 1-2 session intervention delivered by primary health care providers (Selected Triple P), and a 4-session intervention model (Primary Care Triple P) delivered by primary health care providers or accessed online (Eyberg et al., 2008; Prinz, 2019; Sanders, 1999). Level 4 (Standard Triple P) is a 12-session BPT delivered by mental health providers in individual, group, or virtual self-directed formats to address significant behavioral concerns (Eyberg et al., 2008; Gresl, 2014; Prinz, 2019; Sanders, 1999). Level 4 teaches 17 core parenting skills (e.g., physical affection, differential attention, limit setting) and includes planned activities designed to help caregivers generalize skills across environments (Eyberg et al., 2008; Prinz, 2019). Finally, Level 5 (Enhanced Triple P) is designed for families experiencing both significant child behaviors and family stressors (i.e., caregiver conflict, stress, or mental health concerns) and is delivered in 11 intensive family sessions (Eyberg et al., 2008; Gresl, 2014). Both Standard Triple P and Enhanced Triple P are considered evidence-based BPTs for childhood behavior disorders (Eyberg et al., 2008) which require caregivers to practice their skills between-sessions, track their own and their child’s behaviors, and work within-session to modify their responses (i.e., levels 4 and 5 require high caregiver adherence; Agahi, 2016).

**Triple P Engagement Research.** The early literature on Triple P also focused on engagement as defined as attrition or program completion. However, two recent studies were found that suggest growing interest in examining the behavioral and attitudinal factors related to ongoing engagement. Day and Sanders (2017) examined mediators of parenting change, including caregiver engagement, within the online version of Standard
Triple P. Participants ($n = 183, 93.4\%$ Caucasian) were randomized to receive either a self-directed online program, a clinician-supported version of the online program with telephone consultations, or serve as a waitlist control (Day & Sanders, 2017). Although reductions in challenging behaviors and caregiver stress and increased caregiver self-efficacy were of primary interest in the study, one hypothesis did focus on engagement. The authors predicted post-treatment caregiver self-efficacy and decreased negative parenting behaviors would be significantly associated with level of caregiver engagement in the online program (Day & Sanders, 2017). Engagement was measured as both the number of online modules completed and the number of telephone consultations completed. The telephone consultations were theorized to provide additional motivation for completing online modules by helping decrease caregiver distress and increase self-efficacy for completing modules and implementing parenting skills (Day & Sanders, 2017).

Results indicated participants in the clinician-supported intervention group completed significantly more online modules (median = 7) than did those in the self-directed intervention (median = 2), $W = 1,090, p = .001, r = .37$ (Day & Sanders, 2017). The mean number of telephone consultations with clinicians was 4.2 ($SD = 2.75$), and a significant correlation between the number of clinician consultations and the number of online modules completed was found, $\tau = .47, p$ (one-tailed) $< .001$ (Day & Sanders, 2017). Additionally, after accounting for the effects of consultations on the rates of module completion, a path analysis revealed a significant direct pathway from program engagement to reductions in negative parenting behaviors suggesting professional support from a clinician not only improved module completion but itself was a significant
factor in reducing negative parenting behaviors (Day & Sanders, 2017). Interestingly, a similar path was not found between engagement and caregiver self-efficacy, highlighting caregiver’s pretreatment self-efficacy and related distress as important variables in future studies on engagement (Day & Sanders, 2017). While this study again used completion rates and did not study the quality of caregiver participation or adherence, the study did begin to examine how attitudinal factors (e.g., caregiver self-efficacy) impact behavioral factors (e.g., completion of online modules) related to engagement. Unfortunately, the sample was almost exclusively Caucasian so results cannot be generalized to minority populations.

Another recent study was more explicit in its operationalization of engagement as “clients’ behavioral and attitudinal characteristics necessary to receive the intended treatment outcomes for evidence-based interventions”, asserting that caregivers must not only practice skills (i.e., behavioral engagement) but also need to be confident the BPT program will be effective for their individual family (i.e., attitudinal engagement; Lewis et al., 2018, p. 44). Taking a qualitative approach, which is rare in BPT literature, researchers used a semi-structured interview to examine what strategies facilitated caregiver engagement and what caregivers perceived as obstacles to engagement in a modified version of Triple P (Lewis et al., 2018). Pathways Triple P, for use in the child welfare system, is a 14-week home-based intervention; sessions are 60 to 90 minutes long and involve modeling, video vignettes, and in vivo practice of parenting skills (Lewis et al., 2018). Participants (n = 47) were female; the majority of whom identified as African American (65%) and unemployed (60%; Lewis et al., 2018). Interviews were conducted following completion of the program or following the last session attended if it became
clear the caregiver would not complete treatment, which allowed the researchers to gain valuable data about reasons for discontinuing ongoing engagement (Lewis et al., 2018).

In the end, three themes emerged that address both the behavioral and attitudinal aspects of engagement, all related to the caregiver-therapist relationship and therapist behaviors: ensuring comprehension of content; increasing parenting efficacy; and addressing obstacles to participation (Lewis et al., 2018). Participants spoke of the need for therapists to not only continually check for understanding of content, but also to be flexible in content delivery to allow for asking questions, explaining skills in multiple ways, and including extra skill practice time in session (Lewis et al., 2018). The caregiver-therapist alliance was mentioned as a key influencer of both attitudinal and behavioral engagement. Participants reported increased confidence in skills when clinicians provided encouragement and empathy coupled with constructive feedback delivered in a respectful and relatable manner (Lewis et al., 2018). Participants identified lack of social support, stress, and lack of outside resources as obstacles to their engagement in the BPT program. (Lewis et al., 2018). Participants reported the clinician was helpful in overcoming these obstacles particularly in the coordination of additional services, though one participant noted the lack of support and tardiness of the clinician to appointments contributed to her lack of behavioral engagement in the program (Lewis et al., 2018). Importantly, participants spoke of the need for flexibility in adapting the parenting principles to meet caregivers’ specific needs, learning styles, and family context (Lewis et al., 2018).

These findings echo Ingolsby’s 2010 review of engagement interventions, namely that emotional support, flexibility in treatment delivery, and addressing caregiver values
in treatment increase engagement. Findings also support the assertion that clinician behaviors and characteristics effect caregiver engagement (Garland et al., 2010a; Garland et al., 2010b). While this study provides rich insight into caregiver perceptions about both facilitators and obstacles to attitudinal engagement, it is important to note this was a specialized population (i.e., child welfare clients) and therefore results cannot be considered indicative of other minority or low-income populations. Additional research examining the interplay between attitudinal and behavioral engagement with voluntary low-income minority populations in BPTs is needed.

*The Incredible Years (IY-PT) and the Chicago Parenting Program (CPP)*

IY-PT is one part of an integrated, three-pronged approach (i.e., parent, teacher, and child training) to prevent or treat behavior problems and promote socioemotional skills in children (ages 3 to 10 years; Webster-Stratton, 2001). Similar to PCIT and Triple P, program objectives include strengthening familial relationships, improving positive parenting skills, improving children’s emotional regulation and social skills, and reducing challenging behaviors (Webster-Stratton, 2001). Different from other BPTs, IY also aims to promote teacher management of behaviors and to strengthen the connection between home and school when a child’s parents and teachers are both participating in their respective training programs (Webster-Stratton, 2001).

IY-PT is a group program consisting of 12 to 14 sessions in which caregivers view and discuss a total of 250 video vignettes; these short (e.g., 90 seconds) videos focus on child development principles, social learning theory, play, positive caregiver-child interactions, effective discipline techniques, and problem-solving skills (Eyberg et al., 2008; Webster-Stratton, 2001). Facilitators initiate group discussions, lead problem-
solving exercises, and offer role-play scenarios for caregivers to practice skills; IY-PT also encourages adherence through weekly homework activities (i.e., skill practice; Webster-Stratton, 2001).

Using an advisory council of African American and Latino caregivers, CPP was adapted from IY-PT to specifically address the contextual and cultural needs of low-income minority families (Gross et al., 2009). Cultural adaptations include explicit discussion about the cultural acceptability and efficacy of certain parenting strategies (e.g., time-out; child-led play) along with an emphasis on how caregiver stress affects parenting (Gross et al., 2009). CPP is an 11-week group program implemented in childcare centers to reduce logistical barriers for caregivers (Gross et al., 2009). CPP also uses video vignettes to spur discussion, collaborative problem-solving, and inform homework assignments, though CPP videos are filmed in homes and public places (e.g., grocery stores, laundromats) to simulate real-world situations (Gross et al., 2009). All CPP videos are narrated by Latinas and include diverse families (46% African American, 23% Latino, and 31% Caucasian; Gross et al., 2009), making it one of few BPTs (e.g., EP) culturally adapted to simultaneously serve multiple minority groups experiencing poverty.

**IY-PT Engagement Research.** IY-PT engagement research has also historically been conducted using Caucasian samples and in conjunction with outcome research. For example, McGilloway et al. (2012) reported engagement as solely measured by session attendance in a randomized controlled trial (RTC) of IY-PT in a community-based Irish clinic (n = 137 low-income families). Initial results showed 31% of all participants attended 3 or fewer sessions out of the 14-session treatment program (McGilloway et al.,
These authors did, however, run a qualitative follow-up study examining caregiver reasons for low treatment attendance (i.e., behavioral engagement). Furlong & McGilloway (2012) conducted semi-structured interviews with 33 purposively sampled participants (31 mothers, 2 fathers) six months after the RTC ended. While 25 participants (labeled attendees) were sampled because they attended 10 or more sessions, the remaining 8 were included in the study because they had attended less than 5 sessions during the RTC (Furlong & McGilloway, 2012). The authors used constructivist grounded theory to acknowledge sensitivity to any cultural parenting practices that might influence caregiver participation in IY-PT (Furlong & McGilloway, 2012). Attendees identified positive parenting skills, focusing on providing positive attention, developing empathy for their child, collaborating problem-solving skills, increased self-efficacy, and social support as key mechanisms of change for their own mental health, family relationships, and parenting efficacy as a result of their participation in IY-PT (Furlong & McGilloway, 2012).

Despite overall improvement and satisfaction with treatment, it is interesting to note nearly half of attendees ($n = 11$) reported increased conflict with partners over implementation of new parenting strategies, approximately half of the attendees ($n = 13$) reported there was too much emphasis early on in the program on positive attention, and 80% ($n = 20$) of attendees described the video vignettes as “American” and “overly positive,” again indicating the need for cultural sensitivity and adaptation when delivering BPTs (Furlong & McGilloway, 2012, p. 623). All 8 participants included for their lack of engagement reported logistical barriers (e.g., illness, new employment) but some also cited attitudinal factors such as the lack of privacy due to group disclosure of
family difficulties \( (n = 3) \) and belief the program would not be effective for their family \( (n = 2) \) as reasons they would not return to IY-PT (Furlong & McGilloway, 2012).

More recently, a study explicitly examined differences in caregiver perceived relevance and overall satisfaction with IY-PT (i.e., attitudinal engagement) by comparing weekly caregiver-report evaluation forms and final program satisfaction questionnaires of caregivers with \( (n = 43) \) and without \( (n = 19) \) involvement in the child welfare system in Finland (Karjalainen et al., 2020). Across all participants, the mean attendance rate was 11.5 \( (SD = 5.9) \) out of 19 offered sessions and results indicated no significant difference in attendance between caregivers with- and without- child welfare involvement (11.2 vs. 12.0; fixed effect estimate = \(-1.83\), \( SE = 1.90, p = 0.339 \); Karjalainen et al., 2020). The only demographic variables related to low attendance were low education level (10% of participants, \( p = 0.03 \)) and not speaking Finnish (6% of participants, \( p = 0.04 \); Karjalainen et al., 2020). Satisfaction scores (range 0 - 7, 7 being the most satisfied) ranged from 5.8 to 6.2 points across all participants with no significant group differences. Similarly, perceived relevance scores as measured on a 4-point scale (i.e., 1 = not helpful, 4 = very helpful) ranged from 2.8 to 3.3 across participants with no significant group differences (Karjalainen et al., 2020). Though caregivers both with- and without-involvement in the child welfare system in this study appeared to have high attitudinal engagement, the average attendance (i.e., behavioral engagement) rate was 58\% (Karjalainen et al., 2020), and results may not be replicated in other studies as this sample was mostly Caucasian and well-educated.

**CPP Engagement Research.** Similar to other BPTs described here, CPP engagement research has typically been limited to rates of attrition calculated as a
component of outcome efficacy studies. For example, the initial outcome study of CPP \((n = 292\) caregivers of children ages 2 to 4 years old) randomly assigned caregivers to participate in the 11-session CPP or to serve as a control (Gross et al., 2009). Parent attendance in the treatment group was low \((M = 4.3\) sessions, \(SD = 4.2\)); the majority of the 135 participants assigned to the treatment condition \((n = 74, 54.8\%\) attended 5 or fewer total sessions out of the 11 sessions offered (Gross et al., 2009). Researchers then ran outcome analyses twice, once with and once without a dose level (i.e., \textit{low dose} = 0 to 5 sessions, \textit{high dose} = 6 or more sessions). The only demographic differences noted between the low dose and high dose groups were number \((t (131) = −2.7, p < 0.01)\) and intensity \((t (133) = −2.0, p = 0.05)\) of challenging child behaviors pretreatment (Gross et al., 2009).

Model estimates differed when dose level was included in outcome analyses. Important linear dose effects found included increased caregiver self-efficacy, \(F (1,818) = 3.69, p < .05, d = .37, \eta^2 = .013\), and more consistent use of positive parenting strategies, \(F (1,818) = 6.99, p < .01, d = .29, \eta^2 = .044\), when caregivers attended 6 or more treatment sessions (Gross et al., 2009). Though not a study directly looking at engagement, this study did make a tie to both attitudinal (i.e., caregiver self-efficacy) and behavioral (i.e., consistent strategy use) engagement in relation to treatment outcomes in a diverse sample of participants (92% Latino or African American; Gross et al. 2009) with very young children.

\textit{Early Pathways (EP)}

Early Pathways, formerly known as Parenting Young Children (EP; PYC; Fox et al., 2013; Fox & Nicholson, 2003) is similar to CPP in that it was created to specifically
serve low-income minority families of young children (i.e., ages 6 years and under) with behavior or emotional difficulties. Like other early childhood BPTs, EP is based on the following principles: nurturing the caregiver-child attachment through play and other warm interactions; discussing appropriate expectations for child behavior; and modeling cognitive strategies (e.g., stop and think before responding) and parenting skills to reduce challenging behaviors (e.g., limit setting, time-out, differential attention) and increase prosocial behaviors (e.g., positive reinforcement; Love & Fox, 2019). However, EP was designed as an in-home, individualized BPT for the purpose of meeting the unique and individualized needs of families living in poverty (Fung & Fox, 2014). As such, EP contains trauma-informed treatment elements (e.g., establishing safety, collaborative goal setting, naming and practicing feelings, and trauma narrative work) often needed to address emotional and behavioral concerns in this population (Love & Fox, 2019).

Similarly, while EP is designed to deliver both behavioral and trauma interventions in 12-16 weekly treatment sessions, the number of sessions needed by families typically varies due to child and family needs as well as behavioral (e.g., attendance, adherence) and attitudinal engagement (e.g., participation, motivation) of the caregiver (Love & Fox, 2019).

**EP Engagement Research.** EP has also historically studied engagement as treatment attrition or completion as part of randomized controlled trials (RTCs) of treatment efficacy, though all EP research is grounded in diverse populations. For example, Fung et al. (2014) examined whether a two-dimensional definition of treatment completion (i.e., attendance at an intake assessment plus three or more treatment sessions and a reliable change index of 5 points on the primary outcome measure of child
behaviors) was effective in identifying successful treatment completion. A sample of 447 diverse (i.e., 52.8% African American, 19.9% Latino, 16.4% Multiracial, and 11% Caucasian) caregivers of young children ($M_{age} = 3.16$ years, $SD = 1.05$) participated in the study, with 89.6% of participants receiving public assistance (Fung et al., 2014). Using the two-dimensional definition of completion outlined above, the attrition rate for this study was 24.2%, a significantly lower rate than in other BPT research involving low-income families (Chaffin et al., 2009; Fung et al., 2014) while outcome measures simultaneously provided evidence of EP’s efficacy in reducing challenging childhood behaviors.

A subsequent RTC examining efficacy of EP for low-income families whose children exhibit symptoms of traumatic stress redefined treatment completion to include attendance at the intake assessment and five or more treatment sessions to account for the complexities likely to emerge when trying to change behavior in the face of trauma symptoms (Love & Fox, 2019). This study did not employ the reliable change index requirement on the child behavior outcome measure as part of the treatment completion definition; in fact, only treatment completers were included in this RTC. This sample ($n = 64$) had similar demographics to the previous study in terms of race/ethnicity (42.2% African American, 28.1% Multiracial, 18.8% Latina/o or Hispanic, 10.9% Caucasian) and SES (48.5% unemployed; Love & Fox, 2019) though this study used an immediate treatment group ($n = 32$) and waitlist control group ($n = 32$) to compare outcomes. Attrition rates were calculated (27.2% in the immediate treatment group and 13.5% in the waitlist group); independent-group $t$-tests did not reveal any differences in demographic
variables or pretest measures between completers and non-completers (Love & Fox, 2019).

To better understand factors leading to attrition in EP, Gresl (2014) designed an instrument to assess barriers to treatment specific to low-income families. That instrument is described in detail in a later section. Combined, the three studies discussed here examined engagement in terms of attendance without any investigation of treatment factors that may influence attitudinal engagement or how within- and between- session participation may affect treatment outcomes, leaving a gap in the EP engagement and efficacy research. However, Mattek (2014) did examine caregiver’s attributional style related to the cause of their child’s challenging behaviors (i.e., one aspect of cognitive preparation for treatment; Becker et al., 2015) as a predictor of early termination from EP. Results demonstrated that caregivers who attributed the responsibility for the child’s challenging behaviors to the child rather than themselves were significantly more likely to prematurely terminate treatment ($p = .002$) than caregivers who acknowledged responsibility for their child’s behavior difficulties (Mattek, 2014). Finding that caregiver attributions also significantly changed over the course of treatment, $t(171) = 7.14, p < .001$, Mattek (2014) called for further research on how this cognitive aspect of engagement may impact within-session participation in EP as this study also defined engagement as treatment attendance.

**Mom Power**

The 13-week MP parenting intervention program is unique among BPTs as it identifies the mother as the client; therefore, the caregiver is the explicit target of all therapeutic interventions (Mucka et al., 2017; Muzik et al., 2014). MP specifically targets
high-risk mothers, as defined by the presence of subclinical levels of mental illness (e.g., depression, anxiety) or a history of personal trauma (Mucka et al., 2017; Muzik et al., 2014). Based on both attachment theory and trauma theory (Muzik et al., 2014), MP is centered around five core pillars: an attachment-based parenting education curriculum; self-care; parenting practice; social support, and connection to resources (Mucka et al., 2017). While traditional BPTs often contain some of these same components, MP is explicit in teaching maternal self-care skills (e.g., mindfulness techniques) to address the caregiver’s own mental health needs during the process of modifying parenting practices (Mucka et al., 2017; Muzik et al, 2014).

MP combines three individual sessions, usually conducted in the client’s home, with 10 group sessions; this format was intentionally created to allow for individualized attention to concerns, goal setting, and engagement strategies while also allowing for parenting practice, attachment exercises, and social support within the group setting (Mucka et al., 2017; Muzik et al, 2014). Motivational interviewing techniques (MI) have been incorporated into the treatment model as a direct attempt to increase ongoing engagement, as defined as retention (i.e., continued attendance; Mucka et al., 2017). Program authors also drew on literature demonstrating higher retention in preventative parenting programs than in intervention programs, and incorporated engagement strategies common in preventative programs (e.g., provided transportation, food, small monetary incentive to attend each session; Mucka et al., 2017; Muzik et al, 2014).

**MP engagement research.** Two studies have been conducted with a particular focus on factors that may influence participation in MP, each with a diverse sample. First, Muzik et al. (2014) investigated whether mothers with a higher number of risk factors
(e.g., mental health concerns, trauma history) would demonstrate higher attendance rates as a result of a perceived higher need for services. They also explored whether a difference in attendance existed between Caucasian mothers and African American mothers (Muzik et al., 2014). The sample included 150 mothers of young children (i.e., ages 0 – 6 years) whose racial demographics reflected the investigators’ second hypothesis as 52.3% of mothers identified as African American, 40.3% identified as Caucasian, and 5.4% identified as Biracial (Muzik et al., 2014). Socioeconomically, 82.5% of participants reported an annual household income of less than $25,000 (Muzik et al., 2014). The authors did not find any significant associations between race and attendance rates, though they speculated their study did not have sufficient power to do so due to the small sample sizes when the overall sample was grouped by race (Muzik et al., 2014). African American mothers did have slightly lower overall attendance rates ($M = 64.6\%, SD = 35.9$) when compared to Caucasian mothers ($M = 73.3\%, SD = 33.3$; Muzik et al., 2014).

However, the results indicated African American mothers and Caucasian mothers had somewhat opposite demographic factors that appeared to predict attendance. Caucasian mothers were more likely to attend if they were older, married or partnered, had a higher income, and higher level of education, while African American mothers in this sample were more likely to attend if they had lower income, lower education level, were young, and were single (Muzik et al., 2014). Though the associations between maternal mental health or trauma history and attendance did not rise to the level of statistical significance, mothers high in one or both variables did have higher attendance than did mothers without a present mental health or trauma concern (Muzik et al., 2014).
While this study again relied solely on attendance data to measure ongoing engagement, it does point to the need to consider caregiver mental health or personal trauma history as salient factors that may affect ongoing engagement in a parenting program designed for caregivers of young children. It similarly points to the need for additional research into factors responsible for differences in engagement among members of different cultural groups (i.e., African American and Caucasian) and demonstrates the importance of having a large enough sample size to provide ample power to detect significant differences.

The second MP engagement study also included a diverse sample ($n = 99$, 48% African American, 44% Caucasian, 6% Biracial, 73% reporting an income less than $25,000) and included a mixed-methods investigation into demographic and psychosocial factors associated with engagement (i.e., defined as attendance and program retention; Mucka et al. (2017). Using a ground theory approach, investigators qualitatively examined mothers’ motivation for program participation, perceptions of support, and program satisfaction; a quantitative regression analyses was also conducted to test associations between attendance and various demographic and psychosocial factors (e.g., education, marital status, mental health diagnosis, trauma history; Mucka et al., 2017). No significant associations between these variables and attendance were found; however, this study is valuable to the literature because its qualitative component.

Qualitative data were collected using MI from 64 mothers and were coded using thematic analysis. Results revealed three main categories of maternal expectation for the MP program: help-for-self (e.g., coping skills, making friends); help-for-child (e.g., effective caregiver-child separation, improved child coping, improved play); and help for
their parenting (e.g., new strategies, effective discipline, effective co-parenting; Mucka et al., 2017), indicating mothers had a variety of reasons for wanting to participate in the MP program. Indeed, most mothers indicated a high desire for multiple types of help as 90.6% expected help with their parenting and 95.3% expressed a desire for help-for-self; Mucka et al., 2017). It appears explicitly talking with mothers about their expectations for treatment prior to treatment (i.e., a noted gap in engagement literature) may have led to higher-than-expected attendance rates as overall attendance for this study was high with 61.6% of all mothers missing one session or less (Mucka et al., 2017).

Surprisingly, however, the authors did not include raw attendance data or note any difference in attendance between the MI group \((n = 64)\) and the non-MI group \((n = 33; \) Mucka et al., 2017). This information would have given more credence to the importance of explicitly discussing expectations and motivation for treatment prior to treatment as an effective engagement intervention. Additionally, the MI component of the intake interview provided the mothers with directions to consider their motivations and expectations, specific to help for self, child, and parenting, rather than a more general open-ended question about maternal motivation for participation (Mucka et al., 2017), indicating the need for future research in the area of caregiver motivation and expectation for participation in parenting programs using open-ended qualitative techniques. Again, while this study defined ongoing engagement as continued attendance and while no significant associations were found between attendance and demographic and psychosocial variables, this study is relevant to this review as it includes a qualitative exploration of caregiver motivation and expectations for treatment (i.e., attitudinal engagement) that have the potential to influence ongoing participation and adherence to
treatment if those expectations are not met within the treatment program. Finally, the MP program, and the two studies described here, underscore the importance of examining any possible connection between caregiver mental health and engagement in BPTs.

In sum, all six BPTs reviewed focus on increasing caregiver parenting skills in order to reduce challenging behaviors and improve emotional regulation in young children. Engagement studies on these BPTs typically only included engagement, defined as attendance and measured in a variety of ways, as a secondary outcome measure in larger efficacy studies. As such, most literature on caregiver engagement in BPTs has continued to focus solely on the behavioral component of engagement while largely ignoring the attitudinal component of ongoing engagement necessary for most clients to achieve treatment goals. Some qualitative exploration of attitudinal factors affecting ongoing engagement has been done, though additional research in this area, particularly in diverse populations, seems warranted. The key to effectively increasing ongoing engagement in BPTs appears to lie in a thorough examination of factors influencing engagement and barriers preventing caregivers from fully engaging in these programs.

Factors Influencing Ongoing Engagement in BPT

Quantitative studies on BPT engagement have focused on child, caregiver, and contextual variables associated with attendance or attrition. While some associations have been found between child factors (e.g., age, gender, symptom severity), caregiver factors (e.g., physical and mental health, education level, employment status), and contextual variables (e.g., single-parent families, SES) and attendance or attrition (Armbruster & Fallon, 1994; Bornheimer et al., 2018; Chacko et al., 2009; Gresl, 2014; Kazdin et al., 1997b), these associations can at best be described as inconsistent due to the varying
definitions of engagement used and the lack of theories used to understand the associations (Chacko et al., 2016; Morawska & Sanders, 2006). It appears there are other obstacles preventing caregivers from fully engaging in BPTs. This review provides a brief summary of commonly identified barriers to engagement and methods to assess them. The discussion then moves to examining less-studied variables such as treatment location and format, therapeutic alliance, and cultural factors within the treatment process.

**Barriers to Engagement**

A common suggestion for improving engagement in BPT programs is to reduce the impact of barriers that prevent families from fully participating in such programs (Axford et al., 2012; Kazdin et al., 1997a). This appears especially true for minority families, who face higher numbers of logistical barriers (e.g., transportation and childcare difficulties) and higher levels of stress and overall adversity than do Caucasian families (Bornheimer et al., 2018; Santiago et al., 2013a). Indeed, the bulk of research on therapeutic engagement has focused on barriers to treatment (i.e., factors that keep clients from attending, participating, and adhering to treatment).

**Barriers to Treatment Model**

When studying caregiver engagement in child therapy, Kazdin and colleagues (1997a; 1997b) first developed a conceptual *barriers-to-treatment model*. This model theorizes all families experience numerous barriers that have the potential to negatively impact their participation (i.e., ongoing engagement) in their child’s treatment (Kazdin et al., 1997a; Kazdin et al., 1997b). This model not only acknowledges the practical barriers to treatment (e.g., lack of transportation or childcare, cost of treatment) but also includes
attitudinal barriers (e.g., caregiver perception of treatment’s relevance, efficacy, and cost/benefit ratio) and relational barriers (i.e., poor alliance with their child’s therapist; Fernandez & Eyberg, 2009; Gresl, 2014; Kazdin et al., 1997a; Kazdin et al., 1997b; Snell-Johns et al., 2009). In fact, Kazdin et al. (1997a) explicitly argued it was necessary to move beyond the investigation of demographic variables only, which these researchers call "variables of convenience", noting while demographic variables can easily be obtained (e.g., from client intake forms or clinic databases) they do not grant any insight into the specific processes involved in caregiver dropout nor can they inform effective engagement interventions (Kazdin et al., 1997a, p. 453). This model served as the conceptual foundation for the development of the Barriers to Treatment Participation Scale (BTPS; Kazdin et al., 1997b). The BTPS one of the most widely used measures of caregiver engagement used in child therapy (e.g., Bornheimer et al., 2018; Chacko et al., 2017) as is described in detail below.

**Additional Research on Barriers to Treatment Participation**

Building on the barriers-to-treatment model (Kazdin et al, 1997a; Kazdin et al., 1997b), Littell and colleagues (2001) also argued client participatory behaviors are influenced by both pre- and within-treatment factors. Salient pretreatment factors include client characteristics (e.g., symptom severity, single parenthood; Armbruster & Fallon, 1994; Kazdin et al., 1997a); clinician characteristics (e.g., training, experience, attitude toward client); treatment factors (e.g., modality, location, frequency and duration of services); external stressors (e.g., logistical barriers, lack of support system; Kazdin et al., 1997a); and cultural influences (e.g., perceived relevance of treatment, beliefs about mental health treatment efficacy; Littell et al., 2001).
These pretreatment factors are believed to influence within-treatment variables, which also interact with and affect each other. Within-treatment influences on client participation include: the problem domain (i.e., client view’s on cause, development, nature, duration, and control over presenting problem); perceptions of treatment (e.g., perceived relevance, perceived role, expected outcomes, and effort needed to achieve outcomes); working alliance (i.e., the strength and collaborative nature of the therapeutic relationship); and treatment outcomes (i.e., timing and duration of symptom reduction will likely affect future participation within the course of therapy); Littell et al., 2001). It appears these within-treatment factors may produce or exacerbate attitudinal or relational barriers to caregiver engagement (Becker et al, 2014; Lindsey et al., 2014; King et al., 20114). Few studies (e.g., Bernal et al., 2009) have examined the influence of clinician, treatment, and cultural factors on caregiver engagement in early childhood mental health care), despite multidimensional conceptualizations of engagement highlighting these within-treatment cognitive, attitudinal and relational aspects of engagement (Becker et al., 2015; Lindsey et al., 2015; King et al., 2014). Rather, the onus remains on future researchers to investigate variables related to the clinician, treatment setting, and social and cultural factors on within BPT participation (Littell et al., 2001; King et al., 2014; Yatchmenoff, 2005).

As stated, the majority of engagement research has been focused on the clinician’s or agency’s view of caregiver engagement. Only one study examining the caregiver’s perspective on their own engagement was found. Yatchmenoff (2005) interviewed caregivers (n = 287) involved in the child welfare system and developed a four-factor model of caregiver engagement: receptivity (i.e., problem recognition,
perceived need for and openness to outside help); buy-in (i.e., expectation of benefit, hope for positive change, goal ownership, and active participation); working relationship (i.e., interpersonal relationship marked by open communication and collaboration); and mistrust (i.e., an anti-engagement factor, the belief that the agency worker is not working for the benefit of the caregiver or family). Unfortunately, this model of caregiver engagement does exclusively address the attitudinal factors discussed above in reference to engagement in child therapy. Interestingly, the authors found compliance with agency recommendations (i.e., adherence, a behavioral component of engagement) was only modestly correlated ($d = .21$) with caregiver buy-in (Yatchmenoff, 2005), though this can likely be explained because caregivers’ participation with child welfare was nonvoluntary. The authors call for future research to investigate the correlation between buy-in and adherence in non-mandated populations to more thoroughly understand how attitudinal aspects of engagement affect caregiver’s behavioral engagement (Yatchmenoff, 2005). This understanding appears crucial to designing interventions aimed at modifying caregivers’ attitudes on engagement in child therapy (King et al., 2014) in order to reduce attitudinal barriers to behavioral engagement.

One study looking at a potential attitudinal barrier to engagement was found in the scope of this review. Drawing upon Prochaska et al.’s (1992) transtheoretical model, Andrade et al. (2015) examined caregiver readiness to change in a sample of 143 caregivers of children ($M_{\text{age}} = 9.12$ years, $SD = 1.63$) referred for disruptive behavior problems. Caregivers were Caucasian (54.2%), multiracial (22.9%), Black (7.9%), or identified with another race or ethnicity (Andrade et al., 2015). Using latent profile analysis (LPA), the authors generated profiles of participants based on the stages of
change (i.e., precontemplation, contemplation, action) and caregiver perception of current use of parenting skills (Andrade et al., 2015). The *Less in Need* profile (*n* = 56, 39.2%) consisted of caregivers who were high in precontemplation and positive parenting strategies and low in contemplation, action, inconsistent discipline, and supervision problems (Andrade et al., 2015). The *Ready* profile (*n* = 58, 40.6%) described caregivers who were high on contemplation, action, and inconsistent discipline, moderate on positive parenting strategies, and low on precontemplation and poor supervision of their children (Andrade et al., 2015). The *Almost Ready* profile (*n* = 29, 20.2%) was comprised of caregivers with average scores on the stages of change, high levels of poor supervision and inconsistent discipline, and low levels of positive parenting (Andrade et al., 2015).

When applying these profiles to a smaller study of BPT treatment engagement (i.e., as measured by attendance), an association was found between the Less in Need caregivers and an increased number of missed sessions, though no attendance differences were found between the Almost Ready and Ready profiles (Andrade et al., 2015).

While this study is one of very few to examine attitudinal barriers to treatment engagement, it again defined engagement solely as attendance, limiting the application of findings to engagement interventions aimed at increasing within-session participation and between-session treatment adherence. Additionally, the sample included only caregivers of school-age children with behavior problems, again limiting the generalizability of findings to caregivers of preschool-age children. It does, however, highlight the caregiver’s readiness for treatment and perception of own parenting skills and participation as potential important factors to research and measure in caregiver BPT engagement.
Measures of Barriers To Treatment Engagement

This review found treatment engagement is most often measured by quantifying factors (i.e., barriers) that make it difficult for caregivers to fully engage (i.e., attend, within-session participation, and between-session treatment adherence) in treatment with their children. Three measures are described below, two of which were specifically developed for use in BPTs. Additionally, one measure of caregiver’s readiness to change is also discussed.

**Barriers to Treatment Participation Scale (BPTS).** The BPTS (Kazdin et al., 1997b) is a two section, 58-item measure and comes in a parent version or therapist version. The main section contains 44 items within four scales: stressors and obstacles that compete with treatment (e.g., transportation, illness, scheduling conflicts; 20 items); treatment demands and issues (e.g., treatment length, cost of treatment, clarity of handouts, more work than expected; 10 items); perceived relevance of treatment (e.g., did treatment meet expectations, was treatment necessary, was treatment effective; 8 items); and relationship with the therapist (e.g., therapist confidence, support from therapist, communication; 6 items; Kazdin et al., 1997b). A 5-point scale (i.e., 1 = never a problem, 5 = very often a problem) is used to rate all items in the main section. The second section, the critical events scale, which contains 14 yes-no items representing events the family may experience that could lead to premature termination of services. This scale serves to clarify barriers to participation when related to the caregivers’ total barrier score from the main section (Kazdin et al., 1997b).

To validate this instrument, Kazdin et al. (1997b) conducted a study including 260 children between the ages of 3 and 14 years old ($M_{age} = 8.4$, $SD = 2.7$) and their
caregivers ($M_{age} = 34.1$ years, $SD = 6.2$). Children were Caucasian (63.5%), African American (26.9%), Latinx (6.9%), and from other groups or mixed background (3%; Kazdin et al., 1997b). Most children (76.1%) met DSM-III-R criteria for more than one disorder ($M = 2.3$; Kazdin et al., 1997b). 93.8% of caregivers were the child’s biological mother, 46.3% of children lived in single-parent households, and 30.6% of the families received public assistance; in addition, 10 Caucasian therapists (8 female, 2 male, ages 24-56) were involved in the study (Kazdin et al., 1997b).

Results indicated the BPTS showed high internal consistency for the total barriers scale on both the parent (i.e., coefficient alpha and Spearman-Brown coefficient were both .86); and therapist (i.e., coefficient alpha .93 and Spearman-Brown coefficient .89) versions (Kazdin et al., 1997b). Additional results demonstrated high levels of perceived barriers to treatment were associated with high rates of attrition, fewer overall weeks in treatment, and higher rates of cancellations and no-show appointments (Kazdin et al., 1997b). Most importantly, after controlling for parent, child, and family characteristics (i.e., demographic variables such as race, SES, child symptoms, parental stress level, etc.), perceived barriers to treatment that emerged over the course of treatment (i.e., therapeutic relationship problems, treatment relevance concerns, etc.) were shown to add significant variance to the regression model, both for parent-rated total barrier scores $[F(1,233) = 28.50, p < .001, R^2 \text{ change } = .10]$ and for therapist-rated total barrier scores $[F(1,233) = 65.09, p < .001, R^2 \text{ change } = .20$; Kazdin et al., 1997b]. These results demonstrate that child, family, and family characteristics are independent of perceived barriers to treatment participation such as treatment relevance, treatment efficacy, or
alliance (Gresl, 2014; Kazdin et al., 1997b), indicating these attitudinal factors warrant separate study.

Critiques of the BTPS include a lack of rigorous psychometric validation, which was almost exclusively done the original research team (Gresl, 2014). Additionally, the BTPS is long, time-consuming, and relies on caregiver or therapist recall at the end of treatment (Colonna-Pydyn et al., 2007; Gresl, 2014). These characteristics make it problematic to administer in community settings and subject to recall bias in both community and research settings (Colonna-Pydyn et al., 2007; Gresl, 2014). Finally, the BTPS was normed using a mostly Caucasian (63.6%) and middle-class sample, which means its psychometric properties should not be generalized to low-income minority populations (Colonna-Pydyn et al., 2007; Gresl, 2014).

Obstacles to Engagement Scale (OES). Two additional measures specific to BPTs have been developed to quantify barriers to treatment engagement. Dumas et al. (2007) developed the OES which has four subscales: personal/family stressors or obstacles; relevance of/trust in treatment; intervention demands on caregiver, and time and scheduling demands (Dumas et al., 2007). These scales are similar to the BTPS, though the OES divides demands of the program into both logistical (e.g., scheduling) and personal (e.g., talking openly about parenting challenges) while the BPTS combines those demands into one subscale and includes alliance with the clinician as its fourth subscale (Dumas et al., 2007; Kazdin et al., 1997b). Unlike the BTPS, the OES is designed to be administered at the beginning of treatment (Gresl., 2014). Participants rate each of the 14 items on a 4-point scale (i.e., 1 = definitely no, 4 = definitely yes; Dumas et al., 2007). In a study of 451 low-income caregivers of young children (i.e., ages 3 to 6
years old) participating in a group BPT, Cronbach’s alpha for subscale scores were calculated as .73, .77, .77, and .40, respectively (Dumas et al., 2007). The OES also lacks repeated psychometric validation, though a more recent study revealed Cronbach’s alpha to be .97 in a sample of 192 caregivers of children ages 2.5 years to 12 years old (Chaffin et al., 2009; Gresl, 2014). However, the OES normative sample was ethnically diverse and represented a low-income population (Dumas et al., 2007).

**Treatment Barriers Scale (TBS).** Gresl (2014) developed the TBS, a 17-item scale normed with an ethnically diverse (49.4% African American, 21.2% Latino, and 17.3% multiracial) and low-income (87.9% receiving public assistance) clientele. The TBS is a two-factor (i.e., Treatment Process Barriers and Operational Barriers) clinician-report instrument designed to be administered after the third treatment session, allowing for the clinician to have spent time with the family before administration in order to establish rapport, deliver treatment strategies, and assess caregiver motivation and engagement (i.e., attendance and adherence; Gresl, 2014). The first factor, Treatment Process Barriers, contains items related to caregiver attendance, caregiver within-session participation, caregiver between-session adherence, caregiver perception of change as well as the clinician’s view of therapeutic alliance, sense of caregiver motivation, and therapeutic change (Gresl, 2014). The second factor, Operational Barriers, contains items related to basic family needs, home routines, quality of parental supervision, consistency between caregivers, support for primary caregiver, as well as the clinician’s view on caregiver mental and physical health, ability to learn, ability to manage stress, and focus placed on the child during treatment sessions (Gresl, 2014). All items were scored by the clinician on a 3-point (i.e., 1 = *good*, 2 = *fair*, 3 = *poor*) scale making it easy to
administer, score and interpret (Gresl, 2014). Cronbach’s alpha was .88, indicating good reliability (i.e., internal consistency; Gresl, 2014).

While the TBS was specifically created for use with low-income minority populations, it relies solely on clinician report of caregiver variables and therefore may not accurately reflect the caregivers’ view of operational or treatment process variables impeding their ongoing engagement in their child’s services. The TBS was also developed as an easy screening tool to assess for risk of early termination, which again defines ongoing engagement as the lack of attrition and lacks additional psychometric validation. Indeed, all three measures described here (i.e., BTPS, OED, and TBS), quantify a caregiver’s factors preventing ongoing engagement without incorporating caregivers’ qualitative perspectives on factors that may facilitate higher rates on ongoing engagement in BPTs. Future research should seek out caregiver’s perspectives on what attitudinal or relational factors could be targeted for interventions aimed at facilitating ongoing engagement in BPTs. One such instrument assessing attitudinal factors was found.

**Parent Readiness to Change Scale (PRCS).** The PRCS (Littell & Girven, 2005) is a 28-item scale designed to assess a caregiver’s motivation to change parenting behaviors. It was originally developed for use with child welfare populations (n = 263 caregivers of children ages 0-18 years, 81% African American, 83% unemployed; Littell & Girven, 2005). The PRCS includes precontemplation (e.g., “As far as I am concerned, I don’t need to change how I take care of my child”), contemplation (e.g., “I think I might be ready to improve how I take care of my child”), and action (e.g., “I am trying to learn how to take care of my child better”) items (Andrade et al., 2015, p. 368). Items are rated
on a 5-point Likert scale (i.e., 1 = *strongly disagree*, 5 = *strongly agree*). The authors conducted a principal axis factor analysis which produced a two-factor solution: problem recognition (PR; items from the precontemplation scale); and intent to change (ITC; items from both the contemplation and action scales; Littell & Girven, 2005). It is a caregiver-report measure designed to be administered at multiple points during treatment (e.g., pre-treatment, during treatment, and post-treatment; Andrade et al., 2015; Little & Girven, 2005) and has been shown to have acceptable internal consistency (e.g., Cronbach’s alpha scores > .65 on the PR, ITC scale, and overall readiness to change score at all three administrations (Littell & Girven, 2005). While the PRCS does address the importance of assessing a caregiver’s readiness and motivation for change their parenting behaviors, it was developed for use in the child welfare population. Most items have a negative tone which implies need for large amounts of caregiver improvement in parenting behaviors, which may limit its use in community populations.

In sum, while studying factors that prevent participation has value, these measures (i.e., BPTS, OES, TBS) focus mainly on logistical barriers (i.e., typically stable client characteristics) and do little to address the attitudinal component of ongoing engagement. One measure, the PRCS, examined attitudinal factors but cannot be generalized to all community settings. However, this line of research has been valuable in that it has informed research into treatment location and format as additional important factors in ongoing engagement due to their potential impact on caregivers’ attitudes toward treatment. Attitudinal factors may be particularly salient when services are delivered within the family home.
Treatment Location and Format

Home-based Services

Home-based services are considered to be the most accessible for minority families (Armbruster & Fallon, 1994; Azzi, 2013) yet still have a high dropout rate (Azzi, 2013; Fung et al., 2014; Staudt, 2007) despite eliminating two of the most common logistical barriers to treatment engagement (i.e., transportation and childcare; Gopalan et al., 2010). Home-based services for young children (i.e., infants, toddlers, and preschoolers) typically aim to improving caregivers’ capacity to support their child’s development, foster caregiver-child attachment; promote early learning, and prevent child maltreatment, thereby promoting overall wellness for the child and the caregiver (Azzi, 2013). Low-income minority families typically have multiple risk factors associated with living in poverty, such as lack of stable housing, domestic or community violence, caregiver depression or substance abuse, and have been shown to withdraw from home-based services at higher rates than families with less risk factors (Azzi, 2013; Bornheimer et al., 2018; Santiago et. al., 2013a). This may be due to higher levels of adversity or these families may be hesitant to participate in home-based services solely based on experiences with systemic racism, particularly in past services (Azzi, 2013; Harrison et al., 2004).

As such, Azzi (2013) lists several recommendations to providers for improving caregiver participation (i.e., improved attendance and attitudinal engagement) in home-based services in light of racism: pay attention to forming a close alliance with caregivers (i.e., one in which clinician communicates respect for caregivers’ strengths and parenting competencies); emphasize family empowerment throughout treatment; and incorporate
culturally competent practices. These recommendations echo the Axford et al (2012) recommendations for increasing caregiver engagement in BPTs.

Most home-based services research, and particularly research with young children, involves early childhood services (e.g., speech therapy) rather than mental health care. Only one study examining whether home-based services increased engagement in BPTs was found. Lees et al. (2019) conducted a randomized clinical superiority trial investigating whether adding a home parent support (HPS) intervention to the Incredible Years Parent (IYP) program would improve outcomes for high-risk families. The HPS intervention was reflected the authors’ awareness that not all families respond the same to treatment, one-third of families still experience challenging child behaviors post-treatment, and additional caregiver risk factors (e.g., low parenting self-efficacy, authoritarian or punitive parenting styles, parental depression or substance abuse) may prevent caregivers from learning new parenting skills and fully engaging in their child’s treatment (Lees et al., 2019). While behavioral improvement was the primary outcome measure, the study also looked at attendance and retention as secondary outcomes.

Using a sample of 126 caregivers of children ages 3 – 7 years old, the control group \((n = 63)\) received standard IYP while the treatment group \((n = 63)\) participated in standard IYP but also received 10 one-hour in-home sessions (HPS) meant to review key content with the family, tailor strategies to meet individual needs of child and caregiver, explore barriers to change, and practice positive parenting strategies in the family’s natural environment in order to improve caregiver self-efficacy beliefs (Lees et al., 2019). A key part of the HPS intervention was a therapist manual outlining elements of each in-
home session that were designed to keep the focus of the home visit on consistent and effective implementation of IYP strategies and directly addressing barriers to successful strategy implementation with the family (Lee et al., 2019).

Results indicated the treatment group showed a significant reduction in challenging behaviors at the 6-month follow up as measured by the Early Childhood Behavioral Inventory (ECBI; Eyberg, 1978) problem and intensity scales [ECBI-P (F1,83 = 4.7; P = .03), ECBI-I (F1,83 = 4.8; P = .03); Lees et al., 2019]. Related to engagement, significantly more parents who received the home-based treatment intervention completed more than 70% of sessions (52 of 63, 82.5%) as compared with parents who received only standard IYP (41 of 63, 65.1%), $\chi^2_1 = 4.97; p < .05$. Additionally, the dropout rate in the IYP group (12.7%) was more than double the dropout rate of the HPS group (5.6%; Lees et al., 2019). Though this study looked at ongoing engagement in terms of retention and session attendance, it does contribute to the literature on BPT efficacy outcomes by examining the addition of home-based services tailored to improving BPT strategy implementation within the family’s natural environment. The authors recommend high-risk families (i.e., low-income minorities) would benefit from a home-based BPT intervention due to their motivation to participate but high number of logistical barriers (Lees et al., 2019). Further research on ongoing engagement in home-based BPTs (e.g., EP) for young children is needed to understand why overall engagement in these programs remains poor.

**Treatment Format**

In addition to the location of services, the format of BPTs may influence caregiver engagement. While the majority of BPTs share a similar foundation on social learning
theory (i.e., caregiver behavioral responses will influence child behavioral response) and teach similar strategies (e.g., limit-setting, positive reinforcement of prosocial behaviors, emotional regulation, collaborative problem-solving; Garland et al., 2008; Gross et al., 2018; Reyno & McGrath, 2006), BPTs come in a variety of formats (e.g., individual coaching sessions, group programs) and delivery methods (e.g., in-person sessions, digital content; Gross et al., 2018). Recent research has shown caregivers respond differently to BPTs based on their format and delivery preferences (Gross et al., 2018; Wymbs et al., 2016). Examining these preferences appears especially important for low-income minority families who are not only at greater risk for psychological risk factors (e.g., mental health concerns, increased stress levels) but also for BPT dropout (Alegria et al., 2016; Chacko et al., 2016; Gross et al., 2018; Harrison et al., 2004; Haine-Schlagel & Walsh, 2015). Treatment format preferences, like other preferences and expectations for treatment, influence the level of on-going caregiver attitudinal engagement and adherence in their child’s mental health services (Kazdin, 1996; Gross et al., 2018; Morrissey-Kane & Prinz, 1999; Niec et al., 2016; Nock & Kazdin, 2001; Wymbs et al., 2016).

The two main BPT formats (i.e., group programs and individualized coaching) each have advantages and disadvantages when considering caregiver engagement. Group BPTs provide opportunities for caregivers to engage with treatment content and with other caregivers who may share similar experiences, though they are structured to meet group needs and cover specific content at specific sessions, with less attention to paid individual caregiver needs and making it difficult to learn material when sessions are missed (Gross et al., 2018). Groups tend to use videos to model responses to challenging behaviors, which requires comfortability in discussing child and family problems within
the group and necessitates skill practice outside of session (Gross et al., 2018; Niec et al., 2016). Groups are held at fixed times which may not be convenient for all caregivers (Gross et al., 2018; Santiago et al., 2013b). Individual coaching formats not only offer more flexibility in scheduling and in making up missed content but also provides coaching of caregivers through behavioral difficulties with their child in the moment, sometimes in the natural family setting, increasing the likelihood of perceived relevance and efficacy of BPT programs (Gross et al., 2018; Lees et al., 2019). However, individualized programs place a higher demand on caregivers within-sessions and between-sessions as evaluation of skill mastery is much more direct than in group BPT formats (Gross et al., 2018).

Recent studies have specifically examined engagement in BPTs for young children while comparing BPT format. First, Niec et al. (2016) modified PCIT from its original individualized format into a group-based program to examine both adherence and outcomes based on format (i.e., 12 weekly one-hour individual caregiver-child coaching sessions vs. 14 two-hour groups sessions consisting of three to seven caregiver-child dyads). Using a sample of 81 families of young children (ages 3 to 6 years, 85.2% Caucasian) with an ODD diagnosis, the authors measured treatment adherence (i.e., attendance, homework completion, and therapist-rated caregiver participation), perceived social support, and caregiver satisfaction with services (Niec et al., 2016). Results showed similar attrition rates for both formats, 25.6% and 26.3% for group and individual formats, respectively (Niec et al., 2016). Independent t-tests demonstrated no significant differences in attendance, homework completion, or therapist ratings of caregiver participation across treatment formats nor were there differences in
efficacy or satisfaction based on format (Niec et al., 2016). Ultimately, the authors concluded both individual and group PCIT were effective and satisfactory to caregivers. In a study with a similar sample, researchers found preferred treatment format may be associated with different treatment goals, as participants who preferred participation in individualized BPTs were most interested in understanding their child’s problems while those who preferred participation in group BPTs were most interested in active, skill-building interventions (Wymbs et al., 2016), indicating attitudinal factors affect engagement decisions.

Gross et al. (2018) also looked at caregiver engagement as related to preferences for group- or individual- format BPTs with preschool children but did so by comparing two different BPTs in their original format (i.e., group CPP and individual PCIT). This study also differed from Niec et al. (2016) in participant demographics by including a larger ($n = 159$) and more diverse sample (69.8% African American, 22.1% Caucasian, 4.4% Latino, 73% low-income) of 2- to 5-year-old children without a mental health diagnosis (Gross et al., 2018). Caregivers were randomly assigned to CPP (12 two-hour sessions) or PCIT (variable number of one-hour sessions, based on skill mastery) in blocks of 10 participants, thereby eliminating one possible confound of comparing group and individual BPT formats (i.e., participants in group programs must sometimes delay treatment until the next available group start time; Gross et al., 2018).

Caregiver participation in both treatment interventions was measured using the Engagement Form (Garvey et al., 2006), a clinician-rated instrument originally developed during a study of engagement of low-income caregivers in a preventative parenting program for preschool-aged children designed to be implemented within childcare centers
The Engagement Form is filled out by the clinician at the end of the group program, evaluating the following 7 items on a 4-point (e.g., 1 = not at all, 4 = most of the time) scale: attention paid to video vignettes; perceived understanding of content; support given to other caregivers; active discussion participation; willingness to share personal experiences within group; resistance to program content; and correct application of skills learned (Garvey et al., 2006; Gross et al., 2018). Higher scores (i.e., 7 to 28) indicate higher engagement (Garvey et al., 2006). Reliabilities in this study, as measured by Cronbach’s alpha, were .75 (PCIT) and .80 (CPP). While caregivers were rated as highly engaged in both treatment groups by their clinicians, caregivers participating in PCIT were rated as significantly more engaged ($M = 3.4; SD = 0.47$) than were caregivers participating in CPP ($M = 3.2; SD = 0.49$), $[t (97) = −2.47, p = 0.015; 95\% CI [−0.43, −0.05];$ Gross et al., 2018], perhaps due to difference in sessions attended by participants. CPP participants only had the opportunity to attend at maximum 12 two-hour sessions over the course of 84 days, far less than the average sessions attended by PCIT participants ($M = 30$) over 406 days, calling for a higher behavioral and emotional commitment from caregivers in the individualized intervention (Gross et al., 2018). This study also employed clinician ratings of caregiver participation post-treatment, which is subject to recall bias and neglects caregivers’ perspective on within-treatment factors (e.g., alliance) that may impact their ongoing engagement. In the end, more research is needed on whether explaining each format’s strengths and weaknesses to families before treatment would allow caregivers to better match treatment factors with their own attitudes and expectations for therapy; this psychoeducation may also serve to foster therapeutic alliance, another important aspect of caregiver engagement.
Alliance

The therapeutic alliance is considered a strong factor in engagement, particularly treatment adherence (King et al., 2014), as one recommendation aimed at improving engagement in BPTs is to focus on building rapport and relationships with caregivers (Axford et. al., 2012). Alliance is well-studied in adult therapy as its strength is tied to positive outcomes (Miller & Prinz, 2003). Horvath & Bedi (2002) defined alliance as having three parts: the nature of the client-therapist interaction; the personal attachment that develops between the client and the therapist over the course of treatment; and the collaboration of working toward treatment goals. However, in child therapy, there are three possible relationships that can contribute to successful outcomes: the child-therapist alliance; the caregiver-therapist alliance; and the caregiver-child alliance (Garland et al., 2012; Kazdin et al., 2006). Forming a strong therapeutic alliance in child therapy is considered complex due to the multiple people involved in the treatment process and the resulting multiple relationships clinicians must attend to in order to keep families engaged in treatment (Garland et al., 2012; Thompson et al., 2007).

McKay & Bannon (2004) reported alliance difficulties are a large factor in family treatment engagement. More specifically, Morrisey-Kane & Prinz (1999) asserted that caregiver engagement and alliance is directly influenced by their attribution of the cause of their child’s problems, their perceptions about their own capacity to handle their child’s difficulties, and their expectations for how therapy will help with those problems. In fact, caregiver willingness to participate (i.e., cognitive preparation) and actual level of participation (i.e., adherence) are cited as two of the most important factors related to alliance and treatment outcomes for children under the age of 18 years (Becker et al.,
This suggests engagement and alliance may have a bidirectional relationship which in turn effects treatment outcomes.

The literature reflects the overlap between the constructs of alliance and engagement in child therapy. In play therapy and dynamic therapies, the emotional bond (i.e., the therapeutic alliance) between client and therapist is seen as both “necessary and sufficient” for client change (e.g., symptom reduction, improved functioning; Shirk & Saiz, 1992, p. 716; Shirk et al., 2006; Shirk et al, 2011). However, in psychoanalytic and behaviorist traditions, the emotional attachment between therapist and client serves as a facilitator of collaboration on therapeutic work and involvement in both within- and between-session therapeutic tasks in order to reach goals (i.e., suggesting the association between alliance and outcomes in mediated by adherence; Shirk et al., 1992; Shirk et al., 2006; Shirk et al., 2011).

Indeed, Bordin (1979) conceptualized adult alliance as having three separate domains: bond; tasks; and goals (Horvath & Greenberg, 1989). This long-standing view of alliance overlaps with current multidimensional conceptualizations of engagement which stress both attitudinal (e.g., affective bond, client beliefs and perceptions about therapy, therapist, and outcomes) and behavioral components (e.g., task adherence for the purpose of achieving therapeutic goals; Becker et al., 2015; King et al., 2014; Lindsey et al., 2014). The bond domain encompasses the affective aspect of alliance such as warmth, caring, and respect within the relationship while the task domain involves collaboration on therapeutic tasks and activities (including timing and pace) and the perception therapist can help with client problems (Bordin, 1979; Horvath & Greenberg, 1989; Johnson et al., 2002). The goal domain consists of agreement about therapeutic goals and
the commitment to working toward achieving them (Bordin, 1979; Horvath & Greenberg, 1989; Johnson et al., 2002). If forming an emotional bond with the caregiver is difficult, research suggests the therapist may find building alliance based on tasks and goals (i.e., focusing on engagement) is useful in achieving therapeutic gains (Johnson et al., 2002). Agreement on treatment goals and the tasks necessary to achieve them can then be viewed as a central tenet of both alliance (Shirk et al., 2011) and engagement (Becker et al., 2015), particularly for caregivers in skill-based programs such as BPTs.

Karver and colleagues (2005) put forth a Theoretical Model of Common Process Factors in Youth and Family Therapy which clearly demonstrates the overlap between alliance and engagement. In this model, the following components are conceptualized to influence the therapeutic alliance with the youth and their caregivers: client pretreatment characteristics (e.g., child age, problem severity, caregiver mental health, family functioning, expectation for treatment and outcomes), therapist characteristics (e.g., theoretical orientation, personality characteristics, experience level), therapist reactions to the client (i.e., positive or negative feelings); counselor interpersonal skills (e.g., positive regard, warmth, empathy); therapist direct influence skills (e.g., clarity of treatment protocol, corrective feedback, reinforcement strategies); therapist self-disclosure (e.g., revealing own thoughts, feelings, or experiences); therapist credibility (e.g., perceived expertise and trustworthiness); and client autonomy (e.g., motivation, direction, empowerment; Karver et al., 2005). The therapeutic alliance is then hypothesized to influence treatment outcomes (Karver et al., 2005).

Within this model, it is important to note alliance (with the child, the parent, and the family) does not simply include an affective bond with the therapist, but also key
components of ongoing treatment engagement, namely, client/caregiver willingness to participate (e.g., desire for treatment; commitment to time and effort required; perceived relevance and efficacy of treatment) and actual treatment participation (e.g., attendance, in-session collaboration, completion of in-session tasks and between-session homework; Karver et al., 2005). This model demonstrates how the constructs of engagement, participation, and alliance continually overlap in the literature. The authors even cite willingness to participate and level of actual participation in treatment as essential elements of achieving successful outcomes (Karver et al., 2005).

The majority of research on alliance in child therapy has been tied to outcomes and has involved older children and adolescents. Many studies (e.g., Kazdin et al., 2006) only include treatment completers, thereby omitting potentially valuable information about why those families may have disengaged from treatment (e.g., logistical barriers, alliance difficulties). In a recent study of alliance, parents’ perceived barriers to treatment, and therapeutic change in children with behavior problems, Kazdin & McWhinney (2018) found barriers to treatment (i.e., things that affect a parent’s ability to continually engage in services) were correlated with outcome, even when alliance was controlled; this may be due to the likelihood that parents encounter logistical barriers that do not have any relational components (e.g., transportation). The authors also found alliance was correlated with outcome when barriers to treatment were controlled (Kazdin & McWhinney, 2018), indicating a multidirectional relationship likely exists between alliance, treatment barriers, and outcomes.

Some studies have begun to directly look at the association between alliance and client involvement (i.e., continued engagement) in child therapy. Again, most studies
focus on older children and adolescents and thus it is challenging to compare the literature because of the different age groups, different measurements used, different people (e.g., youth, caregiver, or both) completing the measurements, and differing timing of assessments (e.g., pre-, during, or post-treatment) across studies (Karver et al., 2008). Like engagement, meta-analyses have found alliance literature often includes studies of children of a wide age range (e.g., age 4 – 16 years) which does not account for developmental differences in alliance, treatment barriers, and outcomes based on age or developmental stage (Karver et al., 2008; Shirk et al., 2011).

For example, young children (i.e., age 6 and under) may simply view the therapist as a playmate rather than someone who can help them with their problems (Shirk et al., 2011). Similarly, young children likely lack the cognitive abilities to connect therapeutic activities with outcomes, to understand why therapy is occurring, or know what specific goals are being worked toward (Shirk et al., 2011). Parents and other caregivers are involved in the child’s therapy for these reasons. As the caregiver-therapist alliance appears effect ongoing treatment continuation and engagement (Accurso et al., 2013; Shirk et al., 2011), an examination of the caregiver-therapist alliance and its effect on engagement and outcomes is warranted for young children.

Some research is beginning to focus on the caregiver-therapist alliance as tied to outcomes and treatment satisfaction. The quality of both the child-therapist alliance and the caregiver-therapist alliance has been shown to predict positive therapeutic outcomes for the child; additionally, the caregiver-therapist alliance best predicted the improvement of positive parenting strategies used in the home in a study of children ages 6 to 14 years old (Kazdin et al., 2006). More recently, Acri et al. (2016) reported the caregiver-
therapist alliance is influenced by: the caregiver’s perceived relevance and appropriateness of the treatment provided; the perceived helpfulness of the therapist; the caregiver’s satisfaction with services; and potential mistrust or other negative views of treatment or the therapist (e.g., viewing the clinician as judgmental; Santiago et al., 2013a), the same things are posited to influence ongoing treatment engagement.

There is a paucity of research on the caregiver-therapist alliance concentrating on BPTs involving only young children (i.e., < 6 years) nor is there research on how this alliance relates to overall BPT participation and satisfaction in minority populations (Acri et al., 2016; Axford et al., 2012; Kazdin et al., 2006). It appears caregiver-therapist alliance is related to the caregiver’s cognitive preparation and adherence, but more research is needed to clarify the relationship between those variables and the factors that contribute to them within minority populations.

**Measures of Alliance**

Two alliance measures were found that appear applicable to this discussion as they were created using Bordin’s conceptualization of alliance as a collaborative relationship focused on bonds, tasks and goals: The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989); and the Therapeutic Alliance Scale for Parents and Caregivers (TASPC; Accurso et al., 2013).

**The Working Alliance Inventory.** The WAI was developed based on Bordin’s (1979) argument that the working alliance provides the context in which both the therapist and client can interact with treatment strategies (Horvath & Greenberg, 1989). The WAI has both a client and therapist version, each with 36 items (i.e., 12 items related to bond, 12 items related to tasks, and 12 items related to goals) rated on a 7-point scale.
(i.e., 1 = not related to working alliance, 7 = very relevant to working alliance; Horvath & Greenberg, 1989). It was developed to be used with adult clients and administered after the third session (Horvath & Greenberg, 1989).

Though not explicitly designed for use with parents or caregivers, the WAI short form (WAI-S) has been used in BPT alliance research. For example, Hukkelberg and Ogden (2016) recently conducted a confirmatory factor analysis (CFA) using a sample of Norwegian caregivers (n = 259) and their children (M<sub>age</sub> = 8.69 years, SD = 2.14, range 3-12). Caregivers were classified as low to middle class, with 28% of families receiving government assistance (Hukkelberg & Ogden, 2016). The WAI-S contains 12 items rated on a 7-point scale (i.e., 1 = never, 7 = always) and contains items related to tasks (e.g., “The therapist and I agree what to do to improve the situation in my family”), goals (e.g., “The therapist and I work towards mutually agreed upon goals”), and bond (e.g., “I feel the therapist and I trust one another”; Hukkelberg and Ogden, 2016, p. 722). CFA results indicated best model fit (Root Mean Square Error of Approximation (RMSEA) = .093, Tucker–Lewis reliability Index (TLI) = .97, and Comparative Fit Index (CFI) = .97) confirmed the three-factor structure, thereby supporting the description of the construct of alliance in BPTs as made up of tasks, goals, and bond (Hukkelberg & Ogden, 2016). More importantly, as the study administered the WAI-S at both session 3 and session 12, results demonstrated longitudinal measurement invariance; this suggests participants interpreted the assessment items the same way throughout the therapy process, allowing for reliable and valid comparisons at various points throughout treatment (Hukkelberg & Ogden, 2016). Though limited by caregiver self-report data, the WAI-S appears to be an
acceptable measure of alliance in BPTs while also assessing attitudinal (i.e., goals), relational (i.e., bond), and behavioral (i.e., task) components of ongoing engagement.

**The Therapeutic Alliance Scale for Parents and Caregivers.** A revision of the Therapeutic Alliance Scale for Children-Revised (TASC-R; Creed & Kendall, 2005; Shirk & Saiz, 1992), the TASPC contains 12 items based on Bordin’s (1979) conceptualization of alliance (Accurso et al., 2013). Items are rated by the caregiver on a 4-point scale (i.e., 1 = *not true*, 4 = *very much true*) and are related to bond (e.g., “I like spending time with my child’s therapist”), tasks (e.g., “My child’s therapist and I work well together on dealing with our problems”), and goals (e.g., “I use my time with my child’s therapist to make changes in our lives”; Accurso et al., 2013, p. 252). A parallel therapist-report instrument exists.

Researchers examined the psychometric properties of the TASPC using an original sample of 209 caregivers and their children ages 4 to 13 years old. The caregivers were predominantly women (94%), biological mothers (79%), married (44%) and Caucasian (53%); families were classified as low-to-middle class (Accurso et al., 2013). Therapists (*n* = 92) were predominantly trainees (59%), female (84%), and Caucasian (68%) with an average of three years (range = 0-25 years) of therapy experience (Accurso et al., 2013). During the 16-month study, with assessments administered at 4, 8, 12, and 16 months, the participant sample naturally decreased over time due to termination of services and not all caregivers active in therapy completed follow-up interviews (Accurso et al., 2013). The TASPC was completed by 169 (80.9%) caregivers at 4 months, 114 (80.9%) caregivers at 8 months, 79 (79.0%) caregivers at 12 months, and 47 (77.1%) caregivers at 16 months (Accurso et al., 2013). Therapists rated
their alliance with 143 (68.4%) caregivers at 4 months, 88 (62.4%) caregivers at 8 months, 58 (58.0%) caregivers at 12 months, and 37 (60.7%) caregivers at 16 months (Accurso et al., 2013).

Reliability results indicated high internal consistency (Cronbach’s alpha = .85 to .88) of caregiver-reported alliance across all four time points as well as moderate stability over time, which is reasonable given alliance, like engagement, tends to change over time (Accurso et al., 2013; Johnson et al., 2002). Predictive validity was established as caregiver-reported alliance at 4 months showed a significant positive association ($B = .62$, $SE = .18$, $p < .001$) with total number of sessions attended by the family and with increased satisfaction with therapeutic improvement at both 8 months ($B = .03$, $SE = .01$, $p < .005$) and 12 months ($B = .04$, $SE = .01$, $p < .005$) into treatment (Accurso et al., 2013). It appears caregivers’ perception of the alliance with their child’s therapist is strongly tied to both engagement and outcomes in therapy. Though there is a significant lack of research on caregiver-therapist alliance with young children, the TASCP has good psychometric properties and may prove useful in further research in this area, particularly with low-income minority families.

**Cultural Factors**

Cultural factors appear to influence treatment engagement. It is well-documented that poverty rates are higher in ethnic minority families than in Caucasian families and that both the negative stigma around mental health care and logistical barriers (i.e., transportation, childcare, and cost of services) frequently prevent ethnic minority families from engaging in mental health services (Bornheimer et al., 2018; Santiago et al., 2013). Morrisey-Kane & Prinz (1999) found that cultural variables such as race and
socioeconomic status appear to have an association with the rate of attrition (i.e., ending on going engagement) in child therapy, most notably when parental beliefs and expectations about therapy differ from the services received.

Culture appears to influence families’ attribution of cause regarding their child’s concerns, and if those beliefs are not reflected by the therapist, treatment adherence and engagement decreases (Yeh et al., 2005). Additionally, it appears engagement is reduced when the treatment does not recognize cultural norms, values, or variations in coping style (Snell-Johns et al., 2004), or when Black families feel they are not treated with respect by White service providers (Harrison et al., 2004; McKay et al., 1996). These cultural factors have the potential to contribute to effective engagement interventions and warrant further exploration, especially in early childhood mental health care in urban populations. Cultural factors appear especially pertinent in research focusing on BPTs, which were primarily created and assessed for efficacy with middle class Caucasian families (Coard et al., 2004).

There is substantial literature on race and associated cultural factors in engagement in adult psychotherapy, which may give some insight into caregiver engagement in BPTs, as the adult caregiver is the target of many BPT treatment strategies. Adult clients in cross-cultural therapeutic dyads often feel unable or unwilling to discuss the effect of cultural micro-aggressions on the therapeutic alliance with their therapist and will simply end services early (i.e., disengage) instead (Owen et al., 2011). Other key cultural barriers to engagement may include: a lack of trust with a therapist of a different racial background; the lack of therapist’s knowledge of the client’s cultural experience (e.g., values, goals, practices, discrimination within society); and a lack of
sensitivity and understanding of the minority experience within the therapeutic process (Harrison et al., 2004; Thompson et al., 2004).

While these authors did not specifically study the relationship between race, alliance, and engagement within BPTs, it appears the same cultural factors may influence the engagement of caregivers of child clients as influence adult clients themselves. Indeed, Orrell-Valente et al. (1999) found that family coordinators who were similar in ethnic and socioeconomic backgrounds to the caregivers were better able to form a therapeutic alliance than were coordinators of a different cultural background than the family; these coordinators’ clients were found to have both increased engagement and improved outcomes.

In literature studying older children and adolescents, Black caregiver engagement appeared to differ from White caregiver engagement in several ways. First, Thurston et al. (2015) reported African Americans are less likely to seek mental health services for their child than are Caucasian parents, citing cultural mistrust as a reason for this lack of engagement. It also appears Black caregivers may differ from White caregivers in determining what constitutes a behavior or emotional problem that requires therapy; for example, an African American caregiver may believe a Caucasian teacher is overreacting to their child’s behaviors at school and therefore not engage in services (Snell-Johns et al., 2004; Thurston et al., 2015). Similarly, the caregiver and the therapist may have different ideas about what ideal participation in services looks like or the preferred style of caregiver-therapist alliance, again based on cultural perspectives (Asnaani & Hoffman, 2012).
Second, cultural variables such as race and SES are reported to be most influential in reducing engagement in child therapy when parental beliefs and expectations about therapy differ from the actual services received (Morrisey-Kane & Prinz, 1999; Shuman & Shapiro, 2002), this may be particularly relevant in BPTs if the caregiver initially engages in treatment with the expectation that the child will be the focus of the intervention strategies (Wymbs et al., 2016). Engagement in child therapy also appears to be reduced when caregivers and therapists differ in their attribution of cause for the child’s behavior (i.e., intentional maliciousness, organic cause, or ineffective caregiver response style; Yeh et al., 2005). Finally, engagement appears to be reduced in low-income minority populations when the treatment itself fails to recognize cultural norms, values, parenting practices, or coping styles (Morawska et al., 2011; Snell-Johns et al., 2004). While much of this literature studied engagement merely in terms of attendance or attrition, it provides direction for attitudinal factors to explore in relation to cognitive preparation and adherence.

One such factor may be the match in race or ethnicity between the caregiver and the clinician. Researchers now recognize a child from an ethnic minority has multiple influences on their behavior, and those influences are grounded in a particular cultural context made up of familial, community, and societal influences, most of which are different in some way from the experiences of Caucasian families (Alegria et al., 2010). At the same time, most Black clients are receiving services from a Caucasian therapist (Alegria et al., 2010; Halliday-Boykins et al., 2005; Mulvaney-Day et al., 2011), leading to differences in cultural understanding. In a qualitative study on differences between African American (n = 6), Latino (n = 23), and non-Latino White (n = 22) adults’
preferences in clinician relational style, Mulvaney-Day et al. (2011) found four common themes across groups. All three groups wanted a therapist who would listen to them, understand what they were going through, spend ample time with them, and would pay attention to the differences between the client and the therapist (Mulvaney-Day et al., 2011). However, each group interpreted the themes differently. For example, African Americans wanted a therapist who listened to gain a true understanding of the individual client, recognizing the client is the most knowledgeable about self, while Latino participants wanted a therapist who listened to build relationship and give the client attention, and non-White Latino clients wanted the therapist to listen in a way that made them feel safe to discuss their emotions (Mulvaney-Day et al., 2011). Similarly, when talking about negotiating differences between client and therapist, non-Latino White participants wanted a therapist who would not judge them because of any differences, Latino participants spoke of wanting the therapist to be the expert and be directive in problem-solving, and African American clients wanted a provider who would “actively work against the assumption of difference” by meeting the client where he/she was at (Mulvaney-Day et al., 2011, p. 37). It appears a mismatch in provider characteristics and client cultural preferences could lead to a lack of ongoing engagement in services.

Recognizing therapists of the same ethnic background as their clients are assumed to possess knowledge, skills, communication styles, and attitudes that would lead to more culturally sensitive treatment, researchers examined whether an ethnic match between therapist and clinician would lead to improved outcomes in multisystemic therapy with older children and adolescents (Halliday-Boykins et al., 2005). These authors found a small effect on treatment duration (i.e., 10% longer) when an ethnic match between
cared of. Additionally, ethnic match was associated with an increased likelihood of successful outcome at discharge, as those caregivers ethnically matched with their therapist had 70% probability of being terminated for successful treatment while caregivers not ethnically matched with their therapist had a 63% probability of successful treatment being listed as the reason for discharge (Halliday-Boykin et al., 2005). While this study involved older youth and a different treatment modality, it does point to a potential gap in the BPT engagement literature as factors underlying theories on ethnic match (e.g., client and therapist behaviors, communication styles, therapeutic relationship, expectations for treatment; Halliday-Boykins et al., 2005; Mulvaney-Day et al., 2011) appear to overlap with factors of engagement. This may be especially important to consider as ethnic minority caregivers are less likely to view their child’s treatment as relevant or effective than Caucasian parents (Lakind & Atkins, 2018; Nock & Kazdin, 2001).

Another factor to examine may be cultural differences in parenting style and discipline practices between Black caregivers and the BPT program strategies. Compared to Caucasian caregivers, low-income minority parents tend to endorse more authoritative parenting styles, stronger beliefs about the use of punishment and the value of spanking, seemingly more negative perceptions of the child (e.g., the child is intentionally trying to frustrate the caregiver), higher levels of stress, and more intense feelings when parenting (Burchinal et al., 2010; Cooper et al., 2018; Fox & Holtz, 2009; Pinderhughes et al., 2000). African American parents, in particular, are often portrayed in the literature (e.g., Cooper et al., 2018) as overly harsh with their children when their parenting style may be a result of their own parenting, racial socialization practices, or a variety of other cultural
factors (Huang & Isaacs, 2007; Lakind & Atkins, 2018; Neblett, 2019). It may be Black parents begin a BPT program but disengage (i.e., attrition or lack of adherence) when the program does not coincide with their cultural norms around parenting and discipline.

Research on cultural norms and adaptations of BPTs has led to inconsistent results. Morawska et al. (2011) conducted a study in which 137 caregivers of children ages 2 to 10 years old from diverse ethnic backgrounds (26.1% White Australian, 22.4% South-east Asian, 11.9% European, 10.4% African, 9.7% Pacific Islander, 8.2% Southern or Central Asian, and 5.4% Middle Eastern) were asked to evaluated Triple-P Positive Parenting materials for cultural acceptability and appropriateness. Using various 10-point scales (i.e., 1 = not at all relevant, 10 = extremely relevant), participants were asked to rate the usefulness, cultural relevance, and appropriateness along with the likelihood of their participation in the Triple-P program in the future, should their child develop behavior or emotional difficulties (Morawska et al., 2011).

While overall results indicated caregivers viewed the Triple-P Program as culturally acceptable and relevant, it is important to note that when asked to list barriers to implementation, participants did list language barriers, cultural inappropriateness of particular strategies, cultural barriers to accessing services (e.g., lack of support from extended family member), and discomfort in attending a parenting program as barriers in addition to logistic difficulties (Morawska et al., 2011). One reason for this inconsistency is likely the small sample size of each ethnicity represented; though the sample itself was ethnically diverse, it appears the cultural appropriateness and relevance of the treatment program may have been greater for some ethnicities than for others (Morawska et al., 2011). Another limitation is that while this study surveyed participants for potential
engagement with the program, no participants engaged in the treatment protocol as part of this research. It is possible more cultural barriers may have arisen if participants were engaging in the full treatment protocol with their children.

One qualitative study addressing cultural parenting norms that may affect BPT engagement for African American parents was found. Coard et al. (2004) conducted a pilot study in order to better inform interventions aimed at increasing the cultural relevance of an evidence-based BPT, noting that the study was aimed at filling the gap of evaluating whether BPT program efficacy could be improved by incorporating racial, ethnic, and cultural issues important to a specific group (e.g., African Americans) into the treatment protocol. Using a grounded theory approach, the authors interviewed 15 low-income African American caregivers of five- or six-year-old children about how they incorporated racial socialization (i.e., the process of teaching children the values, attitudes, and behaviors of their racial group; Caughy et al., 2002) into their everyday parenting. One hundred percent of participants reported racial socialization is a key element of their parenting style, with most noting their parenting was substantially different and more challenging than Caucasian parents (Coard et al., 2004).

Four themes emerged from participants’ descriptions of how their race effects their parenting style: racism preparation; racial pride; racial equity; and racial achievement. Eleven caregivers (73%) endorsed actively preparing their young children for the racism they will encounter in society, and directly discussing both social mistrust of others outside of their race rules of behavior (e.g., acceptable school behavior, what to do if stopped by the police) in order to succeed in mainstream society (Coard et al., 2004). Fourteen caregivers (93%) endorsed modeling racial pride to their children in
order to combat racism, and thirteen caregivers (86%) reported consciously speaking to their child about similarities between races and how all races are equal (Coard et al., 2004). Ten caregivers (67%) reported they routinely communicate to their child the importance of achievement and how they will have to work harder than other races in order to succeed (Coard et al., 2004). Participants reported teaching their children these lessons through oral communication, modeling, role-playing, and exposure (Coard et al., 2004).

As these are four techniques heavily used in BPTs (e.g., communicating expectations, modeling appropriate behavior in a given situation, role-playing as a way for child to practice new behaviors, exposure to situations where coping skills may be needed), it appears African American caregivers may benefit from incorporating racial socialization techniques into the intervention program itself. Benefits potentially include an increase in caregiver engagement, which could in turn lead to reduced caregiver stress, more effective parenting practices, and higher treatment outcomes for the child (e.g., reduced challenging behaviors and improved emotional regulation; Coard et al., 2004). Unfortunately, while the authors repeatedly call for specific modifications to BPTs in order to meet the unique needs of African American families, they give little information on how to do so. They do call for further quantitative and longitudinal studies using minority populations to better inform how cultural factors may be effectively incorporated into BPTs in order better engage diverse families and prevent or reduce behavior problems in their young children (Coard et al., 2004).

Due to this potential lack of adherence due to differences in cultural norms, BPT programs have been reported to be less effective in minority populations (e.g., Black,
Latino) than in Caucasian families (Meija et al., 2017; Michelson et al., 2013; Reyno & McGrath, 2006). It appears initial treatment gains are achieved but maintenance of gains at one-year follow-up appointments are reduced (Leitjen et al., 2013). For example, Fernandez et al. (2011) found child behaviors decreased during treatment but caregiver stress level remained the same in a study of PCIT in low-income African American families, thereby mitigating initial treatment gains. As this difference in efficacy is attributed to higher levels of stress or adversity in minority (e.g., Black, Latino) populations, and as literature on parenting styles and race often identifies differences without providing recommendations for clinical practice, researchers have cited improving the cultural relevance of BPTs (Michelson et al., 2013; Butler & Titus; 2015) as a much-needed area for future research.

Cultural relevance in therapy refers to ensuring treatment activities, policies, and procedures are consistent with the client’s everyday life experiences as well as overall cultural values (Meija et al., 2017). van Mourk and colleagues (2017) conducted a recent meta-analysis of research focused on cultural adaptations of BPTs. The authors examined 18 randomized controlled trials of group parenting programs aimed at preventing disruptive child behaviors; each program had been culturally adapted in some form and focused on caregivers of children 12 years and younger (van Mourik et al., 2017). While all studies in this sample made *surface-level cultural adaptations* (i.e., changes to an existing program such as translation into another language; Meija et al., 2017), only 7 studies made *deep-level cultural adaptations* such as adding additional content on cultural influences on parenting, racial socialization, or sociopolitical influences on parenting (Meija et al., 2017; van Mourik et al., 2017). Results of the meta-analysis
revealed programs utilizing these deep-level adaptations showed improved child outcomes (k = 18, Cohen’s d = 0.30), parenting behaviors (k=16, Cohen’s d = 0.13), and parenting perspective (k=8, Cohen’s d = 0.19; van Mourik et al., 2017). While these effect sizes are small, and while the meta-analysis addressed outcomes rather than engagement for these cultural adaptations, it is reasonable to consider parenting behaviors and parenting perspectives to be related to treatment adherence and attitudinal engagement in BPTs.

Specific to the use of BPTs with African American families, Ketch-Oliver and Smith (2015) recommended deep-level adaptations like those described in van Mourik et al. (2017). Most notably, using resources specific to African American families (e.g., books, pictures, language), consideration of the strong influence of the caregivers’ racial and sociocultural background on parenting beliefs and behaviors should be explored with caregivers, interventions should be relevant within the caregivers’ cultural context, and extended family or additional caregivers should be included in treatment as families desire (Ketch-Oliver & Smith, 2015).

While there is emerging research on cultural adaptations of BPTs, there is a lack of literature on the clients’ perspective on these adaptations and the provider’s cultural competency as connected with caregiver engagement, especially when the services are delivered in the client’s home (Damashek et al., 2012). It appears home-based services, due to the intimate nature of observing a client’s living situation, cleaning protocols, and parenting practices within their natural environment, may need providers who put high importance on respecting cultural factors within the therapy itself (Damashek et al., 2012). Unfortunately, the engagement literature that does exist on in-home programs
(e.g., Lewis et al., 2018) focuses on the child-welfare population which cannot be
generalized to voluntary low-income minority participants. Based on this review, it
appeared studying the cultural relevance of home-based BPTs with low-income Black
families would contribute to the literature on ongoing engagement in BPTs.

**Conclusions and Call for Research on Engagement Interventions**

Engagement is a complex construct consisting of behavioral (e.g., attendance),
attitudinal (e.g., participation), cognitive (e.g., expectations), and relational (e.g., alliance)
components (Becker et al., 2014; Becker et al., 2015; Lindsey et al., 2014; King et al.,
2014). Despite this acknowledgement by researchers, there is no common
operationalization of engagement within the general child therapy literature or within
empirical studies on BPT engagement (Staudt, 2007). BPTs are skill-based programs
which require caregivers to engage in their young child’s treatment both within- and
between- sessions in order to gain the maximum benefit from treatment (Butler & Titus,
2015; Gross et al., 2018; Kazdin & Whitley, 2003; Lees et al., 2019). To date, research
on ongoing caregiver engagement in BPTs has focused on attendance and adherence (i.e.,
behavioral engagement) with little study of the attitudinal, cognitive, or relational
components within caregiver’s decision to engage or disengage from BPT treatment. The
few studies presented here that do address those components are difficult to compare, due
to varying operation definitions, wide age ranges of children involved, and the lack of
multiple studies on the same component to compare and synthesize. More research
dedicated to caregiver engagement in BPTs with young children (i.e., under the age of 6
years) is needed to understand the unique demands treatment may place on these
caregivers. Additionally, as most BPTs were created and normed with Caucasian
populations (Coard et al., 2004; Gresl et al., 2014, studies of attitudinal, cognitive, and relational components of caregivers from low-income minority studies are even rarer within this literature. The literature is largely quantitative, as behavioral components of engagement are easier to measure, though the few qualitative studies presented here (e.g., Yatchmenoff, 2005; Mulvaney-Day et al., 2011) have demonstrated the need for additional qualitative investigations with low-income minority families to not only better inform the cultural relevance of BPT programs, but also to work toward reducing attitudinal, cognitive, and relational barriers to caregiver engagement.

Research has previously focused on interventions aimed at increasing treatment attendance (e.g., telephone reminders of upcoming appointments; McKay & Bannon, 2004), though some recent researchers are beginning to examine the effects of interventions targeting the attitudinal aspects of engagement. For example, in a systematic review of 17 RTCs of engagement and retention interventions aimed at both caregivers and youth under the age of 18 years, Ingoldsby (2010) found the most effective engagement interventions involved personal conversations with families regarding engagement, interviewing families about their motivations and expectations for treatment, addressing the family system in treatment, and improving the family’s coping and functioning. Lindsey et al. (2014) cited psychoeducation about the nature of services and assessment measures utilization as additional ways to engage families more fully. Both authors call for continued examination of attitudinal factors that may inform engagement interventions in order to move beyond attendance data and to increase intervention efficacy. Specific to families in poverty, Lakind & Atkins (2018) call for the employment of an ecological framework to increase ongoing caregiver engagement in
child mental health services, citing many of the factors discussed in this review as key parts of that framework. Services should be delivered in community settings such as homes or schools, led by or be supported by community partners and practitioners through relationships built on respect and empowerment, offered through multiple formats to address families’ needs and preferences, be aligned with the goals and values of the family and the community, and be tailored to individual families’ needs and contextual demands (Lakind & Atkins, 2018). Services that draw on caregivers’ cultural strengths and resources and empowers caregivers to modify BPT strategies in a culturally sensitive way will likely not only improve caregiver-therapist alliance but, in turn, increase other facets of attitudinal and behavioral service engagement (Asnaani & Hoffman, 2012).

Upon completion of this review, it appears additional qualitative research with urban populations, who typically experience a higher number of logistical and attitudinal barriers (Bornheimer et al., 2018; Santiago et al., 2013a) is warranted to better understand the concept of ongoing Black caregivers’ ongoing engagement in BPTs with young children. Interventions aimed to increase attitudinal engagement (i.e., based on treatment location or format, caregiver-therapist alliance, cultural relevancy) of the caregivers of young children cannot effectively designed until the concept is more fully understood from the caregiver’s perspective.
CHAPTER 3: METHOD

Consensual Qualitative Research

In an effort to better understand the experience and engagement of Black caregivers participating in a home-based BPT program, the present study employed the Consensual Qualitative Research method (CQR; Hill, 2012; Hill & Knox, 2021; Hill et al., 2005; Hill et al., 1997). Grounded in a constructivist paradigm, CQR is useful in studies that aim to gain understanding of participant experiences, attitudes, and beliefs (Hill & Knox, 2021). The method recognizes the individual experiences of each participant while simultaneously exploring common aspects of the experience across participants (Hill & Knox, 2021; Hill et al., 1997). At the same time, CQR also reflects post-positivist elements, using semi-structured participant interviews, consensus among research team members, and a clearly outlined procedure for data analysis (Hill & Knox, 2021; Hill et al., 1997). CQR aims to not only have researchers learn about the topic at hand from participant interviews, but also to help participants explore and understand their own experience on a deeper level (Hill & Knox, 2021). To this end, individual participant quotations are directly woven into study results to allow for rich understanding while staying as close as possible to participants’ own words (Hill & Knox, 2021).

CQR was chosen for this study because the method is particularly suited for investigating topics not previously well-explored in the literature (Hill et al., 1997), such as caregiver engagement in their young child’s mental health care. CQR was also selected as it aims to understand participant’s attitudes, beliefs, and experiences at a deep level (Hill & Knox, 2021), allowing participants’ cognitive preparation and attitudes about
therapy to be explored. CQR was also appropriate because it recognizes how crucial context is to experience, using context to fully understand each case and to make comparisons across all cases (Hill, 2012; Hill & Knox, 2021; Hill et al., 1997). The method recognizes there is no one “true” experience that researchers are trying to understand but rather CQR allows researchers to use participant data to construct an understanding of these participants’ perceptions of their experience with a specific context at a particular time (Hill & Knox, 2021). This is important as the research team acknowledges while there may be commonalities between Black caregivers engaging in this type of therapy, there is not one universal experience among all participants. Finally, CQR is appropriate for use in underserved populations due to the collaborative relationship between participant and researcher (Hill et al., 1997); this aspect of the method enables it to inform both research and clinical practice, which was an aim of this study.

Participants

Black Caregivers

Black caregivers who completed the home-based EP treatment program with their young child within six months of interview participation were the focus of this study. Recruitment yielded 12 participants. All participants self-identified as Black or African American. Caregivers included nine biological mothers, one adoptive mother, and two kinship caregivers (one maternal grandmother and one maternal aunt, both of whom had obtained legal guardianship of the child). Participants ranged in age from 24-52 years ($M = 33.67, SD = 9.44$) at the time of the interview.
This clinic defines the completion of treatment as 1) the caregiver has attended the intake evaluation and at least five treatment sessions, and 2) a minimum of two behavioral management strategies or trauma interventions have been covered during treatment (Love & Fox, 2019). All participants met this definition of treatment completion through attendance data and therapist report. Participants completed their child’s intake evaluation over the course of 2-5 intake sessions ($M = 2.58, SD = 1.0$).

Treatment sessions attended by the caregiver and child varied significantly among participants based on presenting concern (e.g., trauma exposure) and contextual factors (e.g., Covid-19 pandemic; range 5-86 treatment sessions, $M = 20.25, SD = 21.71$, Mode = 10.00, Median = 12.00), with one participant engaging in services for almost two calendar years (i.e., far longer than is typical for this type of treatment program).

Similarly, the total number of sessions attended by participants also varied significantly (range 7-90 total sessions, $M = 22.92, SD =22.26$, Mode = 12, Median = 14.50).

Of note, two participants had met the definition for treatment completion but had not yet terminated services at the time of the research interview. Of the 10 participants who had terminated services, all were reported to have successfully completed treatment by their clinicians and all self-reported they would describe the treatment episode as successful. Eight participants terminated services because treatment goals had been met and two participants were referred to more appropriate services (e.g., autism services).

**Clinicians**

Four clinicians and one student clinician provided EP services to the participants of this study. All five clinicians self-identified as White. Two clinicians held the licensure of Licensed Professional Counselor (LPC) while two held a Professional-Counselor-in-
Training License (LPC-IT) at the time of service delivery. The student clinician was completing her internship placement at the clinic in fulfillment of program requirements for a master’s degree in Clinical Mental Health Counseling at a local private university. Clinicians ranged in age from 25-31 years ($M = 27.20$, $SD = 3.03$) and had between 6 and 88 months experience ($M = 44.20$, $SD = 35.71$) delivering the in-home EP treatment model to Black caregivers at the time of study onset.

**Research Team**

The primary investigator (PI; author) and interviewer for this study was a 48-year-old White female in her fourth year of doctoral studies in an APA-accredited counseling psychology graduate program. She has extensive experience working with children and families in a variety of roles, including delivering home-based EP services in a diverse community while working as an LPC prior to beginning her doctoral studies. The research team included the interviewer, two additional advanced counseling psychology graduate students in the same program as the PI, and the auditor. All participant interviews, transcription, domainning, writing core ideas, and drafting an initial cross analysis were completed by the PI. Team members reviewed and edited domains and core ideas as well as contributed extensively to multiple revisions of the cross analysis.

Team members included a 36-year-old White female in her sixth year of doctoral work and a 27-year-old Black female in her second year of doctoral studies. The White female team member completed her master’s level internship delivering EP services at the clinic. The PI and White female team member had both previously been on at least one CQR research team. The Black female team member had previously been a team member on a study using a different qualitative methodology but the current study was
her first experience with CQR. As such, this team member was asked to read the seminal
CQR articles and books (i.e., Hill, 2012; Hill & Knox, 2021; Hill et al., 2005; Hill et al.,
1997) along with published examples of well-conducted CQR studies (e.g., Knox et al.,
2009). She was also provided both verbal instruction and written examples of each stage
of the data analysis by the PI. The auditor was a White male counseling psychology
professor and department chair with more than 25 years of experience conducting,
authoring, and publishing CQR studies; he also serves as the consulting psychologist at
the clinic.

**Biases**

Hill et. al. (1997) recommended research teams set aside time to discuss both their
expectations for the study (i.e., based on prior knowledge and literature review) and any
personal biases that could make it difficult to objectively collect and analyze the data.
This can help researchers increase their awareness of their biases so that study results can
be grounded in participant views, not the researchers’ bias (Hill & Knox, 2021). In
addition to this initial meeting, ongoing discussions around researcher bias should take
place throughout the study as researchers attempt to bracket their biases and stay close to
participant data; researchers will hold each other accountable in situations where it
appears personal bias might be affecting objectivity (Hill & Knox, 2021). As both PI and
the White female researcher have experience with BPT training programs in this
population, and therefore potential biases, it was important to have numerous open team
discussions about bias and to include a third team member with no prior such experience.
Multiple perspectives and the arrival at consensus are necessary to analyze the data with
minimal bias (Hill & Knox, 2021).
The team met to discuss biases prior to beginning the data analysis. The team first discussed their general thoughts on caregiver engagement. The PI explained how this study’s research question was born from her professional experience of working with some caregivers who either would be very involved during therapy sessions but not use therapy strategies outside of session or would not be very involved during the sessions themselves yet not want to terminate services. The White female researcher she had had similar experiences on internship and admitted she wondered if many clients were engaged both within- and between- sessions. The Black female researcher stated she believed engagement had a motivational component, namely, how motivated the caregiver was to be a part of their child’s treatment, both during the session and using recommended interventions on their own. The team agreed, similar to the research presented in Chapter 2, that engagement has both attitudinal (e.g., motivation) and behavioral (e.g., putting in “the work” of using the strategies) components.

The team then moved on to discussing bias regarding caregivers who are engaged or not engaged in their child’s mental health care. Both the PI and White researcher discussed feeling frustrated as a clinician when caregivers would appear unengaged (e.g., on phone, not practicing strategies with therapist) during session, and wondering what they as the clinician could or should have been doing differently. Both team members admitted it was difficult at times not to view caregivers as “not caring enough” or feel like caregivers wanted the therapist to “fix” the child. The Black researcher offered the perspective that, never having done this work, she expected caregivers whose child’s behaviors were less severe would be more engaged during session as they may have more energy or emotional resources to engage in efforts to change the child’s behaviors.
Alternately, caregivers whose child has a lot of severe behaviors may feel overwhelmed or depressed by their child’s behaviors and may, in turn, view therapy as a much-needed break in which the therapist could work on the child’s concerns. The team discussed this perspective, which led to a discussion of ways the clinic could discuss the caregiver’s expectations for therapy, motivation and capacity for change given external barriers, and balance caregiver needs and participation expectations throughout the therapeutic relationship.

Finally, the team discussed their biases and expectations for participants’ answers to the protocol questions related to therapeutic alliance, cultural understanding, and treatment relevance. The PI shared that these questions were asked because of the discomfort she felt when delivering this in-home treatment protocol to Black families, wondering what the caregivers thought of a White woman coming into their home and telling them how to parent their children differently. The White researcher expected that participants would discuss cultural mistrust in opening up to the therapist as well as questioning the therapist’s legitimacy to make parenting recommendations without understanding the caregiver’s experience. Both the PI and White researcher discussed sometimes feeling, while delivering strategies in clients’ homes, that some strategies were not culturally relevant to Black families living in poverty, despite EP being designed for use in this population. Both team members expected participants to discuss the cultural relevance of strategies in response to the protocol question regarding the usefulness of treatment. The Black researcher reported she expected participants would likely feel the need to mask when answering these protocol questions given that the researcher is White. This team member shared she expected participants might not feel
safe answering the questions about alliance, cultural understanding, or cultural relevance with a White researcher due to fear of judgement, particularly around parenting strategies or parenting values. The PI acknowledged this had likely happened with at least some of the participants.

**Measures**

*Informed Consent*

Participants were sent informed consent paperwork via email or postal service (based on participant preference) prior to the interview. As outlined in the ethical standards, this document contained information related to the study’s purpose, potential risks and benefits of participation, limits of confidentiality, researchers’ contact information, and the right of the participant to decline participation or to withdraw at any time during the research (APA, 2017, Section 8.02). Participants were asked to review this information prior to the interview appointment. At the start of the interview, all informed consent information was verbally reviewed with the participant to ensure a clear understanding of the study and what their participation entailed. Participant questions were answered and verbal consent was obtained prior to starting the interview. One participant did electronically sign and return the consent form to the researcher prior to the interview date; verbal review was still completed and verbal consent obtained with this participant at the beginning of the interview. See Appendix A for informed consent document.

*Demographic Form*

Prior to scheduling their interview, all participants completed a short demographic form (see Appendix B) via phone with the PI. This form collected the participant’s name,
contact information (i.e., phone number and email address), mailing address (i.e., for
delivery of gift card), age, gender, race/ethnicity, and relationship to the child(ren) who
received EP services. Additionally, the form asked whether or not the caregiver viewed
the treatment as successful. This question was included as an initial gauge of treatment
satisfaction as it could have provided potential insight into some data, such as alliance,
cultural understanding, or outcomes. As two participants completed the interview prior to
fully terminating services, there was not participant data for this question from all twelve
study participants.

Upon verbal completion of the form with the participant, the PI added the
following information taken from the clinic database: number of intake and treatment
sessions attended by the participant; the total number of treatment sessions scheduled;
therapist on the case; therapist’s race/ethnicity; therapist’s view of whether treatment was
successful; and whether or not a student clinician was also on the case. If a student was
present for all treatment sessions, the student’s race/ethnicity will also be added to the
demographic form. The total number of sessions scheduled was originally collected to
compare sessions attended vs sessions scheduled. As this variable is collected from the
therapist’s discharge report at the time of termination, there was not data available from
all twelve participants for this question on the demographic form.

*Interview Protocol*

The complete interview protocol appears in Appendix C. The protocol consists of
three main sections: opening questions, targeted topics, and closing questions. In the
opening section, the goal was to build rapport with the participant by broadly discussing
the general research topic (Hill & Knox, 2021). For example, asking participants to
explain why they first sought treatment for their child was meant to orient them to remembering their experience with the therapy. Other opening questions aimed at gauging the participant’s cognitive preparation for treatment (e.g., What did you think therapy would look like? What did you think the therapist was going to do in the sessions?) and attitudes about therapy (e.g., How did you feel about participating in therapy with your child?) were also included.

The second section contained more specific questions aimed to gather targeted data about participants’ experiences and their attitudes and beliefs about those experiences (Hill & Knox, 2021). Targeted topics in the protocol include engagement within treatment sessions (e.g., What did the therapist do to help involve you in your child’s therapy?), factors influencing the caregiver-therapist alliance (e.g., What did the therapist do to create a positive relationship with you?), influence of cultural factors on alliance and participation (e.g., What, if anything, did the therapist not understand about your experience as a Black mother/grandmother?), adherence between sessions (e.g., What helped you use the strategies between sessions) and overall relevance (e.g., How, if at all, was your child’s therapy useful in your daily life?).

The closing section allowed participants to reflect on their answers and make suggestions, as well as debrief about the experience of the research interview itself (Hill & Knox, 2021). Participants had the opportunity to offer feedback to the clinic to better inform engagement interventions (e.g., What suggestions do you have for how the clinic can better involve Black caregivers during treatment?).
Data Collection Procedures

Piloting the Protocol

The interview was piloted with two EP clinicians. The decision to use clinicians as pilot interviewees rather than former clients who met inclusion criteria was made as to not preemptively exclude two potential participants from a small recruitment pool. The first pilot was conducted with a 30-year old White female LPC who had 88 months experience delivering in-home EP treatment to Black caregivers; this clinician was also one of the five clinicians who delivered services to actual study participants. This clinician answered all questions except Questions 9 and 10 (i.e., questions about perceived cultural understanding) based on her clinical experience with this participant population. The second pilot interview was conducted with a 25-year-old Black female Licensed Marriage and Family Therapist-in-Training (LMFT-IT) who had been hired by the clinic one month prior to study recruitment. The Black female clinician also had two young children similar in age (i.e., under the age of 6 years) to study participants and was being trained in EP at the time of the pilot interview. This clinician answered all study interview questions based on her personal experiences and training in EP.

Both clinicians provided positive feedback on word choice, question clarity, and overall interview flow. No changes were made to the interview protocol based on these pilot interviews. However, conducting these pilot interviews provided the PI with a valuable opportunity to gain experience moving through the interview protocol before beginning data collection with actual participants. It also allowed the PI to provide study participants with an accurate estimate of the study interview length (i.e., one 45-60
minute phone interview), which allowed study participants to make an informed choice about their ability to voluntarily participate in this study.

**Recruitment and Contacting the Participants**

Recruitment took place via convenience sampling, as an aim of this study was to provide information for improving the ongoing engagement of Black caregivers in treatment at this clinic. Clinicians were asked to recommend caregivers for this study and either verbally described the study or delivered an informational letter (Appendix D) containing study details to interested caregivers upon completion of treatment, using the clinic’s established research definition as described above. Clinicians emphasized study participation was completely voluntary and a caregiver’s choice to participate or not would have no effect on their remaining treatment (if not yet terminated) or any future services with the same or another child. Clinicians communicated initial interest to the PI and caregiver contact information was provided by the therapist or obtained from the clinic database for the purpose of study recruitment only. This method yielded eight participants over an eight month time period.

Simultaneously, the PI created a recruitment database subset of the existing clinic database for the purpose of recruiting participants who terminated services in the six months prior to study onset, using session attendance data and termination data as search variables. When cross-referenced with caregiver ethnicity, this provided an additional 12 caregivers who were recruited for potential participation, initially through a phone call from the PI. Potential participants who were not reached by phone were emailed or mailed the informational study letter, depending on the available contact information. This method of study recruitment yielded four additional participants. One additional
participant completed the demographic form and scheduled an interview but could not be reached at the scheduled appointment time or in a follow-up attempt to reschedule the interview, yielding a total of 12 study participants. Participants were offered a $25.00 store gift card for completion of the study, as the clinic has demonstrated success recruiting study participants using similar incentives in the past. Completion of the study is defined as completion of the demographic form, scheduling an interview, verbal consent after reviewing informed consent documentation, and participation in a 45- to 60-minute audiotaped interview.

When caregivers communicated initial interest in participating, the PI explained the purpose and procedures of the study in more detail, discussed informed consent (e.g., risks and benefits of participation, confidentiality, data handling) and completed the demographic form with participants over the phone. The interview date and time was also scheduled in the same phone call. All participants elected to have the PI contact them via text message the day before the scheduled interview to remind them of the appointment. Informed consent documents and the interview protocol were emailed to the participant prior to the interview so the participant had the chance to review both documents before the actual interview appointment.

**Interviews**

Interviews were conducted over the phone by the PI. All interviews were recorded on a hand-held digital audio recording device to allow for exact transcription of the data. The standardized interview protocol was used with all participants; however, the interviewer used probing questions to clarify individual responses as needed. Of note, it became clear after the first three interviews that participants found Questions 9 and 10
(i.e., What if anything was the therapist able to/not able to understand about your experience as a Black caregiver) challenging to answer. Additionally, the planned probing questions for these two interview questions related to the effects on participants’ engagement were confusing and somewhat frustrating for participants to answer. As such, these planned probes were abandoned after consultation with the study auditor. Based on participant response style and individualized use of probing questions, interviews lasted approximately 30-70 minutes. A thank you letter (see Appendix E) and the store gift card were mailed to the mailing address provided by the participant within 24 hours of the completed interview.

As recommended by Hill and Knox (2021), the PI took notes during the interview (e.g., noted probes used, recorded short versions of participant answers) as a safeguard in case portions of the recordings are difficult to decipher during transcription. 10 out of 12 participants were caring for their small children during the research interview, so these notes proved helpful during the transcription process when transcription was challenging due to background noise.

**Transcription**

All interviews were transcribed verbatim from the digital recordings by the PI, minus minimal encouragers or other utterances. All potentially identifying information (e.g., child’s first name, therapist name) was also excluded from the transcription. All transcripts were assigned a participant code number; only the PI had access to the key to these code numbers. Given the amount of background noise, all transcriptions were checked against the audio recording for accuracy at least once by the PI. Sections of recordings with a lot of background noise (e.g., loud crying) were reviewed multiple
times; despite this review, short sections (e.g., a few words, a clause of a sentence) of participant data remained indecipherable in multiple transcripts.

**Data Analysis Procedures**

Reflecting CQR’s constructivist stance, participants’ own words served as the raw data for this study. As described above, CQR collects this raw data through the use of open-ended questions within a semi-structured interview protocol to examine the individual experience of each participant while also exploring commonalities of the experience across participants (Hill & Knox, 2021; Hill et al., 2005). In addition to the semi-structured protocol, CQR contains other post-positive elements, including a clear procedure for data analysis (i.e., domaining, developing core ideas, cross analysis), the use of a research team that works together at all stages of the data analysis to ensure multiple perspectives, required consensus among all team members about the meaning of the data, and the use of an external auditor to examine the team’s work and provide feedback at multiple stages during the analysis (Hill & Knox, 2021; Hill et al., 2005; Hill et al., 1997).

**Consensus**

Consensus is a cardinal feature of CQR. The consensus process involves first having research team members examine the data independently before meeting to discuss and decide on the best representation and interpretation of the data (Hill & Knox, 2021). Working in a team of researchers allows multiple viewpoints to be heard and considered when analyzing the data; the consensus process allows for open discussion of these viewpoints. The research team reached consensus on all analytic decisions, which included the assignment of data into domains, writing core ideas, reviewing the cross-
analysis, and responding to auditor feedback (Hill & Knox, 2021). In times when consensus was not easily reached, the team referred back to the transcripts and audio recordings to assist in resolving disagreements (Hill et al., 2005).

**Domaining the Transcripts**

Domains are topic areas into which all data are initially coded and as such, serve as an organizational tool during the analysis (Hill & Knox, 2021). As the first few transcripts are reviewed, domains can be expected to organically emerge. During the initial team meeting, team members generated a list of potential domain names based on the interview protocol. As the research team worked through the first four transcripts, this domain list was repeatedly modified (i.e., domains renamed, more specific clarification on what each domain included) through consensus. At this point, the team had a good working knowledge of the domains, initial consensus on domain names had been reached, and no new domains appeared to emerge (Hill & Knox, 2021).

Transcripts were domained individually by team members and then reviewed for consensus by the team during weekly meetings. All data (i.e., phrases, sentences, or paragraphs that pertain to the same topic) from each transcript was coded into one or more domains. Ideally, data would be coded into multiple domains only occasionally (Hill & Knox, 2021). Due to the brevity of some participant responses, each transcript did contain sections of data that were coded in multiple domains.

Data viewed as related to the study’s research questions but not appearing to immediately fit into a specific domain were temporarily coded into a domain labeled “Other”. After all transcripts were domained, this domain was examined to see if a new domain(s) would emerge from this data (Hill & Knox, 2021). No such new domains
emerged. Similarly, the team agreed to disregard some small portions of transcripts (e.g., greetings, participant talking to child in background) as they did not directly relate to the research questions (Hill & Knox, 2021). The team reviewed all transcripts and agreed on the domain names and placement of data within each domain for each transcript.

**Developing the Core Ideas**

Core ideas succinctly capture the essence of the data within domains while remaining close to the participants’ actual words (Hill & Knox, 2021; Hill et al., 1997). This is accomplished by reading all raw data within each domain and then summarizing the data into main ideas, while keeping the context of each case and the focus of each domain in mind (Hill & Knox, 2021; Hill et al., 1997). Core ideas, therefore, reflect the essential aspects of the raw data (Hill & Knox, 2021). The PI wrote core ideas for each transcript and sent the core ideas to the research team for review. In the instances where data were coded in multiple domains, distinct core ideas were written to ensure relevance in each domain. The research team met and team members provided the following feedback on the core ideas: whether or not each core idea fit into the domain; word choice or grammatical changes; and addition of core ideas based on review of the raw data. After consensus on all core ideas in a transcript was reached, a consensus version containing the domains, core ideas, and raw data was created and sent to the auditor for review. This process was repeated until a consensus version was created for all transcripts.

**Cross Analysis**

At this stage of the analysis, the research team begins to look across all cases for the purpose of identifying similarities among the individual cases (Hill & Knox, 2021).
The PI first created a master document containing all core ideas within each domain. Participant code numbers were included on this master document in case the raw data needed to be reviewed. The PI took responsibility for initially examining the core ideas within each domain and grouping those core ideas into categories (and in some cases, subcategories; Hill & Knox, 2021; Hill et al., 1997). Similar to the process of domaining, an “Other” category was used within each domain to capture core ideas that might not fit into a category across cases. Starting with the smaller domains, the PI sent the initial cross analysis for each domain to team members. The team met and provided feedback regarding the overall structure of categories and subcategories, goodness of fit of the cores within those categories and subcategories, and suggested title changes (Hill & Knox, 2021). Categories and subcategories were modified until all core ideas had been assigned to one or more categories via consensus. At times, the team referred back to transcripts during this process to ensure categories accurately described the data (Hill & Knox, 2021). The team also worked to ensure no new categories emerged from core ideas assigned to the “Other” category in each domain.

**Frequencies**

Once all core ideas had been placed in categories, each category was assigned a frequency label designed to describe its representativeness to all cases from the sample. Per Hill et al. (2005), the label *general* was assigned to categories that apply to all but one or all of the cases (i.e., 11-12 cases). The label *typical* was assigned to categories that apply to more than half through all but two of the cases (i.e., 7-10 cases) The label *variant* was assigned to categories that apply to half or fewer but at least two of the cases
(i.e., 2-6 cases). Once frequencies had been assigned, the PI sent each cross analysis to
the auditor for review.

**Auditing**

Auditing is an iterative feedback process between the auditor and the research
team designed to provide the team with an external perspective on the data and its
analysis (Hill & Knox, 2021). As described, auditing took place at two stages during the
data analysis of this study: review of the consensus version containing the core ideas; and
review of the cross-analysis. First, the auditor will reviewed consensus version of all
cases and provide feedback to the team on the core ideas. Similar to team members, the
auditor read the raw data and provided feedback related to placement in each domain,
representation in its core ideas, and relevance of the core ideas written for each domain.
He also provided feedback related to missing cores or other improvements of the
analysis. The PI sent the auditor’s feedback for each consensus version to the team for
review. Members individually considered auditor feedback and then met to discuss the
acceptance or rejection of each piece of feedback. Revisions to core ideas were made
based on team consensus, and no consensus versions needed to be sent back to the auditor
for additional review during the course of this study.

During the cross-analysis, the auditor reviewed and provided feedback on the
cross analysis of each domain as it is finished, as outlined in Hill and Knox, 2021. The PI
again shared auditor feedback with the team, who reviewed feedback individually and
then met to revise categories and subcategories through consensus. While some domains
were only reviewed by the auditor once, an iterative feedback process of auditor review
and team revision took place for three domains until consensus between the team and auditor was reached.

When all domains had been cross analyzed, the final version was sent back to the auditor, who checked category labels, assessed the refinement and succinctness of the overall analysis (Hill & Knox, 2021), and provided feedback to the team that a final consensus had been reached between the research team and the auditor.

Though CQR methodology can involve presenting the results to the participants and soliciting feedback to ensure results generally capture participants’ experiences in an accurate way (Hill et al., 1997; Hill et al., 2005), the PI did not send the results to the participants in this study. This choice was made for several reasons. First, there were concerns about having accurate contact information as some participants were interviewed more than a calendar year before study results were ready for distribution. For example, contact was lost with at least one participant, as the incentive gift card was returned as undeliverable by mail and the participant could not be reached by phone to provide an alternate mailing address. Clinic families often change addresses and phone numbers during treatment and do not have consistent access to email. Second, results were not sent to participants out of consideration for the participants’ time. Almost all participants were caring for their young children during the interview itself, and almost all participants made verbal references to the difficulty in splitting their attention between their child and the interviewer. The PI recognized the potential added burden of asking participants to allocate time to the study beyond their initial interview commitment.

The results of the data analysis are presented in Chapter 4.
CHAPTER 4: RESULTS

The results of this study are presented in three major sections. The contextual findings regarding participants’ cognitive preparation for treatment (i.e., reasons for seeking therapy, expectations for treatment), attitudinal factors (i.e., feelings about starting therapy, hesitations about participating), and participants’ description of their session participation are presented first. These findings provide background information about how participants first prepared for and participated in treatment, and offer some context for in-therapy factors that influence ongoing treatment engagement. Hence, the second section contains findings related to therapist engagement strategies, participants’ own influences on engagement, the therapeutic alliance, and cultural understanding between the therapist and participant. The third section contains findings on treatment adherence (i.e., between-session and post-treatment strategy use), treatment outcomes, and suggestions for better engaging Black caregivers in treatment at the Behavior Clinic. Using the frequency criteria developed by Hill and Knox et al. (2005), categories were labeled general if they applied to all or all but one case (i.e., 11-12 cases), typical if they applied to more than half of all cases (i.e., 7-10 cases), and variant if they applied to two to half of the cases (i.e., 2-6 cases). Themes that emerged in only one case were placed in an “Other” category in that domain and are not discussed in these results.

Contextual Findings

The initial interview questions yielded five contextual domains. Participants were first asked to reflect on cognitive (i.e., reasons for therapy, expectations) and attitudinal factors (e.g., feelings, hesitations) present prior to treatment. Together with participants’
description of their session participation, these responses provided the context for participants to discuss therapeutic influences on their ongoing engagement in treatment.

These findings are presented in Table 1.

Table 1

Domains, Categories, and Frequencies of Contextual Findings regarding Cognitive Preparation, Attitudinal Factors, and Treatment Participation

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for seeking therapy for child</td>
<td>Child exhibited emotional or behavioral concerns</td>
<td>General (12)</td>
</tr>
<tr>
<td></td>
<td>Exhibited externalizing behaviors</td>
<td>General (12)</td>
</tr>
<tr>
<td></td>
<td>Exhibited internalizing behaviors/symptoms</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>Engaged in self-harming behaviors</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>P noted other concerns for child</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>P felt unable to manage child’s behaviors</td>
<td>General (12)</td>
</tr>
<tr>
<td></td>
<td>Wanted to learn effective parenting strategies</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Pre-therapy attempts were unsuccessful</td>
<td>Variant (6)</td>
</tr>
<tr>
<td></td>
<td>Experienced emotional distress</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Wanted to understand behavior or symptoms</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Other caregivers struggled to manage child’s behaviors</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Outside agency recommended therapy</td>
<td>Variant (5)</td>
</tr>
<tr>
<td>Feelings about starting therapy</td>
<td>Felt a need for help with child’s concerns</td>
<td>Typical (7)</td>
</tr>
<tr>
<td></td>
<td>Felt apprehensive about starting therapy</td>
<td>Typical (7)</td>
</tr>
<tr>
<td></td>
<td>Felt hopeful about outcome</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>Felt prepared due to prior personal psychotherapy experience</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Expectations for therapy</td>
<td>Anticipated learning behavior management strategies</td>
<td>Typical (8)</td>
</tr>
<tr>
<td></td>
<td>Thought therapist would work more directly with child than with P</td>
<td>Typical (8)</td>
</tr>
<tr>
<td></td>
<td>Thought therapy may be similar to Birth-to-Three services</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Was unsure what therapy would be like</td>
<td>Variant (5)</td>
</tr>
<tr>
<td>Hesitations about participating</td>
<td>Wondered if therapy would be effective</td>
<td>Typical (7)</td>
</tr>
<tr>
<td></td>
<td>Wondered if program was right match</td>
<td>Variant (6)</td>
</tr>
<tr>
<td></td>
<td>Wondered if strategies would work with child</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Reported no hesitation</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>Experienced mistrust toward therapist</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Felt apprehensive about aspects of therapy</td>
<td>Variant (3)</td>
</tr>
<tr>
<td>Caregiver participation</td>
<td>Learned behavior management strategies</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Practiced behavior management strategies</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Observed therapist interact with child</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Played or participated in activities with child</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Consulted with therapist about child’s concerns</td>
<td>Typical (6)</td>
</tr>
</tbody>
</table>
Learned and practiced coping strategies

* 12 total cases. General = 11-12, Typical = 7-10, Variant = 2-6.

**Reasons for Seeking Therapy for Child**

When participants were asked why they initially sought treatment for their child, two general and two variant categories emerged. Generally, participants reported observing emotional or behavior concerns in their child. Among these emotional or behavioral concerns, one general and three variant subcategories emerged. Participants generally reported their child was exhibiting externalizing behaviors, such as aggressive temper tantrums (e.g., hitting, kicking, screaming, throwing things), destruction of property, and oppositional behaviors. One participant described her child as having “a very bad temper problem” where:

He’ll get to throwing stuff, like furniture, clothes, it doesn’t matter what it is, he’ll throw it. Or if he’ll be outside, I’ll tell you one time [child’s name] got real mad at somebody and he was running around the yard just throwing bikes everywhere. Or he’ll get mad, like when he gets mad at his siblings, he’ll try to fight them.

Variantly, participants reported their child was exhibiting internalizing symptoms or behaviors, such as separation anxiety or withdrawal from others. One participant noted her child “has an attachment touching thing or issue where he has to touch you somehow someway.” Participants also variantly reported their child engaged in self-harming behaviors, such as head-banging or unsafe behaviors. One participant described concern that her two-year-old twins routinely engaged in “daredevil” behaviors such as climbing up and jumping off furniture in the home. Participants also variantly reported having other developmental concerns for their child, such as trauma exposure or speech and language delays. One participant explained “Not being able to speak when it was time for
her to begin forming words, that brought on another form of aggression. So, it just made a lot of stuff very hard.”

In the second general category, participants reported they sought treatment because they felt unable to manage their child’s concerns on their own. One typical and three variant subcategories emerged in this category. Participants typically reported they wanted to learn effective parenting strategies. For instance, one participant stated she wanted to learn “what is another way to help a behaving child instead of always putting them on time out or punishing them?” Variantly, participants noted their pre-therapy attempts to manage the behaviors and symptoms were unsuccessful. One participated stated she was “running out of ideas” because parenting strategies that had “worked” with her other children were not working with this child. Participants also variantly reported experiencing emotional distress related to their child’s behavior. After stating “when they get too hyper or something, it kinda make me feel down. Not angry, it just makes me feel like, what am I doing wrong?” a participant further explained her own depression and anxiety sometimes makes dealing with her children’s behaviors “very emotional for me.” Finally, participants variantly reported wanting to understand their child’s behavior or symptoms. One participant stated she sought therapy because:

I was looking for ways, to find ways to help her cope with whatever was going on with her that I didn’t understand, or that I didn’t know how to address. So that she, I didn’t want for her to suffer or to be in suffering because there was a barrier.

In a variant category, participants reported seeking therapy because other caregivers in the child’s life were also struggling to manage the child’s behaviors, including other family members, daycare providers, and teachers. To illustrate, one
participant shared she had tried three separate environments in which teachers could not manage her son’s behaviors:

So I thought, first I thought maybe, I was like maybe it’s the environment, maybe it’s the teachers at this childcare, that they just can’t deal with his behaviors so then I found him a new childcare. And this was while I was on the waiting list still for therapy, so I found him a new childcare and he was displaying the same exact behaviors with different teachers, different kids, same behaviors. So he started PreK. I thought, okay, maybe if he starts an actual school with more structure, maybe that can help him while I was still on the waiting list for Penfield to reach out. He started PreK last fall, and after ten days they told me he couldn’t come back.

In the second variant category, participants reported seeking therapy because an outside agency, such as the child’s pediatrician, school, or daycare had recommended that the child receive therapy to address behavioral or emotional concerns. One participant described the encouragement of her child’s pediatrician to seek therapy as important because “that was his doctor and someone I trusted.”

Feelings About Starting Therapy

When asked how they felt about starting therapy to with their young child, two typical and two variant categories emerged. Typically, participants reported feeling a need for outside help with their child’s concerns as their own methods of managing their child’s concerns were not effective. One participant stated “before it started, I was looking for everything and anything to help me. I needed the help.” At the same time, participants typically reported feeling apprehensive about starting this therapy as the therapist, the treatment program, and how their child would respond to treatment were unknown to them. One participant described how she was unsure about letting the therapist into her home:

I was a little scared, you know, I was a little scared even though I didn’t want to be scared, but you know, to try to open up to someone new coming into the home,
cause you don’t know really if someone is trying to help you or if they’re against you. I was a little, I kind of had my guard up a little bit with [therapist name].

Participants variently reported feeling hopeful about the outcome of therapy, namely that therapy would help reduce their child’s challenging behaviors or symptoms. For example, one participant reported “I felt like it would possibly help him with those behaviors so I was pretty interested and I was looking forward to the information that I would get and that he would get out of it.” Similarly, participants also variently reported feeling prepared to start therapy due to a prior personal psychotherapy experience for themselves or with a different child. One participant shared “I was in therapy myself before, and I know, like it helps you if you’re willing to let it help. If you actually does what you supposed to be doing, it will help.”

**Expectations for Therapy**

Two interview questions asked participants to reflect on their expectations for therapy (i.e., what they anticipated the therapist would do during sessions, what participants thought their own role in the therapy might look like). Two typical and two variant categories emerged. Typically, participants reported they anticipated learning behavior management strategies during the therapy, either through direct instruction from the therapist or by observing the therapist interact with the child. When prompted to described what information she thought she would learn, one participant said, “Strategies that I could possibly use to decrease the behaviors that he was having and then also like strategies that they could give to him to be able use in replace of the behaviors.” At the same time, participants also typically reported they had an expectation the therapist would work more directly with the child to address the child’s concerns rather than working directly with the participant to change their responses to the child’s behaviors.
One participant envisioned the therapist “being able to be with the kids one-on-one without the parent” and later openly shared:

“Before, I thought it was specifically teaching the kids how to do better, like helping the kids. But then I found out it was for us parents to do it with the kids. And okay, if that was the case I could have just YouTubed it and done it myself. Like I got a therapist for my kids because my kids need it, not me”.

In a variant category, participants reported thinking this therapy might be similar to the Birth-to-Three services they had previously participated in with the same child or with another one of their children. When asked what she thought the therapist might do during sessions, one participant responded, “I was kinda familiar with what she was going to do, cause my other toddler was in Birth-to-Three, so I kinda was familiar in how they was gonna work with them.”

In the second variant category, participants reported being unsure of what this therapy would be like as they had no previous psychotherapy experience or no experience in therapy of this type. One participant described having no frame of reference as to what sessions might look like:

I had no idea! (Laughs), I watched so many movies and so many reality shows. It’s like each therapy session that they have on those shows or movies, they be different. I just wanted to make sure, because I’m a go-with-the-flow type of person until you show me otherwise. So, I really didn’t have no, I don’t know the word, I didn’t have no expectations. I just wanted to see what it would be like and just go from there.

**Hesitations About Participating**

When asked to describe any hesitations they had about participating in this therapy with their child, one typical and three variant categories emerged. Typically, participants reported being hesitant to engage because they wondered if the therapy would be effective. Two variant subcategories emerged within this category. First,
participants described wondering if the program was the right match for their child’s concerns. To illustrate, one participant reported skepticism about different aspects of the treatment program:

So I was kind of scared, and thinking like what could happen? What kind of program is this? And you know, just skeptical...well, as I’m meaning skeptical, like cause it’s always a lot of rumors about programs and doctors and things like that so I was just, I didn’t know if they was coming to me or I have to bring my baby down to the clinic. You know, just skeptical of what type of program is it, like is it really just a clinic for kids with problems. You know, just curious and not sure of what I’m getting myself into.

Second, participants wondering whether the therapeutic interventions would work with their specific child. One participant stated her only hesitation about participating was that “it wasn’t going to take.”

In a variant category, participants reported experiencing mistrust toward the therapist, particularly during the intake process. To illustrate, one participant reported:

It was like you don’t know if she was there for you or if, you know, just trying to ask me sneaky questions that I don’t know, to like try to get my child tooken from me or something like that. I felt like that at one point in time. Cause some of the questions was asked that then I had to think, like, well there were just some questions that made me, you know, that her boss might be asking her to ask me. And maybe she is for us, and maybe she’s not against us, you know? Cause, I don’t know, when you are a parent, you know, and a person asks you a certain question you be like, hold on! Where did that come from? They was questions that make you look sideways.

In the second variant category, participants also variantly reported being apprehensive about specific aspects of the therapy. For example, one participated shared she felt “a little nervous” to learn more about her child’s diagnosis as well as the new ways she would need to interact with her child based on that diagnosis.

Of note, in the third variant category, participants reported not having any hesitations about participating in this therapy due to their own readiness for treatment or
the recommendation from a trusted professional. One participant explained “I didn’t really have any hesitations in participating because I was to the point where I was desperate for help so I was willing to try anything that I could to get my child the help that he needed.”

**Caregiver Participation in Session**

The last contextual question asked participants to describe the ways they participated in treatment sessions with their child and the therapist. Five typical and one variant category emerged in the data analysis. First, participants typically reported they learned behavior management strategies through direct verbal instruction from the therapist and written handouts. One participant described this process:

She’d have a written paper on what we’d be focusing on that day. Like say it’s, so one of the times it was introducing time out. So she would basically give me what to do and how to start time out.

Second, participants typically reported they also practiced the strategies in session with the therapist. As an example, one participant described redirecting her child away from challenging behaviors during session by asking “Do you want to play with your toys? Do you want the football or do you want the blocks?” Third, participants typically reported observing the therapist interact with the child, both to see how the therapist responded to the child’s behaviors and to see how their child responded to the therapist. One participant described explaining to the therapist her reasoning for wanting to observe in session:

Just watch and see how she’s [child] behaving with somebody different with me around, you know? And you [therapist] already know the things that are going on, so let me see if there’s something, that whatever you’re doing I can do when it’s just her and I.
In the fourth category, participants typically reported playing with toys or participating in therapeutic activities (e.g., drawing) with their child while the therapist observed the caregiver-child interaction. One participant described how during some sessions, the therapists “might wanna see how I play with the kids, how I interact with the girls, they wanna see that theirselves, how do I tell them to stop, how do I calm them down, things like that.” In the fifth typical category, participants reported spending time during the session consulting with the therapist about their child’s concerns, including the overall treatment plan, session goals, the child’s behaviors since last session, and about how previously introduced strategies were working between sessions. In addition to talking with the therapist at the beginning of the session, one participant described using a written “trauma tracking” sheet the therapist had provided after the participant reported to the therapist that behaviors were increasing after the participant and therapist discussed the behaviors in front of the child.

In the final category, participants variantly reported participating in session by learning and practicing coping strategies with their child, such as using feeling faces to describe and name emotions, using stress balls or other tools to help calm down, or learning emotional regulation techniques such as deep breathing or muscle relaxation. One participant described this process:

If they were to do like, like breathing games or the muscle one to calm down and the other thing, I can’t think of what the thing was called. Like the pop-its or stuff like that. So, I also did the same thing with them. The message was to calm down, and if I can do it you can do it too.

**Influences on Caregiver’s Ongoing Engagement**

This second section contains findings related to therapist engagement strategies, participants’ own influences on engagement, the therapeutic alliance, and the therapist’s
level of understanding of the caregiver’s cultural experience. After contextual questions, the participants were asked to reflect on in-therapeutic factors that influenced their ongoing engagement, namely the ways the therapist involved them in the therapy, how the therapist formed a positive working alliance with the caregiver, and the therapist’s level of cultural understanding of the caregiver’s experience. These questions yielded three domains. A final question in this section asked participants if there were any additional factors that may have influenced how or why they participated in treatment sessions with the therapist. Data analysis yielded one domain related to participant’s personal influences on their own participation. The findings for these four domains are presented in Table 2.

Table 2

Domains, Categories, and Frequencies of Therapy and Caregiver Influences on Caregiver Engagement, Alliance, and Cultural Understanding

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy Influences on Caregiver Engagement in Treatment</td>
<td>Therapist actively involved P in session</td>
<td>General (12)</td>
</tr>
<tr>
<td></td>
<td>Taught P how to use strategies</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Modeled strategy use for P</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Involved P in therapeutic activities and play</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Provided support to P</td>
<td>Typical (8)</td>
</tr>
<tr>
<td></td>
<td>Collaborated with P on interventions or goals</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Coached P through handling behaviors in session</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Therapist supported family with resources</td>
<td>General (11)</td>
</tr>
<tr>
<td></td>
<td>Provided items to facilitate strategy use</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Gave P instructional handouts</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>Brought activities or toys to use in session</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Provided outside resources or referrals</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Other helpful engagement strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Having two clinicians</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Therapist available to consult outside session</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Therapy was in-home</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Caregiver Influences on Caregiver Engagement in Treatment</td>
<td>P was motivated</td>
<td>General (11)</td>
</tr>
<tr>
<td></td>
<td>To improve child’s behavior</td>
<td>Typical (7)</td>
</tr>
<tr>
<td></td>
<td>By maternal drive to help child</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>To avoid stereotypes and generational trauma</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>By others’ encouragement to participate</td>
<td>Variant (2)</td>
</tr>
<tr>
<td></td>
<td>Had concerns about treatment</td>
<td>Typical (7)</td>
</tr>
</tbody>
</table>
Therapy Influences on Caregiver Engagement in Treatment

Data analysis yielded two general and one variant categories as findings for in-therapy influences on caregiver engagement. In the first general category, participants reported the therapist actively involved the participant in treatment sessions. Four typical and two variant subcategories emerged within this larger category. Typically, participants reported the therapist taught the participant behavior management strategies through verbal instruction and by using written handouts the participant could keep. When asked how the therapist involved her one participant replied, “She was explaining dos and don’ts with her [child] about behavior. And she give me some programs to help her, like some lessons, how to teach a child what behavior is. You know, she gave a lot of papers.”

In the second typical subcategory, participants reported therapists modeled strategy use
for the participant during session. To illustrate, a participant shared an example where the therapist not only modeled how to not “react” to the participant’s son when he had a temper tantrum in session, but modeled coping skills and redirecting as well: “She literally like got up and went over there and talked to him to calm him down and try to get him to like, instead of throwing it and picking it up, they were play-tossing it.” In the third typical subcategory, participants reported the therapist involved them in play and other therapeutic activities, such as emotional regulation strategies, reading books, and making schedules and charts to use with their children. One participant described how the therapist overtly invited the participant to engage throughout the session:

She was very friendly, so she tried to involve me in everything, and everything I was getting involved with. Like anything they was, she was doing with him it was like, “c’mon mom, let’s show him how to do this” and “let’s find another method we can work out about handling this situation.” So she, she kept me involved in everything.

In the fourth typical subcategory, participants reported the therapist engaged them by providing support to the caregiver about the child’s behaviors and strategy implementation since last session. When asked about how the therapist supported her, one participant described a weekly “check-in” where the therapist provided reassurance about the child’s behaviors as well as the caregiver’s responses to those behaviors: “Each week she would come and she would just ask me how it’s going with the strategies that she gave me. And I would explain to her, you know, it’s getting there but I’m still not there.”

In the first variant subcategory, participants reported they felt invited to participated when the therapist collaborated with the caregiver on treatment goals or
interventions. One participant shared how she and the therapist worked together to design an incentive system for her child:

So, initially I thought in therapy, the therapist runs the show. With this therapy session, and with this therapist, we basically piggy-backed off each other. So I brought forth the red-light, the stop light system, and then she said okay, since he likes to be rewarded, she brought in the tokens. Yeah! So we created a token system.

In the second variant subcategory, participants reported being actively engaged by the therapist when the therapist coached the caregiver through responding to challenging behaviors with a specific treatment strategies as behaviors occurred in session. When prompted to describe the coaching, one participated responded:

She [therapist] teach me how to like talk to her [child] instead of like telling her to get over here, don’t do that. She teach me how to talk to her when she responding like in a negative way…If I was saying it the wrong way, she’d just come up like, “[child’s name] no, no, no, you can’t play with this or this is not yours.”

In the second general category, participants reported the therapist engaged them in treatment by supporting their family with various resources. One typical and three variant subcategories emerged within this general category. Participants typically reported the therapist provided the caregiver and child with multiple items the family was able to keep and that these items facilitated strategy use. For example, one participant shared the therapist provided “potty charts” the caregiver could use during toilet training, a coping skills box filled with sensory items the child could use to calm down, and a “smell the flower, blow out the candle” card the caregiver was able to carry in her purse to help the child calm down through deep breathing when tantrums occurred in public. In a variant subcategory, participants reported the therapist provided instructional handouts that helped the caregiver implement the strategies on their own. One participant shared her
appreciation for these handouts, as she was able to hang them in her home and refer to them between sessions:

She always hand me papers. Her paper and mine was printed out, that’s what I loved about her so much. She was always two steps ahead, had my paper printed out for me. She’s like “this is mine, and I also got yours.” So cool! I loved that so much! And as we speak, I got ‘em hung around my house. So it’s play time, or it’s time out time. She gave me them, and I got ‘em pinned up around the house.

In the second variant subcategory, participants reported the therapist engaged them in session by bringing toys and activities the child and caregiver could use during the session. One participant remarked this was especially helpful because “they came with toys and stuff, blocks. Stuff I never knew he would like. So I learned a lot from them.” In the third variant subcategory, participants reported the therapist also provided the family with additional resources or outside referrals. One participant reported “the pouring on of resources” was helpful both during the therapy and after the treatment episode as the family was transitioning to more appropriate services.

In a variant category, participants identified other helpful engagement strategies related to aspects of the treatment program itself. Three variant subcategories emerged here. First, participants variably reported having two clinicians (i.e., one therapist and a student clinician) was helpful in allowing the caregiver space to engage one-on-one with the clinician. One participant explained she would talk or do paperwork with the therapist while the other clinician would play with the child, which provided the caregiver “a little break.” Second, participants variably reported the therapist was available outside of session time to help caregivers problem-solve responses to their child’s behavior. When asked if there was anything that was particularly helpful in encouraging her participation, one participant responded: “Being able to just have the freedom to call her and talk, if I
needed to ask questions or if I needed help looking for a resource, or asking for one on the days that we weren’t scheduled.” Third, participants variantly reported having sessions conducted in their home was helpful in encouraging them to engage in the treatment. One participant shared, “I didn’t have to go to the program, they came to me. I loved that!”

**Caregiver Influences on Caregiver Engagement in Treatment**

One interview question asked participants to identify any additional factors that influenced their session participation. This question was included as a “catch-all” question meant to organically capture external factors that influenced the caregiver’s engagement. However, data analysis yielded one general, one typical, and one variant category all relating to the caregivers themselves. Generally, participants reported that their own motivation was influential in their level of session participation. One typical and three variant subcategories emerged, each outlining a separate motivation participants experienced. In a typical subcategory, participants reported they were motivated to participate because they wanted the child’s behavior to improve. One participant, whose daughter was exhibiting behaviors after the child’s father died, described this motivation: “I only participated because I wanted to see what was bothering her about her dad passing away and what could I do to fix things. Or if I couldn’t fix it, at least try to maintain it.” In a variant subcategory, participants reported their motivation stemmed from a maternal drive to help their child. One participant stated she would “do anything to help my child” while another explained “whatever can make my babies better and make me a better mother for my babies, I’m for it.” In a second variant subcategory, participants reported they engaged in this therapy as a way to avoid
stereotypes (e.g., having people think “Black people act like that” when their children misbehave in public) and to prevent further generational trauma in their families. One participant shared:

A part of that is just me challenging my history. Doing things different than what my parents did, did with me. Don’t leave stuff quiet, aggressive stuff. So changing that what was to what really needs to be. There’s no need for a kid to grow up with all these issues when there’s something you can help fix. Or begin to change the cycle for them to be more healthier as they grow, or as they become an adult.

In the final variant subcategory, participants shared they were motivated to participate because others (e.g., doctors, teachers, friends) provided encouragement that therapy could help their child. One participant described the support she received from her children’s pediatrician when asked what motivated her to participate:

Just the doctor’s reference, “Give it a try. It might be relieving just to give it a try, it might help your girls. So, it was really their primary care doctor referring me and kept, you know, every appointment saying “hey, did you get in contact with Penfield?”

In a typical category, participants reported they had some concerns about treatment which made their engagement challenging at times. Three variant subcategories emerged outlining specific treatment concerns. First, participants variantly reported they found treatment strategies difficult to learn or implement. One participant explained:

She [therapist] do keep me involved but it’s just like, she tell me how to do it and then it be so much at one time. And then when you get the papers, it’s double so much and it’s just like, I’m not going to remember to do this in actual, when my daughter is actually having a temper tantrum. Like it’s gotta be something shorter and easier than this.

Similarly, participants variantly reported in another subcategory that they were uncertain about intervention effectiveness. When talking about the times when the therapist would ask to observe the caregiver playing with the child, one participant shared:
I was just not sure what the therapist was getting out of that. I didn’t find it helpful. I actually didn’t understand why we were just sitting and playing with toys. I didn’t understand how that was helping with his behavior at all.

In the final variant subcategory, participants reported their participation in therapeutic activities was impacted when their children would not participate in the activities the therapist suggested. A participant described working with the therapist to engage the child in “hands-on activities” such as blocks or Legos but it was hard for them to get the child to participate because the child would “move on to his own thing.”

In a variant category, participants reported they had personal challenges, such as chronic health concerns or attending to multiple responsibilities within the home, that impacted their ability and motivation to participate. For example, one participant shared the impact of her literacy level when she received treatment handouts or her children’s care plan:

Cause I don’t, I wasn’t taught to read, I was teaching myself. I know how to read and everything, but English was not my thing, nor history, nor social studies. Anything that had to do with books, I just didn’t like it. So when I get paperwork, it just don’t intrigue me. I just put it somewhere and I’ll get to it eventually.

Factors Influencing Alliance

To explore factors that contributed to the caregiver-therapist alliance, one interview question asked participants to reflect on how the therapist created a positive relationship with them. One general, one typical, and two variant categories emerged in the data analysis. Participants generally reported they felt the therapist specifically focused on building a relationship with the participant, not just with the participant’s child. When asked to reflect on how the therapist did this, one general, one typical, and three variant subcategories emerged within this umbrella category. In a general subcategory, participants reported the therapist provided support and reassurance to the
caregiver during therapy, including coming from a place of encouragement and having a non-judgmental stance. In describing a situation in which she was struggling with consistent responses from other caregivers in the child’s life, one participant described feeling supported and protected by the therapist, which meant a lot to the participant as she is typically the “protector” in her family:

So basically I explained to her how they try, they always try to triple-team me, call me back-to-back-to-back, stuff like that. Just harassing me in the moments where I’m trying to get him back in line with himself. And she gave me the go-ahead to kind of put the blame on her, like “this is what the therapist said needs to happen”. So she let me use her as a shield.

In a typical subcategory, participants noted the therapist actively collaborated with them during the therapy on treatment goals, plans, and interventions. For example, one participant described how the collaboration with the therapist began before the first session even occurred:

She actually reached out to me personally right before we even started the sessions just to talk to me and get an overview of how I feel about the whole thing. So, that is a plus for me cause I love when people do that, to get me comfortable about anything that I’m starting with the condition of my child.

In a variant subcategory, participants reported the therapist actively helped them during the treatment process, in addition to helping their child. One participant remarked the therapist was “not just helping him but helping me, giving me different ways to cope with his behavior. That was really helpful for me.” In another subcategory, participants variantly reported appreciation for the way the therapist interacted with their child, including feeling comfortable with the child’s behaviors and engaging the child in activities and conversations. One participant explained the therapist noticed the child liked her nails so she let him choose her next nail color, noting this meant a lot to the caregiver “because that’s something that he yearns for, to develop trust.” In the final
subcategory, participants variantly reported the therapist respected the caregiver’s autonomy as the child’s caregiver, allowing caregivers to have decision-making capacity within the session. One participant shared, “She let me know that if at any moment, anything, any plans that she would have or anything that she would say would make me uncomfortable, just let her know.”

In a typical category, participants reported the therapist performed the tasks and responsibilities of her job well. Five variant subcategories emerged here, identifying specific professional tasks which helped contribute to the caregiver-therapist alliance. First, participants variantly reported the therapist behaved in a professional manner, including being prompt, flexible, and displaying a positive attitude no matter what the child or caregiver did. One caregiver described how her therapist behaved in session:

She was real respectful, she wasn’t like discouraged, she wasn’t irritated or nothing like that. She still had her, she was still in control. Even if I was tired, she wasn’t like, “okay, we won’t do this, we’re done, okay you just go.” She wasn’t like that. She still do her job and make sure my child get her learning.

In a second subcategory, participants variably reported the therapist made herself readily available to the caregiver outside of scheduled session times. One participant described the therapist as “very open with allowing me to reach her,” which “made a huge difference,” particularly during the pandemic, when “stuff got very, very intense.” In a third variant subcategory, participants reported the therapist was accommodating of scheduling concerns, including rescheduling a session or changing a session from in-person to virtual if a family member was ill. One participant noted “it wasn’t a big deal” when she told the therapist a session needed to be rescheduled. In the fourth subcategory, participants variantly reported the therapist provided additional resources to the family.
To illustrate, one participant described a time when the therapists arrived with unexpected gifts during the holiday season:

She really helped us. It was Christmas, and it was like a surprise as well. It was a bunch of participants from Penfield and they brought them not one or two gifts but they brought them multiple things. And it was just a big surprise for my girls because they did not see it coming, they just thought, that’s our teacher, she’s just gonna come color with us, things like that. But no, they was bringing them presents to make their day, to make them feel happy, you know? It made me feel very happy, very appreciative.

In the final subcategory, participants variantly reported the therapist collaborated with other professionals, such as other therapists, teachers, or daycare providers, in order to help their child. One participant stated the therapist told her “if his childcare would need any strategies to help him also she would offer to give them, you know, a one-time session with the childcare.”

In a variant category, participants reported they appreciated the therapist’s personal qualities, such as friendliness, warmth, kindness, and honesty. When describing her therapist, one participant stated, “And it’s just [therapist], her personality and her character just really stands out. She is very warm, very inviting, very relaxed. She, I don’t know, she won me over. That’s the best way I can describe it.”

In the final category, participants variantly reported feeling initial mistrust of the therapist’s intentions. One participant described an “assessment period” early in the therapeutic relationship in which she felt she and the therapist were assessing each other. When asked what she was assessing the therapist for, the participant replied:

Relatability is one. Comfort, definitely. The ability, definitely for me, to be open and free and to put my family on the line because that was the whole point of this. So that I can be, to be genuine, basically. So that we could really get the real help that we need. Not to have a mask, because in a lot of programs, and I’m just gonna be honest, we go in and people of my culture, because of things we’ve been
through, we’ll put a mask on because we’re afraid, to be honest, to get the true help that we really need.

**Therapist’s Understanding of the Caregiver’s Cultural Experience**

To examine any effects on caregiver engagement based on cultural differences between the caregiver and the therapist, two interview questions asked participants to identify aspects of their own experience that the therapist could or could not understand. Two typical and three variant categories emerged during the data analysis. Typically, participants reported they felt understood as a parent, namely that the therapist was able to understand their child’s behaviors, the concerns the caregivers had related to those behaviors, or their experience as single mothers. One participant reported “I felt like she was able to understand me with a lot a stuff. She knew I was a single mother, I was doing everything for my children” while another participant reported:

> Actually, that was the thing, because like you said we did come from two different backgrounds. She actually understood everything I was going through with [child name] because she did have that experience before with other kids. So that was a big plus. So I didn’t have, it wasn’t nothing she didn’t know or understood that [child name] did.

In the second category, participants typically reported that they also felt understood as a Black caregiver. When asked what about their experience as a Black mother the therapist was not able to understand, one participant denied a lack of understanding and exclaimed:

> That’s what made it surprising! It’s rare, in my experience, in life, because of the cultural difference. But I was, she was, she was rare. I’ve been blessed to run across a few of those people who seem to be seasoned in terms of relating to my ethnicity. To me, that says you’ve experienced probably friendships, relationships somewhere in your own life that allows you, or you’ve dealt with people in your profession on a regular basis, to see and to be so skillful.
In a variant category, participants reported their therapist openly communicated support for the caregiver’s experience. For example, after describing a situation in which a lack of transportation was preventing the caregiver from picking the child up from school in time for the therapy session, the participant shared, “She made me feel comfortable with the situation, like “oh, that’s okay, I understand where you’re coming from, I understand how hard it is to deal with certain things.” In another variant category, participants also reported the therapist demonstrated respect and a willingness to learn from the caregiver.

One participant shared:

I just think she didn’t care about Black or not, cause of culture. I just think she was there to learn, was there for me and my daughter, from my culture, that’s what I believe. Because she wasn’t like, you know, little attitude, or tell us do this do that, she wasn’t like that. She was the type of person who want to learn, with us… She always very positive, there wasn’t a negative thing about her.

At the same time, in the final category, participants variantly reported they felt the therapist did not understand some aspects of their experience as a Black caregiver, including both cultural differences in parenting values and because the therapist was not a mother herself. One participant felt the therapist was uncomfortable when the participant reported a incident of using physical discipline when her child became aggressive:

She asked me, you know, how it happened and I explained to her what had happened. Like I said, it was like a “pop-pop” to get your attention...Like I said I try all avenues, talking, restraint, spanking. You gotta do what you gotta do sometimes. I’m not a fan of it, I don’t do it at all, but when I have to, it is what it is. I could just tell, her body language was like “Oooh, okay.”

When prompted to describe how the therapist’s reaction affected her, the same participant shared, “I just felt I had to be a little bit more careful. It just made me reflect like I have to dig a little bit deeper in different avenues on dealing with that type of temper tantrum.”
Closing Questions

This section presents findings from the closing section of the interview. These questions asked participants to describe their use of strategies between sessions, to identify factors that made it easier or challenging to adhere to treatment recommendations, and to reflect on how useful or relevant they found the therapy to be in their daily lives. These questions yielded two domains and provide additional information about caregivers’ ongoing engagement with the therapy both during and after treatment. Finally, participants were asked to provide suggestions as to how the Behavior Clinic might better engage Black caregivers in treatment in the future, yielding one additional domain. These findings are presented in Table 3.

Table 3

Domains, Categories, and Frequencies of Adherence, Outcomes, and Suggestions for Improving Black Caregiver Engagement in Treatment

<table>
<thead>
<tr>
<th>Domains</th>
<th>Categories</th>
<th>Frequencies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence</td>
<td>P used strategies consistently</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Implemented behavior management strategies</td>
<td>Typical (10)</td>
</tr>
<tr>
<td></td>
<td>Used coping strategies or tools with child</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>Some factors positively influenced use of strategies</td>
<td>Typical (8)</td>
</tr>
<tr>
<td></td>
<td>Communicating with therapist made use easier</td>
<td>Variant (6)</td>
</tr>
<tr>
<td></td>
<td>Seeing results motivated P to keep using strategies</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Some factors adversely influenced use of strategies</td>
<td>Typical (9)</td>
</tr>
<tr>
<td></td>
<td>Had difficulty implementing strategies without support</td>
<td>Typical (7)</td>
</tr>
<tr>
<td></td>
<td>Felt strategies were not effective outside session</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Had difficulty implementing strategies while caring for multiple children</td>
<td>Variant (2)</td>
</tr>
<tr>
<td></td>
<td>Attempted to generalize strategy use across family</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>P used strategies inconsistently</td>
<td>Variant (2)</td>
</tr>
<tr>
<td>Treatment Outcomes</td>
<td>Aspects of therapy were effective</td>
<td>General (11)</td>
</tr>
<tr>
<td></td>
<td>P learned ways to manage child’s concerns</td>
<td>General (11)</td>
</tr>
<tr>
<td></td>
<td>P noticed positive changes in family</td>
<td>Typical (7)</td>
</tr>
<tr>
<td></td>
<td>P experienced other positive change in self</td>
<td>Variant (5)</td>
</tr>
<tr>
<td></td>
<td>Aspects of treatment were ineffective</td>
<td>Variant (4)</td>
</tr>
<tr>
<td></td>
<td>Strategies did not work outside of therapy</td>
<td>Variant (3)</td>
</tr>
<tr>
<td></td>
<td>Changing P’s responses will take ongoing work</td>
<td>Variant (3)</td>
</tr>
</tbody>
</table>
Suggestions for Improving Black Caregiver Engagement

- Communicate effectively with caregivers
- Communicate professionally and non-judgmentally
- Collaborate with caregivers to address all behaviors within home
- Provide encouragement to Black caregivers seeking help
- Continue to develop cultural competence
- Be responsive to cultural mistrust
- Strengthen cultural understanding of Black caregivers

P had no suggestions

Typical (10)
Variant (4)
Variant (4)
Variant (3)
Variant (4)
Variant (4)
Variant (2)
Variant (2)

* 12 total cases. General = 11-12, Typical = 7-10, Variant = 2-6.

Adherence

Participants were asked to describe their use of behavior management and coping strategies between therapy sessions. Participants were then prompted to reflect on factors that encouraged their use of strategies or made it easier as well as factors that discouraged use or made it challenging. Three typical and two variant categories emerged in the data analysis. In the first category, participants typically reported they used treatment strategies consistently between sessions. One typical and one variant subcategory emerged here, providing detail about the type of strategies caregivers implemented consistently. Participants typically reported use of the behavior management strategies, such as incentive charts, positive reinforcement and praise, ignoring, time out, visual schedules, and redirection. One participant described her consistent use of both a schedule and sticker incentives both during and after therapy:

We had made a chart of his everyday, like everyday things he does. And I still use it to this day, even though I don’t have my sessions anymore. It helps me a lot with him. Waking up every day, and him just putting like a sticker onto his chart to help him use the bathroom, once he throws things in the garbage. It just really helps every day.

Participants variantly reported using of the coping strategies and tools in the second subcategory. A participant reported using the “feelings faces” cards that showed the
feeling on one side (i.e., “the happy, the sad, the frown face and the happy face”) as well as “there were things on the back of the card that you could do with the kid.”

In the second typical category, participants reported that there were some factors that positively influenced their use of the treatment strategies. Two variant subcategories emerged within this category. First, participants variantly reported that communicating regularly with the therapist, either at weekly sessions, between sessions, or after therapy ended, made using the strategies easier for them. For example, when asked what helped with strategy use, one participant responded that if she had a concern with a strategy she always knew:

> There’s never a moment when the teacher’s [therapist] not coming. So I just sit and wait and then I just explain everything to them, any questions I had, anything… If I don’t understand this, maybe she can explain, try her best to explain a way, a better way in the situation.

Second, participants variantly reported seeing results motivated them to keep using the strategies. One participant explained:

> I noticed a change in him. When we started doing the positive reinforcement or like using stickers or you know, being able to get a treat after dinner or whatever, you know. It was just, it was easy because you could see a difference.

At the same time, in the third typical category, participants reported there were also some factors that adversely influenced their use of strategies. One typical and two variant subcategories emerged in this category. In the first subcategory, participants typically reported they had difficulty implementing strategies without support, for reasons such as lack of support from other caregivers, conflicting demands on the caregiver (e.g., working from home while caring for a toddler), or difficulty understanding the strategies themselves. One participant described this challenge of being in school while working and participating in this therapy:
I’m learning I really can’t utilize nothing because I don’t, I don’t take the time out to read their care plan because it be so much. I don’t have, I try to make time in the day to study that stuff, but right now, I got other stuff that’s going on too… not having the time to actually sit down and let my brain regulate what was said.

In a variant subcategory, participants reported difficulty using the strategies because they felt the strategies were not effective outside of the sessions. Describing her efforts to use coping strategies with her child, one participant shared the coping tools were not “helpful in the moment” because, while her child used the tools during therapy sessions, the child “wouldn’t even think about them” when he got upset and would still act out instead of “going to go and find one of those gadgets and use those to calm down.” In the last subcategory, participants reported they had difficulty using implementing the strategies while caring for multiple children within the home. For example, one participant described this challenge: “He has a twin brother too. And then, I was like, okay, do I do the time out for both of them? And how would I do time-out for two children, you know?”

Similarly, in a variant category, participants reported they attempted to generalize strategy use across other family members, including teaching the strategies to other caregivers and attempting to use strategies with other children. One participant described this effort:

I have more of the siblings than her, and everybody’s got different personalities. And I was like okay, what I learn from this session, how can I use it with the other kids? If I go to this behavior specialist, and learn the strategy, what they’re doing, with her siblings maybe I could do it with them too.

In the final category, participants variantly reported they used treatment strategies inconsistently; this included both using only select strategies (e.g., “lately, I just use the
coping tools”) or irregular patterns of attempting to use the strategies to respond to their child’s behaviors:

I tried the time-out thing, not every day because some days it was, like, hard. I tried sometimes, like the not yelling, but a lot of times I would still yell cause it’s hard, it’s something I’m still working on. So throughout the week, within the day I would try the strategies but sometimes I wouldn’t. Sometimes I would fall back into the negative responses.

Outcomes

The interview protocol contained a question meant to have participants reflect on the overall usefulness or cultural relevance of the therapy program. The data analysis revealed the participants answered this question by describing treatment outcomes. One general and one variant category related to outcomes emerged. First, participants generally reported they found aspects of treatment were effective. One general, one typical, and one variant subcategory emerged within this larger category. In the first subcategory, participants generally reported they learned ways to manage their child’s concerns. One participant reported the therapy was relevant because it helped alleviate her stress by teaching her how to handle her children’s challenging behaviors: “I remember before the Behavior Clinic, I didn’t really know what to do with the tantrums, you know. Or the time-out or the redirecting. Those were not things I knew or I thought of. So it helped.”

In a typical subcategory, participants reported they noticed positive changes in their child or other family members as a result of the therapy. One participant described multiple changes in her child’s relationship with his sister as a result of the therapy:

It helps a lot more because [child name] used to like, he might think it’s a joking way but he used to just like push her down or just like really just be mean to her. Now things changed. He helps her. He plays with her, he give her things. He
shares now. If he has any piece of candy, he’ll try to give her some. And before, it was never that. He never did anything with her or just try to do something to her.

In the final subcategory, participants variantly reported experiencing other positive changes in themselves as a result of the therapy. One participant described personally coming to terms with her son’s autism diagnosis because of this therapeutic experience:

> It was very useful! Showing me what to do, how to be a become a better Black strong mother, how to become very independent, and just stay strong. Don’t let nothing, you know, down me because my son is different. I don’t let that bother me or be shamed.

In the second outcome category, participants variantly reported they found some aspects of treatment to be ineffective. Two variant subcategories emerged here. First, participants variantly reported the treatment strategies did not work outside of therapy. One participant described becoming angry, frustrated, or stressed because treatment recommendations did not work with her child:

> I also explained to her [therapist] about the time out, she told me to try, like his age he was three at the time so she would say do three minute time outs. I tried that and I would explain to her how it wouldn’t work because he wouldn’t sit, he wouldn’t sit at all. Or he wouldn’t sit in the corner for three minutes. So she suggested that I take the time out with him, like I sit him down and I sit there with him. I tried that but that didn’t work because he would just get up and run off and then I’ll have to keep chasing him. She would tell me to go back and get him and put him back on the couch and start the three minutes over. It wasn’t really helpful, like I said because he wouldn’t sit, he would not sit at all. So it was just me trying to constantly chase him throughout the house and bring him back to the couch.

In the second subcategory, participants reported that changing their own responses to their child’s challenging behaviors will take ongoing work, citing difficulty changing their responses due to personal challenges, ingrained negative reactions, or trying to change the cycle of physical discipline in their family. One participant openly shared that she explored her thoughts on physical punishment with her therapist:
We spent a lot of time talking about it and I really don’t, I’ve come to the summation that I really don’t like it. I just, I really don’t like it. But you know, it’s just something that was a part of me for a long time and it’s not just gonna go away overnight. It’s gonna take some time and some dealing with, and that means I’m gonna have to look at some maybe not so pretty stuff about myself.

**Suggestions for Improving Black Caregiver Engagement**

As the final main question in the interview protocol, participants were invited to provide suggestions on how the Behavior Clinic might better engage Black caregivers in their treatment program in the future. One typical and two variant categories emerged from the data analysis. Typically, participants suggested clinicians communicate effectively with Black caregivers. Three variant subcategories related to effective communication emerged within this category. In the first subcategory, participants variantly suggested clinicians communicate professionally and non-judgmentally with caregivers, both verbally and non-verbally. One participant explained:

I know a lot of times the reason why people in the Black community or the Brown community don’t necessarily go to help is because of the judgment which comes from it. The tone, I should say, not necessarily the words that you say, but the tone or the body gestures. We are already on edge and already looking over our shoulders making sure we do what we have to do and in the right way.

In the second subcategory, participants suggested collaborating with caregivers to address all behaviors seen in the home, not just what the therapist is able to observe within the sessions. One participant shared:

And it’s just like the communication, the reaching out before the session, or just to give the parent like an understanding, or get their input on everything with the situation with their child, even with the program, it’s a big help. So they know where we’re coming from, and what we see versus what they see when they come.

In the final subcategory, participants suggested the therapists provide encouragement to Black caregivers who are seeking help. To illustrate this encouragement, one participant
provided this example: “Don’t be ashamed to go for it, reach out. Ask questions, it’s
 gonna be okay. Stand up for yourself, stand up for your kids. Stay on the program as long
 as you can, as long as possible.”

In the second category, participants variantly suggested clinicians continue to
develop cultural competence in working with Black families. Two variant subcategories
emerged here. First, participants variantly suggested the therapists be responsive to
cultural mistrust by having open conversations with caregivers from the beginning of the
therapy. To illustrate this cultural mistrust she has experienced at the hands of other
mental health professionals, but not within this treatment episode, one participant framed
her suggestions to future clinicians in this way:

Stop making them feel like they’re doing a bad job and it’s bad that they want
help for their kids. And stop making them feel like CPS gonna get involved
because of it. Stop coming in as the authority, as better than, thinking you all
better than us. I’m saying, cause I experienced this too, and that’s what made me
not mesh with them therapists. Thinking they better than us because we want
better help for our kids. So make us feel like you, like how aunties come over,
like how the village used to come over and raise the kids. That’s how it should be.

Second, participants variantly suggested clinicians strengthen their cultural understanding
of Black caregivers and their experiences. One participant suggested:

I would say if you could tell people in training before they go out, if they could be
mindful, that because of what I just told you, how Black people are always on
guard because of how we’ve been raised or our experiences in life… We always
think that programs, government or any programs, we think that they’re going to
screw us over. You know, that’s our attitude or our mentality. We try, and we take
chances and we do these things that sometimes we’re forced to do them, or we get
to the place where there’s nowhere else to turn, it’s like “I’m trying but I really
don’t believe this is gonna work or be beneficial”… All Black people are not hard
to work with or have bad attitudes. We just, you know, we be frustrated or have
issues and you know, some people don’t take the time to really hear the need or
address things appropriately. Which keeps the same cycle of frustration, and hurt
or anger or fear and all that other crap going on. And we still never meet the
mark.
In the final category, participants variantly reported they had no suggestions for the better engaging Black caregivers in treatment at the Behavior Clinic because they themselves had a positive experience, felt understood by their therapist, and treatment was effective. One participant also added: “To be honest, I don’t think there’s nothing I could tell Penfield Behavior because it’s got people that’ve been working in the clinic for years that understand us Black parents with our children.”
CHAPTER 5: DISCUSSION

This study explored factors that influenced Black caregivers’ ongoing engagement in their young child’s BPT therapy by asking caregivers to reflect on their engagement before, during, and after the treatment experience. Recent multidimensional conceptualizations suggest ongoing treatment engagement is a complex construct comprised of cognitive, attitudinal, and behavioral components (Becker et al., 2015; Lindsay et al., 2014) that may wax and wane throughout treatment (Coatsworth et al., 2006; Macdonald et al., 2007). The purpose of the present study was to explore ways cognitive (e.g., expectations for treatment), attitudinal (e.g., readiness to change), relational (e.g., alliance), and cultural (e.g., mistrust, relevance) factors may have influenced Black caregivers’ experience and ongoing engagement in therapy at a clinic focused on treating trauma in young children. The hope was to better inform future engagement interventions and fill a gap on caregiver engagement in the child therapy literature.

Overall findings suggest participants committed to engaging in this BPT therapy with their young child both within- and between- therapy sessions to learn more effective ways of managing their child’s behaviors. Cognitive and attitudinal factors emerged as important influences on participants' engagement, both initially and throughout therapy. Cognitively, participants entered the treatment episode expecting to learn behavior management strategies, though findings suggested participants also expected the therapist to work more directly with the child than the participant during the therapy sessions. At the same time, most participants noted feeling apprehensive about certain aspects of the therapy (e.g., efficacy, therapist’s intentions) while only some also described feeling
simultaneously hopeful therapy could help with their child’s concerns. Collectively, the overall findings indicated that most participants entered treatment with thoughts and feelings of ambivalence toward participating in treatment and the potential for positive outcomes.

Importantly, participants noted therapists engaged them during treatment sessions in a variety of ways, including direct instruction on parenting strategies, participation in play and other therapeutic activities with their child, coaching on implementing strategies during session, and observation of therapist-child interactions. It may be possible that these in-session therapist engagement strategies satisfied participants' desire to learn behavior management tools and instilled further hope that their child's concerns could improve, causing them to continue their engagement with services.

Findings similarly suggest relational and cultural factors also played a significant role in participants' decision to stay engaged in therapy. In a key relational finding, participants reported having a positive working alliance with their child's therapist and described the therapist as supportive, non-judgmental, and encouraging while problem-solving their family's concerns. While some participants spoke of initial mistrust or occasional cultural misunderstandings during treatment, overall findings suggest participants felt their White therapist generally understood their cultural experience, particularly in relation to helping caregivers better manage their child’s behavioral and emotional concerns. Importantly, findings indicate participants felt that no significant cultural differences between the participant and their therapist impacted their decisions regarding ongoing engagement or completing treatment. It appears the therapist’s
engagement and alliance interventions may have alleviated or at least reduced participants’ initial cultural concerns or mistrust.

Additionally, the working alliance and within-session engagement with the therapist appear to have strongly contributed to between-session treatment adherence. Participants reported use of behavior management strategies between sessions, noting seeing positive results and interacting with the therapist positively influenced their adherence. Ultimately, it appears participants stayed engaged with treatment because they felt connected to the therapist and because they found aspects of treatment effective in producing desired changes in their child, themselves, and their family environments. These and other findings will be explained in more detail in the sections below. Study findings also include meaningful suggestions from participants for improving Black caregiver engagement in this type of early childhood BPT therapy in the future. Limitations of this study and implications for both future research and clinical engagement interventions are also discussed.

**Contextual Findings**

Participants noted they initially engaged in this BPT therapy because their child was displaying significant emotional or behavior challenges. Most described difficulty managing their child’s externalizing behaviors (e.g., aggressive tantrums, opposition) though some described concern over observing self-harm, anxious behaviors, speech concerns or trauma responses in their child. As discussed, BPTs are evidenced-based treatment programs specifically designed to address these types of challenging behaviors in young children through a two-pronged approach: caregiver interventions aimed to increase positive parenting strategies (e.g., consistent limit setting, positive
reinforcement) and attachment; and child interventions aimed to improve coping skills, emotion regulation, and problem-solving ability (Beauchaine et al., 2005; Dretzke et al., 2009; Garland et al., 2010b; Gross et al., 2018; Ketch-Oliver & Smith, 2015; Prinz, 2019; van Mourik et al, 2017). It is therefore not surprising that participants were seeking this type of specialized therapy for their young child, though this finding is important as it affirms the goals of the treatment program were aligned with participants’ main objective for treatment (i.e., to reduce the child’s challenging behaviors).

The current study is unique in the child therapy literature as it explicitly asked caregivers themselves to describe their cognitive preparation and attitudes about treatment (i.e., attitudinal engagement) prior to the start of therapy, which researchers argue strongly influence both adherence and alliance within therapy (Becker et al., 2015; Ingoldsby, 2010, Lindsey et al., 2014) and which emerged here as contributing to these participants’ ongoing behavioral treatment engagement.

Overall, participants appeared to have mixed thoughts and feelings at the beginning of the treatment episode. They sought professional help after recognizing they were unable to manage their child’s behaviors on their own. As noted above, the child’s challenging behaviors within the home were significant. Additionally, other caregivers (e.g., school and daycare) were also struggling to manage the child’s concerns across settings. As such, it appears possible participants may have felt some sense of pressure for outside intervention to avoid further logistical difficulty finding alternate caregivers for the child, either immediately or in the future. This finding is inconsistent with prior child therapy literature which demonstrated Black caregivers at times disagreed with schoolteachers’ assessment of their older child’s challenging behaviors in the classroom.
(Snell-Johnson et al., 2004; Thurston et al., 2015). As caregivers of very young children, not being able to send their child to school or daycare may have created an urgent need to work on changing their child’s behaviors. It is not surprising, therefore, that some participants wanted to not only improve their child’s symptoms at home but also at school or daycare to in turn manage their own distress and perceived inability to solve the problem at hand.

Despite feeling a strong need for outside help with their child’s behaviors, most participants felt apprehensive about starting this therapy. This finding was consistent with earlier research on Black caregiver engagement in therapy with their older child or adolescent (LaKind et al., 2018; Santiago et al., 2013; Snell-Johnson et al., 2004; Thurston et al., 2015) as their apprehension was related to uncertainty about the program, both how it would work and its reputation within the community, mistrust about the provider, especially as the therapist would be within the family home, and concerns about treatment efficacy. Alternately, only some of the participants felt optimistic about the therapy before it started. These participants looked forward to the help they and their child would receive, holding the hope that treatment may be effective in reducing or eliminating their child’s emotional or behavioral concerns or feeling prepared by having prior psychotherapy experiences. Taken together, these findings are consistent with King et al.’s (2014) model of caregiver engagement in which the clinician must actively work with the caregiver to create a sense of openness to the intervention, a belief in the caregiver-therapist alliance, and instill hope for positive outcomes in therapy. To encourage ongoing treatment engagement in this and other BPTs, therapists may have to be more attuned to caregivers’ apprehension about treatment at its onset, openly discuss
caregivers’ ambivalence, and more actively work to instill optimism about the therapy process and potential outcomes.

In terms of expectations for treatment, many participants anticipated they would learn behavior management strategies during the sessions, which is not surprising as it was their reason for seeking treatment and the purpose of this type of early-childhood therapy. What is surprising, however, given the explanation of treatment provided to caregivers during the informed consent process, is that participants often anticipated the therapist would spend more time working directly (i.e., one-on-one) with the child than happened during the therapy. Though these participants all completed this BPT program, this finding may shed light on why other caregivers prematurely end services, as prior research has demonstrated engagement decreases when the caregiver’s treatment expectations differ with the provided treatment and its outcomes, such as when a caregiver initially engages with a BPT program with the expectation that the child will be the sole focus of treatment interventions (Corcoran & Ivery, 2004; DeCarlo Santiago et al., 2013; Ellis et al., 2013; McKay et al., 1996; Kil et al., 2020; Nock & Ferriter, 2005; Patterson & Chamberlin, 1994), especially among low-income Black families (Morrissey-Kane & Prinz, 1999; Shuman & Shapiro, 2002; Wymbs et al., 2016). It appears that even caregivers who completed treatment did not fully understood their role in treatment as explained to them while being initially screened for services, perhaps because their role wasn’t explained clearly enough by agency staff or because the caregiver’s need for a reduction in their child’s behaviors was so great that they were not able to fully attend to what their role in the therapy would entail.
While most study participants were pleasantly surprised at their level of involvement in therapeutic activities, some expected that therapy would focus more on working to teach the child to change their own behavior rather than working so directly with the caregiver. This is consistent with Mattek’s (2014) findings that caregivers who attributed the child’s behavioral challenges to innate child characteristics rather than to caregiver responses were significantly more likely to drop out of EP treatment that caregivers who recognized their responsibility in modifying their child’s behavioral difficulties. Similarly, some participants had previously engaged in Birth-to-Three services (e.g., speech therapy, physical therapy) and anticipated their personal level of involvement would be similar to those services, which likely contributed to their expectations that therapists would work directly with their children. It may be possible that some caregivers choose to disengage from this treatment once they realize how large their expected role in this therapy is and how modifying their responses to their child’s behaviors will be the focus of most treatment interventions. As such, more recent engagement researchers have highlighted the need for specific psychoeducation aimed at the caregiver about what services will entail, their role in their child’s therapy, and what realistic treatment outcomes may look like (Becker et al., 2015; Chacko et al., 2017). Targeted psychoeducation about the caregiver’s role in EP during referral, intake, and initial treatment sessions appears especially warranted, as almost half of participants reported being unsure of what this therapy would be like or their own role in it before it started.

As discussed above, most participants were apprehensive about starting therapy. When asked directly about their hesitations, participants described hesitations related
both to starting treatment and about participating in the treatment sessions themselves. One type of hesitation was focused on the therapy program itself, including rightness-of-fit with their child’s concerns or their parenting style. This is consistent with Coard et al.’s (2004) study demonstrating Black parents’ concern for how their parenting values (e.g., racial socialization) will be incorporated into BPT treatment. Interestingly, participants again voiced concern that their child’s behavior may ultimately not improve despite participating in the therapy. Consistent with the earlier finding about apprehension, these findings seem to suggest that caregivers are experiencing some ambivalence about treatment overall, which would appear to be important for therapists to overtly address with caregivers (King et al., 2014).

Similarly, some participants openly described initial mistrust of the therapist, particularly around what the therapist’s intentions were when entering the home (e.g., was the therapist trying to get the caregiver’s children taken away from them), if the therapist would be negative or judgmental toward the caregiver or the child, and whether the caregiver could be open and vulnerable with the therapist about the child’s concerns. This sense of mistrust could certainly help explain the earlier findings about participants’ apprehension in starting therapy, as well as provide insight into engagement during treatment sessions when coupled with the discrepancy between caregiver role expectation and demand in the therapy. Yatchmenoff (2005) described such mistrust (i.e., the belief that the agency worker is not acting in the best interest of the child or caregiver) as an anti-engagement factor. Though these participants were able to complete treatment despite their mistrust of the therapist, prior research indicates cultural mistrust may negatively impact caregiver engagement (Acri et al., 2016; Asnaani & Hoffman, 2012;
Santiago et al., 2013; Thurston et al., 2015). It stands to reason that other caregivers may not be able to work through this mistrust, particularly when combined other attitudinal factors such as hesitations about treatment efficacy (Becker et al., 2015; Lindsay et al., 2014; King et al., 2014; Yatchmenoff, 2005) and may instead choose to disengage from treatment.

Despite their feelings, expectations, and hesitations that appeared contrary to participating in treatment, caregivers noted they participated in multiple ways during treatment sessions that are consistent with the founding principles of EP and most other early-childhood BPTs (Eyeberg et al., 1995; Gross et al., 2009; Fox et al., 2013; Muzik et al., 2010; Prinz, 2019; Sanders, 1999). This participation included discussions of age-appropriate expectations for child behavior, nurturing the caregiver-child attachment through play and other warm interactions, learning to model cognitive strategies and emotional regulation for their child, and learning more effective parenting responses to reduce and increase prosocial behaviors. Of note, within-treatment engagement included both active participation (e.g., talking with therapist, playing with child, practicing strategy in real time) and passive participation (e.g., observing therapist-child interactions) on the part of the caregiver, consistent with Littell et al.’s 2001 description of participatory behaviors in therapy and how they may change over time.

When considering participants’ main reason for seeking therapy was to get help in these specific areas and participants’ main expectation for treatment was that they would learn effective behavior management strategies, it appears this reason and expectation described above aligned well for participants with what eventually took place during therapy. This alignment may ultimately bode well for treatment outcomes, as engagement
researchers now posit cognitive (e.g., expectations of role, expectations of efficacy) and attitudinal (e.g., feelings about mental health care, readiness to change, cultural mistrust) factors are a strong influence on the therapeutic alliance and treatment adherence (e.g., within-session caregiver participation and caregiver’s use of treatment strategies between session and after treatment ends; Becker et al., 2015; Ingoldsby, 2010, Lindsey et al., 2014). High caregiver adherence in BPTs is associated with higher levels of positive treatment outcomes, such as increased caregiver and child skill acquisition, more effective parenting behaviors, increased prosocial behaviors (i.e., listening and following directions), and reduced challenging behaviors (i.e., aggressive tantrums; Beauchaine et al., 2005; Gross et al., 2018; Nock & Ferriter, 2005; Patterson & Chamberlain, 1994).

Taken together, the contextual findings indicate participants entered treatment because they needed help managing their child’s challenging behaviors or emotional concerns. However, most participants were apprehensive about starting therapy and hesitant about aspects of the treatment and its outcomes, while only some participants felt hopeful participating in this treatment program would help with their child’s concerns. It appears most participants were at least somewhat ambivalent about treatment, both before and during the therapy. Another important contextual finding related to the impact of aspects of the therapy itself on caregiver engagement appears to be that once therapy began, most participants learned their role within the therapy was larger than they had initially expected; indeed, that most therapeutic interventions were designed for the caregiver to implement with the child. Caregivers who are not cognitively prepared to change their parenting responses or take on that large of a therapeutic role may choose to disengage rather than complete treatment (Becker et al., 2014; Nock & Ferriter, 2005),
and yet this sample all completed EP treatment despite this lack of cognitive preparation and their ambivalent attitudes toward treatment. With participants’ descriptions of numerous types of behavioral engagement within session in mind, the discussion now turns to other in-therapy factors such as therapeutic alliance or cultural understanding and their impact on participants’ ongoing attitudinal and behavioral engagement.

Influences on Caregiver Engagement and Alliance

Therapy Influences

Previous research has relied on the therapist’s description of caregiver engagement (e.g., passive or active participation, attitudes or behaviors consistent or inconsistent with treatment goals; Littell et al., 2001; Patterson & Chamberlain, 1994; Yatchmenoff, 2005), which provided little insight into the client’s experience of within-treatment factors (e.g., therapist actions, specific strategies) that may be affecting their level of participation at any one point in time in the therapy. When asked what facilitated their session involvement, all participants initially described numerous ways (e.g., direct instruction, therapeutic activities, coaching) the therapist actively sought to engage them in their child’s therapy during treatment sessions. Second, almost all participants talked about how therapists also supported the participant’s use of strategies both within- and between sessions by providing targeted resources to the family.

These findings appear important because as described above, most participants were not expecting to be the main target of treatment interventions and yet they felt invited by the therapist to be actively involved in session through the therapist’s various methods of teaching, modeling, and coaching the participants through learning and practicing behavior management strategies, the key component of early-childhood BPTs
(Beauchaine et al., 2005; Dretzke et al., 2009; Garland et al., 2010b; Gross et al., 2018; Ketch-Oliver & Smith, 2015; Prinz, 2019; van Mourik et al, 2017). Being actively invited by the therapist to learn these strategies also aligned fully with participants’ reason for entering therapy and their goal of learning effective methods to manage their child’s concerns. Therefore, it appears that although these participants may not have been fully prepared to be so actively involved in the treatment before it started, they were willing to do so to reach this goal when encouraged and supported by the therapist. It also appears the therapist used multiple methods of engagement (e.g., therapeutic play, modeling, walking through strategy implementation; observation) with each family, consistent with the protocol for most early-childhood BPTs (Eyberg et al., 2008; Fox et al., 2013; Gross et al., 2009; Sanders, 1999, Webster-Stratton, 2001). As participants often described more than one of the therapist’s methods as helpful, it appears this approach was useful in keeping participants engaged across treatment as different methods may have worked better for some participants or for the same participant when learning some treatment strategies. This is consistent with prior research demonstrating clinician behaviors and flexible treatment delivery both contribute to caregiver engagement (Garland et al., 2010a; Garland et al., 2010b; Ingolsby, 2010).

There also appears to be an interaction between the therapist’s direct engagement strategies and the resources they provided to the participants. In fact, providing instructional handouts and other tangible tools to facilitate behavior management strategies (e.g., timers for time-outs, visual schedules) or to assist the child in practicing emotional regulation skills (e.g., coping boxes containing stress balls, picture cards to use with breathing exercises, feelings books) may be viewed as its own form of an
engagement strategy, as it appears having these items readily available within the family home helped with both in-session practice and encouraged strategy use when the therapist was not present. As 90% of the clinic’s families receive public assistance (Tomlin et al., 2019), participants may not have been able to purchase these items if not provided at no cost to them by the therapist. Some participants also described the books, toys, and games the therapist brought to therapy sessions as beneficial to engaging both the caregiver and child in session activities. Participants appeared to view these toys and other materials as not only key to therapeutic activities, but as valuable suggestions for additional ways the caregiver could engage with the child in positive and nurturing interactions within the family home (Eyburg et al., 2008; Fox et al., 2013; Love & Fox, 2019) outside of sessions. No matter the type of resource, it appears that providing this type of support when needed not only contributed to caregivers’ ongoing engagement (Garland et al., 2010a; Ingolsgy, 2010), but also contributed to the caregiver-therapist alliance as the therapist was seen as providing effective tools and suggestions for improving their child’s behavior, again aligning with participants’ main goal for therapy.

Other aspects of the therapy program itself emerged as supportive to participants and facilitators of their engagement. These aspects included having two clinicians (e.g., one therapist and one student clinician), having sessions within the family home, and being able to consult with the therapist outside of sessions, all appear to have made participating in this therapy easier for the caregiver. All three aspects work to reduce barriers to engagement by allowing the caregiver to directly engage with the therapist which the student clinician manages behaviors within session; by eliminating logistical barriers (e.g., transportation) by bringing the therapy to the home, and by reducing
potential caregiver stress of having to wait until the next session to problem-solve with the therapist. Indeed, EP was specifically designed to be provided within the clients’ home to reduce logistical barriers to engagement that many Black or low-income families face and to meet the individual needs of children and caregivers within the family’s natural environment (Fung & Fox, 2014; Love & Fox, 2019), though service delivery location has been impacted by the need to provide at least some sessions virtually for most participants during the pandemic. This finding is consistent with prior engagement research demonstrating therapists and agencies must work to reduce the barriers to engagement that impact many Black families seeking BPT treatment (Axford et al., 2012; Bornheimer et al., 2018; Santiago et al, 2013a; Kazdin et al., 1997a; Kazdin et al., 1997b; Littell et al., 2001).

Overall, it appears participants felt encouraged by their therapist’s actions and the treatment protocol to be actively involved in their child’s therapy and they felt supported by their therapist in doing so. This active participation in learning effective behavior management strategies and the resources provided to families directly aligned with participants’ main goal for the therapy. Additionally, it appears this treatment program had several elements that worked to reduce barriers and facilitate the participant’s active engagement, both within- and between- treatment sessions.

**Caregiver Influences**

An unexpected finding emerged when participants were asked to identify additional influences on their in-session participation. Participants’ general response was that they felt a strong motivation to do so, with their main motivation being a prominent desire for their child’s behavior to improve through both caregiver and child skill
acquisition and emotional regulation. This finding is not surprising as this desire also emerged as a reason for initially seeking treatment, and as both a hope (e.g., attitudinal factor) and expectation (e.g., cognitive factor) for the therapy. Participants also spoke about their willingness to engage in the therapy because they wanted their child to be happy and healthy, and they would do whatever it took to help their child. This finding again makes sense, given these participants all completed treatment with their child for the purpose of reducing the child’s symptoms. Feeling encouraged by others to participate may also speak to the importance of community outreach, including positive referral relationships with community physicians and positive word-of-mouth within neighborhoods (Lakind & Atkins, 2018; Santiago et al., 2013a).

As another type of personal motivation, participants spoke about their desire to avoid additional generational trauma within their family, including moving away from authoritarian parenting practices (e.g., use of punishment or physical discipline, negative responses to behavior; Burchinal et al., 2010; Cooper et al., 2018; Fox & Holtz, 2009; Lees et al., 2019; Pinderhughes et al., 2000) that were a result of how they themselves were parented or racially socialized (Coard et al., 2004; Huang & Isaacs, 2007; Lakind & Atkins, 2018; Neblett, 2019) or to avoid their children being further discriminated against in society (Coard et al., 2004). Participants shared that open conversations about with their child’s therapist around physical discipline and negative responses to challenging behaviors were both difficult and supportive. As existing research on Black parenting practices tends to be shaming of Black caregivers (e.g., Cooper et al., 2018), these supportive conversations may help explain why these participants chose to continue to engage despite being asked to change their parenting practices. Earlier research has
suggested other Black caregivers may preemptively disengage from BPT programs when interventions do not include discussions related to racial socialization or line up with their cultural norms related to discipline or other parenting values (Coard et al., 2004; Morawska et al., 2011; Snell-Johns et al., 2004). As such, culturally based parenting practices may be an important topic for therapists to discuss and provide on-going support around as caregivers participate in BPTs as these programs are inherently based on modifying caregivers’ parenting practices (Beauchaine et al., 2005; Dretzke et al., 2009; Garland et al., 2010b; Gross et al., 2018; Ketch-Oliver & Smith, 2015; Prinz, 2019; van Mourik et al, 2017).

Taken together, these personal motivations to participate appear consistent with Mucka et al.’s (2017) qualitative investigations on maternal motivation and expectations for participating in the *Mom Power (MP)* program, the only early childhood BPT that identifies the caregiver as the identified target of all treatment interventions. The study indicated mothers had a variety of reasons for wanting to participate, including help for themselves, their child, their parenting practices, and increased social support (Mucka et al., 2017). Similarly, participants’ motivations in this study aligned with their goal for treatment and with the aims of the treatment protocol.

In addition to strong personal motivations to participate, it is important to note that some participants did identify personal barriers (e.g., literacy level, health) that, at times, made their participation in the therapy difficult. This finding is consistent with previous research (Armbruster & Fallon, 1994; Kazdin et al., 1997a) that indicates there likely are salient client characteristics and external stressors that need to be addressed in treatment, even for those caregivers who are able to complete BPT programs. Therapists
may need to make sure they thoroughly assess for caregiver’s personal experiences and potential personal barriers. As research has demonstrated that Black families face higher levels of adversity (e.g., chronic illness) and logistical barriers (e.g., literacy level) than Caucasian families do (Bornheimer et al., 2018; Santiago et al., 2013a), one suggestion for improving caregiver engagement in this population has been to address the impact of these pre-treatment caregiver variables within the therapy itself (Armbruster & Fallon, 1994; Axford et al., 2012; Kazdin et al., 1997a; Kazdin et al., 1997b; Littell et al., 2001). This suggestion appears applicable here, as participants reported a negative effect on their engagement despite their strong motivation to participate in the therapy. It appears therapists may be remiss in not fully understanding or addressing the impact of these personal barriers on caregivers’ engagement.

Participants also described having specific concerns about the therapy that made their engagement in treatment challenging at times. Here, participants spoke openly about finding certain strategies too involved or difficult to implement with a young child due to the child’s behaviors (e.g., running out of a time-out) or the caregiver feeling too overwhelmed in the moment (i.e., during an aggressive tantrum) to remember to use the strategy. Other participants also spoke of concerns around treatment effectiveness. These concerns included a fear that behaviors would return to pre-therapy levels, a concern that the therapist was suggesting strategies for “the average child,” or thoughts of ending therapy when the benefit of participating was not readily apparent to the caregiver. Though these participants ultimately completed treatment, it appears important for clinicians to address individual caregivers’ concerns, the cause and severity of the child’s behavior as well as intervention efficacy actively and repeatedly during the treatment
process to prevent attrition (Corcoran & Ivery, 2004; Kil et al., 2020; Mattek, 2014). Specific to Black caregivers, conversations related to the attribution of cause of the challenging behaviors appear important in previous studies (Ketch & Oliver, 2015; Mattek, 2014) and may help caregivers reframe their child’s behaviors and actively problem-solve strategy use with the therapist. Similarly, caregivers may need additional support, psychoeducation around age-appropriate behaviors in very young children, problem-solving sessions with the therapist, and in-session practice on redirection or other behavior management strategies for this age group (Kaminski et al., 2008; Mattek, 2014).

Taken together, these findings related to participants’ challenges to engagement appear similar to the pretreatment ambivalence described earlier, as here participants are describing being strongly motivated to participate to improve their child’s behavior and yet feeling somewhat disengaged when treatment is not immediately effective or the child or caregiver experiences some personal setbacks. Engagement researchers describe fluctuations in caregiver engagement due to personal challenges or concerns about intervention efficacy as realistic and typical throughout the course of therapy (Bamberger et al., 2014; Becker et al., 2014; Ellis et al., 2013; Harrison et al., 2004; Lindsey et al., 2019; Littell et al., 2001; Nock & Kazdin; Staudt, 2007). As such, it appears therapists can greatly influence ongoing caregiver engagement (Becker et al., 2014; Becker et al., 2015; Lindsey et al., 2014; Lindsey et al., 2019) by recognizing it is both a dynamic and malleable part of BPT treatment and by directly addressing these unique caregiver and child concerns as part of the therapy.
Factors influencing Alliance

One in-therapy factor thought to significantly impact ongoing engagement is the therapeutic alliance (King et al., 2014), so much so that one recommendation aimed at improving engagement in BPTs is to focus on the complex task of building rapport and relationships with caregivers (Axford et al., 2012; Garland et al., 2012; Kazdin et al., 2006; Thompson et al., 2007). Overall, findings in this area are consistent with Bordin’s (1979) conceptualization of alliance (i.e., bond, tasks, goals) in adult therapy.

In the first major finding, participants described ways their therapist worked to form a strong therapeutic bond with them separate from the relationship the therapist formed with their child. Participants found the therapist to be supportive, reassuring, collaborative, respectful, and non-judgmental of them as caregivers, consistent with Bordin’s (1979) explanation of a warm therapeutic relationship (Horvath & Greenberg, 1989). Participants also appreciated how collaborative the therapist was with them in relation to therapeutic interventions and activities, both in explaining their relevance but also in allowing the caregiver to be involved in the timing, pace, and design of therapeutic activities (i.e., the task domain of alliance) as well using significant caregiver input to determine overall treatment goals (i.e., the goal domain of alliance; Bordin, 1979; Horvath & Greenberg, 1989). This shared decision-making on goals and the activities necessary to achieve them appears to have contributed not only to the working relationship, but also to the participants’ willingness to engage in treatment sessions and complete the BPT (Becker et al., 2015; Karver et al., 2005; Shirk et al., 2011).

Specific to BPTs, however, two interesting subcategories emerged within this finding. Participants appreciated the ways the therapist interacted with their child,
particularly in being non-reactive to the child’s behaviors and working to establish trust with the child. This aligns with Karver et al.’s (2005) Theoretical Model of Common Process Factors in Youth and Family Therapy which suggests therapists’ reactions and interactions with clients are a key components of alliance with youth and their caregivers. Participants also noted the importance of the White therapist showing respect for the caregiver’s autonomy around parenting decisions within the family home. This finding aligns with Karver et al.’s (2005) inclusion of client autonomy as an important part of alliance in child therapy. As Black participants are describing ways White therapists interacted with them and their Black children as important to helping them form a relationship with their child’s therapist, it may be these cross-cultural interactions were somewhat unique in their experience and important in overcoming initial mistrust of providers which prior research has demonstrated influences both alliance and engagement (Harrison et al., 2004; McKay et al., 1996; Owen et al., 2011; Snell-Johns et al., 2004; Thurston et al., 2015). Finally, some participants also described personal characteristics of the therapist that contributed to a positive relationship, consistent with Karver and colleagues’ (2005) inclusion of therapists’ personal characteristics (e.g., warmth) as playing an important role in forming alliance with caregivers.

A second major finding in this area is that most participants also identified the therapist being good at her job (i.e., performing the tasks and responsibilities of being a therapist well) as contributing strongly to the therapeutic alliance. Participants described their therapist as professional, prepared, knowledgeable, diligent, and positive when working with them on their child’s concerns. Participants spoke of the therapist’s availability and responsivity to the participant between sessions, flexibility in scheduling,
providing resources, and willingness to collaborate with teachers and daycare providers as all important factors in forming a working relationship with the therapist. Karver et al. (2005) included these characteristics in their model, which demonstrates the overlap between alliance and engagement, as therapist credibility (e.g., perceived expertise, trustworthiness) and therapist direct influence skills (e.g., clarity of treatment protocol).

This finding appears to be an important factor in both therapeutic alliance and ongoing engagement as prior research has demonstrated Black caregivers often report significant therapist or agency-level barriers such as lack of contact from the provider, missed appointments by clinicians, and reluctance to schedule or reschedule appointments around family availability, which can further contribute to cultural mistrust and lack of desire to continue in therapy (Harrison et al., 2004; Lakind & Atkins, 2018). For these participants, however, it appears that the therapist behaving professionally, following through on job responsibilities, and being sensitive to the family’s unique scheduling and resource needs may have influenced study participants’ reduction of cultural mistrust, the building of a strong working relationship (i.e., bond), and ultimately, participants’ effective completion of treatment (i.e., tasks and goals; Bordin, 1979; Horvath & Greenberg, 1989).

Indeed, researchers have recommended therapists focus on tasks and goals as a way to build alliance if forming an emotional bond with the caregiver proves difficult (Johnson et al., 2002). One-third of all study participants struggled when initially forming a trusting relationship with the therapist, citing mistrust as a factor. Again, these participants spoke of being wary at initial sessions, assessing if the therapist was trustworthy or judgmental. This finding is consistent with prior literature demonstrating
mistrust as an influential factor on ongoing engagement when Black adults engage in therapy with a White provider (Alegria et al., 20190; Halliday-Boykins et al., 2005; Harrison et al., 2004; Lakind & Atkins, 2018; Mulvaney-Day et al., 2011; Thompson et al., 2004; Thurston et al., 2015; Santiago et al., 2013a; Yatchmenoff, 2005). It appears that these Black caregivers were able to engage in treatment long enough to overcome this mistrust, eventually describing their White therapists as nonjudgmental and caring. It may be that other Black caregivers may choose to disengage from services rather than working to overcome their cultural mistrust with the therapist (Owen et al., 2011).

**Therapist’s Understanding of Caregiver’s Cultural Experience**

When asked how cultural differences (e.g., lack of sensitivity to the Black experience; Harrison et al., 2004; Thompson et al., 2004) with their White therapist may have impacted their engagement with the therapy, most participants described feeling understood by their White therapist, first around the participants’ parenting concerns. Participants felt their therapists were both knowledgeable and skilled at dealing with challenging behaviors in young children and were nonjudgmental and supportive when helping the caregiver modify strategies based on the child’s unique needs. This finding speaks to the importance of the therapist meeting the caregiver’s needs in therapy for both strong alliance and engagement within cross-cultural therapeutic dyads. That is, these participants’ main goal was to receive professional help to learn to better manage their child’s behavior concerns and they felt their therapist was a credible expert in this area (Karver et al., 2005). It appears that because the therapists were skilled at helping young children with challenging behaviors and their caregivers, participants felt their therapist had listened to their concerns, understood their individual needs, and spent
ample time helping them, the lack of cultural match between therapist and participant did not impact the alliance or the caregiver’s ongoing participation, similar to a prior study of Black adults receiving therapy from White clinicians (Mulvaney-Day et al., 2011).

Indeed, most participants noted they felt the therapist understood their experience as a Black caregiver and participants did not believe cultural differences impacted the therapists’ ability to work with them effectively on their child’s concerns. These participants talked about the comfort they felt with their White therapist (e.g., “I did not get one of those types of therapists”) in working with their child and noted they knew the therapist had experience working with other Black families. This finding appears important as most Black caregivers, regardless of treatment modality, will receive services from a White therapist (Alegria et al., 2010) and previous researchers have demonstrated cultural differences may lead to disengagement among Black caregivers (Ansaani & Hoffman, 2012; Harrison et al., 2004; Owen et al., 2011; Thompson et al., 2004). In this study, however, participants not only felt understood by their White therapist but were able to describe how they were able to know the therapist understood the participant’s experience. In discussing the therapist’s cultural understanding, some participants described how the therapist overtly conveyed understanding the participant’s experience by both her words (e.g., “I understand where you are coming from”) as well as her actions (e.g., “She acted like she be knowing me for years”). Additionally, some participants reported the therapist openly conveyed respect for the caregiver and adopted a stance of learning about the family’s culture within the therapy, consistent with Mulvaney-Day et al.’s (2011) study which suggested Black clients want a therapist who
actively works to address cultural differences within the therapeutic relationship and includes the client’s cultural values in treatment.

Collectively, these findings appear important as previous engagement literature suggests adherence is reduced and early attrition is more likely to occur when Black caregivers do not feel respected by White providers or they feel their cultural values are not recognized within the therapy (Harrison et al., 2004; McKay et al., 1996; Morrisey-Kane & Prinz, 1999; Mulvaney-Day et al., 2011; Snell-John et al., 2004; Yeh et al., 2005). Most study participants, however, in addition to reporting a strong, trusting relationship with their White therapist, also reported here they felt their therapists were able to understand what these Black caregivers were going through and openly demonstrated understanding and respect during the therapy. While most BPTs were created for and normed with middle class White families (Coard et al., 2004), EP was specifically designed for low-income ethnic minority populations (i.e., Black and Latina families; Fox et al., 2013; Fox & Nicholson, 2003; Fung & Fox, 2014). Grounded in this population, it appears the EP therapists working with study participants communicated knowledge, cultural understanding, experience and skills in working with these Black caregivers and participants felt their therapists understood their experience enough to successfully form a strong alliance and help them better manage their child’s concerns as described above.

At the same time, it is important to note that a few participants did indicate they felt there were some parts of their experience (e.g., severity of child’s behaviors outside of session, motherhood itself, use of physical punishment) the therapist did not understand. This may have led to the hesitations around engaging in therapy or the
ambivalence in caregiver’s expectations for outcomes as described above. It appears these participants were able to overcome these cultural concerns due to the strength of the working alliance described above (e.g., therapist’s effort to form a supportive relationship and therapist’s ability to help caregivers learn more effective ways of managing their child’s behaviors). It stands to reason that other Black caregivers may choose to disengage if cultural misunderstandings occur early in treatment before such an alliance is formed, as previously suggested by other researchers (Alegria et al., 2010; Halliday-Boykins et al., 2005; Morawska et al., 2011; Mulvaney-Day et al., 2011; Snell-Johns et al., 2004). Prior research also suggests that therapists have open conversations related to cultural differences, parenting values, and cultural relevance of treatment recommendations with Black caregivers participating in BPTs (Ketch-Oliver & Smith, Meija et al., 2017; van Mourik et al., 2017) to improve alliance, engagement, and outcomes. For example, the Chicago Parenting Program, similar to EP in that it was created for use with low-income Black and Latina families, includes open discussions emphasizing the effects of caregiver stress on parenting and examining the cultural acceptability and efficacy of parenting strategies (e.g., time-out; child-led play; Gross et al., 2009). Some caregivers initially engaging in EP may need similar conversations early on in treatment to help resolve their ambivalence regarding this treatment and foster ongoing engagement.

**Between Session Engagement and Outcomes**

**Adherence**

When participants considered what helped them adhere to treatment (i.e., consistent use of the strategies given to them by their therapist outside of session; Becker
et. al., 2015; Chacko et al., 2016; Ros et al., 2016), findings indicate most participants used or attempted to use treatment strategies consistently between sessions. Typically, participants described using the behavior management strategies, such as time outs, redirection, ignoring, positive reinforcement for desired behaviors, encouraging child use of coping skills, and engaging in play with their child. This finding appears consistent with caregivers’ motivations to improve their child’s behavior through participating in the therapy as well as their belief that the therapist understood their parenting concerns and knew how to address them in therapy. This finding appears important, as BPTs are heavily skill-based programs for both the caregiver and the child and generally require a high level of between-session adherence in order to reach treatment goals (Baydar et al., 2003; Beauchaine et al., 2005; Dretzke et al., 2009; Dumas et al., 2007; Gross et al., 2018; Kaminski et al., 2008; Littell et al., 2001; Nix et al., 2009). Interestingly, this finding is inconsistent with prior BPT research that indicates most clients do not attempt or complete homework assignments (Chacko et al., 2016; Kazantzis & Shinkfield, 2007) and therapists may not always practice strategies or review homework in session with caregivers (Garland et al., 2010a; Garland et al., 2010b). For these participants, it appears their high level of in-session participation with their therapist as described earlier, coupled with their strong motivation to improve their child’s behaviors and their belief their therapist could help with those concerns, likely led to consistent use of treatment strategies between sessions.

Additional findings indicated participants felt two factors facilitated their consistent use of strategies between sessions. First, the ability to communicate and problem-solve with their therapist, both within the weekly treatment sessions and via
phone between-sessions, helped caregivers use the strategies within session. This finding directly aligns with two previous study findings, as participants identified the availability of the therapist to consult with them outside of session as both an aspect of the therapy itself that directly influenced their continued engagement and as a factor that influenced the formation of a strong therapeutic alliance. It appears that having their therapist’s encouragement to contact them outside of treatment sessions was key in helping these participants feel supported by the therapist in their efforts to meet their ultimate goal of better manage their children’s behaviors. This out-of-session access to their therapist appears to have helped participants feel both bonded with their therapist and supported in their attempts to implement strategies on their own, as they knew the therapist could be contacted if the participant needed help with implementation. This finding again speaks to the importance of Karver et al.’s (2005) model, emphasizing that therapist’s credibility and direct influence skills (i.e., being able and available to help the caregiver with challenging behaviors) in both understanding caregiver engagement and the caregiver-therapist alliance. It also appears supportive of previous research suggesting a possible bidirectional relationship between adherence and alliance (Garland et al., 2010a; Garland et al., 2010b; Nock & Ferriter, 2005; Patterson & Chamberlain, 1994).

Second, participants identified seeing a positive impact on their child’s behavior served as additional motivation for the participant to keep using the strategies on their own. This finding is not surprising, as seeing reductions in their child’s concerns was participants’ main reason for initially engaging with this early-child BPT protocol and their self-identified main motivation for staying engaged as described earlier. It is also not surprising as EP is heavily caregiver skill-based, covering a treatment strategy within
session and then asking the caregiver to implement throughout the week (i.e., as homework) and report back. Prior studies have positively correlated the quality of caregiver adherence with improved outcomes (e.g., Ros et al., 2016) and this finding both supports that research and indicates adherence and outcomes may in fact have a bidirectional relationship, with adherence leading to stronger outcomes and outcomes also potentially leading to stronger adherence.

At the same time, participants identified three factors that made their between-session adherence challenging at times: at least some difficulty using the strategies on their own; frustration when strategies (e.g., time-out, coping skills) were not effective outside of session; and difficulty caring for multiple siblings within the home while trying to modify one child’s behavior. Taken as a group, these findings echo earlier study findings related to caregiver concerns about treatment on session engagement and overall hesitations or ambivalence about participating in the treatment program. These repeated findings across domains appear to support King et al.’s (2014) multidimensional conceptualization of engagement, in which researchers emphasize caregivers’ affective involvement (e.g., emotional investment and commitment to the treatment plan), cognitive involvement (e.g., belief in treatment effectiveness), and behavioral involvement (e.g., within- and between- session strategy implementation) as three distinct elements of caregiver engagement in child therapy. As such, these findings appear to again point to the need for some caregivers, even those who complete the BPT program, to have additional education and skill-building practice targeted toward their unique contextual concerns in order to increase confidence, skill, and consistency in using treatment strategies both independently and effectively within the family home (Baydar
et al., 2003; Dumas et al., 2007; Ketch-Oliver & Smith, 2005; Littell et al., 2001; Meija et al., 2017; Nix et al., 2009; van Mourik et al., 2017).

A few participants also spoke of their desire to use treatment strategies across their family environment. This included between-session attempts to have multiple caregivers within the home or the child’s life give consistent responses to the child’s behavior or the participant trying to use treatment strategies with other children within their care. As these participants indicated some difficulty generalizing strategy use across the family, this may be another area that Black families may need additional support in from the therapist (e.g., including extended family members within the home who may be caring for the child in the therapy; Ketch-Oliver & Smith, 2005; Meija et al., 2017; van Mourik et al., 2017).

As the final finding related to adherence two participants reported inconsistent use of treatment strategies on their own between sessions, which aligns with previous studies that demonstrated caregivers may engage within-session but not between-sessions (Kazantzis & Shinkfield, 2007; Kazantzis et al., 2010; Garland et al., 2010a; Garland et al, 2010b). A discrepancy between within- and between-session behavioral engagement is thought to mainly reflect the caregivers’ perceived relevance, benefits, and demands of the interventions along with the caregiver’s confidence and belief in their ability to independently implement the strategies (i.e., attitudinal engagement; Becker et al., 2014; Garland et al, 2010b; Kazantzis & Shinkfield, 2007; Kazantzis et al., 2010). This finding indicates at least some caregivers who complete this BPT program may not be consistently implementing skills and general recommendations outside of sessions and may need extra support in this area in order to increase caregiver skill and confidence and
improve treatment outcomes (Beauchaine et al., 2005; Gross et al., 2018). This may again speak to the need for additional caregiver psychoeducation around the consistency and time frame typically required to modify behaviors in very young children along with additional within-session practice on behavior management strategies (Kaminski et al., 2008).

Viewed as a group, these findings on adherence in an early-childhood BPT may be important as previous research (e.g., Nix et al., 2009) has relied on therapists’ ratings of caregiver adherence and has not solicited caregivers’ own perspectives on their use of treatment strategies on their own, within the context of their attitudes about treatment, the therapeutic alliance, and other in-therapy factors and client characteristics as described above (Becker et al., 2015; Haine-Schlagel & Walsh, 2015; Lindsey et al., 2014; Littell et al., 2001; Lewis et al., 2018; Miller, 2008; Nock & Ferriter, 2005; Stadnick et al., 2016; Staudt, 2007). These participants attempted to use treatment strategies consistently on their own. Though challenges in adherence occurred for some, participants were able to reach out to their therapist for help and were motivated to keep using strategies when they saw positive results.

**Outcomes**

This study intended to elicit Black participants’ opinions on the cultural relevance (i.e., how consistent participants felt the therapy’s activities were with their life experiences and parenting practices; Meija et al., 2017). In response to a question about therapy relevance and usefulness, participants responded by describing how effective they found the strategies to be with their child, and thus two findings related to outcomes are discussed here.
First, most participants answered that they found aspects of the therapy worked for them and their family. Participants learned strategies (e.g., different communication style) that were effective in helping them manage their child’s challenging behaviors (e.g., tantrums) by responding differently than they had before the therapy. Participants found therapy useful as they noticed changes in the child’s behavior and emotional regulation. These findings directly align with participants’ main goal for initially seeking therapy and their motivation to participate in sessions. These findings are also consistent with BPT outcome research demonstrating efficacy with young children (i.e., under the age of six years; Butler & Titus; 2015; Fung et al., 2014; Gross et al., 2018; Lees et al., 2019; Love & Fox; 2019). Participants also found therapy effective in enacting other positive changes in the family home (e.g., improved sibling relationships) and other positive changes in themselves (e.g., increased positivity, decreased parenting stress). As a whole, this finding strongly supports previous attendance-based engagement research demonstrating BPT completion is strongly tied to three types of positive outcomes: child (i.e., reduction in challenging behaviors); caregiver (i.e., reduced stress, increased parenting skills); and the family (i.e., improved overall functioning; Kazdin & Whitley, 2003; Morawska & Sanders, 2006). In this study, participants were able to provide qualitative data suggesting that their cognitive, attitudinal, and behavioral engagement in the therapy led to the outcomes they were seeking.

Similarly, Kaminski et al. (2008) reported BPT program participants who actively engage with program content focused on positive caregiver-child interactions, increased prosocial behavior, and modification of caregiver responses (e.g., EP) to better manage difficult behaviors through in-session instruction, modeling, and practice experience
treatment as effective. As study participants described engaging with this content in these ways, it follows that most participants found at least some aspects of therapy to be useful and effective in the daily management of their young child’s behavior. Similarly, as most participants also described consistent strategy practice and implementation between treatment sessions, positive treatment outcomes for both caregiver and child are to be expected in this type of skill based BPT (Berkel et al., 2018; Nock & Ferriter, 2005; Patterson & Chamberlain, 1994; Ros et al., 2016).

At the same time, there were some study participants who openly talked about finding at least some aspects of treatment to be ineffective, which appears consistent with prior literature demonstrating BPT programs are less effective in Black families than in Caucasian families, most likely due to higher levels of overall parental stress and adversity (Lakind & Atkins, 2018; Meija et al., 2017; Michelson et al., 2013; Reyno & McGrath, 2006). Specific to early childhood BPTs, PCIT research has demonstrated that while the early childhood BPT program may be initially effective at reducing challenging behaviors in the child, it was not effective in reducing caregiver stress in Black families (Fernandez et al., 2011). Participants again also spoke about finding that the provided strategies did not work in reducing or eliminating their child’s behavior, which may speak to the need for therapists to continue to tailor interventions to each child and family environment and ensure caregivers feel heard when discussing implementation concerns. Some participants also reported treatment goals were originally met but strategies lost efficacy after treatment ended due to child or caregiver characteristics or external family stressors. This is consistent with Leitjen et al.’s (2013) research demonstrating BPT treatment gains were achieved in Black and Latina families but those gains were reduced
at one-year follow-up. This may speak to the need for additional focus on reducing caregiver stress or longer treatment episodes for minority families. Finally, some participants again acknowledged the challenge in modifying their parenting responses and voiced the intention to keep working on consistent strategy implementation on their own post-treatment. As discussed above, it appears at least some EP participants may need additional in-session practice (Kaminski et al., 2008) or additional support and problem solving in order to consistently use treatment strategies independently, both between-sessions and post-treatment. Though study participants did not explicitly voice concerns related to the cultural relevancy of the treatment program, this finding also may speak to the need for further exploration into how EP treatment strategies may align or conflict with Black caregivers’ parenting practices and beliefs, as therapists may need to address these potential differences more explicitly within treatment in order to address future caregivers’ efficacy concerns (i.e., attitudinal engagement) and treatment adherence (i.e., behavioral engagement; Butler & Titus; 2015; Caughy et al., 2002; Coard et al., 2004; Michelson et al., 2013; Morawska et al., 2011).

**Participant Suggestions**

Finally, this study solicited participant’s opinions on how the clinic could improve the ongoing engagement of Black caregivers who initiate EP services in the future. Findings indicate two main suggestions: ensure effective communication with caregivers; and commit to the ongoing development of therapists’ cultural competence in working with Black families.

Speaking to communication, participants indicated the importance of agency staff being professional and non-judgmental with Black caregivers as caregivers will be
attuned to providers’ word choice, tone, and body language no matter the setting (e.g., in home, virtual meetings, text) of the interaction. Therapists should be genuine and clearly explain things to caregivers. Participants also spoke of their desire for their own input to be valued within the treatment, particularly in collaborating with the therapist to address the unique needs of their child within the individualized context of the family home, and in practicing strategies within session until caregiver feels competent to implement on their own. These suggestions align with the earlier discussion of professional behaviors influencing both alliance and engagement (Harrison et al., 2004; Lakind & Atkins, 2018) and the need for White providers to attend to the family and societal contexts in which a Black child’s behavior occurs (Alegria et al., 2010). Additionally, participants took on the role of modeling how clinicians should speak to Black caregivers, encouraging them to not be ashamed to ask for help for their family, to support their children the best way they can, to work through cultural mistrust and stay positive about treatment, and to stay engaged in the program in order to learn knowledge and skills.

Second, participants highlighted the need for therapists to continue working on their personal cultural competence when working with Black families. Participants described the importance of therapists openly responding to caregiver’s cultural mistrust, even if the caregiver does not bring the topic up in session. This could include repeated conversations about the therapist’s intent to help the family, the lack of intent to report families to CPS (unless situations in which therapist in mandated to do so occur), recognition of Black caregivers’ anxiety about their child’s behaviors and the stigma of asking for parenting help, and therapists creating a space for caregivers to be vulnerable without fear of judgment from the therapist. Similarly, some participants voiced the need
for White providers to be attuned to the systemic barriers (e.g., racism, poverty) Black families face and to be understanding of Black caregivers’ resulting frustration and wariness of seeking outside help for their family’s concerns.

This suggestion points to the continual need for training on cultural competence and anti-racism work for therapists working with Black families (Coard et al., 2004; Owen et al., 2011; Orrell-Valente et al., 1999; Mulvaney-Day et al., 2011), particularly when services are delivered within the family home (Damashek et al., 2012). Given the problem with participants understanding the research question aimed at assessing cultural relevance of the treatment program (see limitations below), their suggestion here may indicate their desire for the consideration of additional deep-level cultural adaptations to the EP program, such as discussions of cultural and sociopolitical influences on Black caregivers’ parenting beliefs and practices and continued tailoring of interventions to be effective with the context of each Black family’s environment (e.g., including extended family members within the home who may be caring for the child in the therapy; Ketch-Oliver & Smith, 2005; Meija et al., 2017; van Mourik et al., 2017).

Conclusions

In conclusion, there were several findings from this study that may help extend the existing understanding of Black caregivers’ engagement in their young children’s mental health care. Most significantly, findings indicate that study participants felt understood by their White therapists and that no major cultural misunderstandings occurred within the working alliance or impacted participants’ decisions to stay engaged in treatment. This finding is inconsistent with previous research have demonstrating cultural differences as a factor leading to disengagement among Black caregivers
(Alegria et al., 2010; Ansaani & Hoffman, 2012; Harrison et al., 2004; Owen et al., 2011; Thompson et al., 2004) but may be a result of EP being specifically created for low-income ethnic minority populations (i.e., Black and Latina families; Fox et al., 2013; Fox & Nicholson, 2003; Fung & Fox, 2014).

Another significant finding was the self-identification of participants’ desire to help alleviate their child’s behavioral and emotional difficulties as a main influence on their engagement, so much so that participants stayed engaged in treatment despite not knowing the magnitude of their own involvement before treatment began. As participants felt their therapist had expertise in helping caregivers learned behavior management and in helping young children cope more effectively with their emotions, it appears study participants were able to overcome initial cultural mistrust and remain in treatment (Karver et al., 2005; Mulvaney-Day et al., 2011). In fact, it appears most study participants had not previously considered how cultural differences may have affected the working relationship because the therapist was meeting participants’ need of remediating their child’s concerns, suggesting collaboration on treatment goals and the therapeutic tasks to meet those goals may have been the most salient factor in these participants’ alliance with their therapist (Bordin, 1979; Horvath & Bedi, 2002) and in their overall engagement in this BPT.

**Limitations**

This study did have several important limitations. First, though the study intended to fully investigate attitudinal and cognitive factors related to engagement within an in-home BPT, this study took place during the Covid-19 pandemic. As such, participants varied in the percentage of treatment sessions that took place within the family home
versus the percentage of sessions that took place virtually based on the timing of treatment within the pandemic, current CDC guidelines, or clinician or family illness. In addition to the method of treatment instruction (e.g., explaining strategy, modeling, in-session coaching), alliance, adherence, and effectiveness likely fluctuated among participants based on these percentages, as EP was designed to be implemented completely in the family’s home environment. Study findings may have been different if all treatment sessions had taken place within the home.

Second, all study participants were sent the interview questions ahead of time so they could become familiar with what they would be asked. However, only one participant reported looking at the protocol ahead of time. As such, participants appeared unfamiliar or surprised by some questions and “thought out loud,” sometimes giving one initial answer and later providing conflicting data. Findings may have been different if participants had had initial familiarity with the questions and had been able to formulate thoughts prior to the interview itself.

Tied to this, most participants did not respond using complete sentences or what would be considered "academic English." This response style complicated the CQR analysis process because there were times where the team would infer what the participant likely meant, but the participant did not necessarily articulate their idea fully. For this reason, the choice of CQR as the methodology for this study can itself be viewed as a limitation, as CQR does not allow for inference or interpretation when analyzing data. The exact transcription of the participants words are used as the only raw data, and the research team aims to stick as close as possible to those words during all stages of analysis, particularly when writing core ideas (Hill et al., 1997). During the interviews,
the PI asked some clarifying questions and made numerous clarifying statements but did not attempt to clarify every participant response as to not alienate participants. Consensual analysis decisions needed to be made but may not reflect participants’ true responses at all times. Another qualitative method that allows the consideration of other aspects of language (e.g., tone of voice), that uses interviewer notes within the analysis process, or that does not rely as heavily on consensus may have yielded different results.

Third, and again perhaps related to a lack of review of the protocol, some interview questions did not “land” with the majority of the participants, in particular the questions related to the perceived cultural understanding the therapist had or did not have of the participant’s experience as a Black caregiver. Though both pilot interviewees understood this question, it appears in retrospect this question may have been awkwardly worded, as several participants asked for it to be repeated multiple times, or this topic may have been difficult for participants to discuss over the phone with the researcher. Findings may have been different, and participants may have be able to understand the related prompts related to the effect of cultural understanding on their engagement, if the question had been more straightforward. Similarly, the question related to the cultural relevance of the therapy itself also got lost. When writing the interview protocol, the auditor suggested incorporating the phrase “culturally relevant” was using jargon and so the question was instead phrased “How useful was the therapy in your daily life? How was it relevant?”, with the idea being that Black participants are inherently discussing culture when describing their personal experiences. Participants answered this question exclusively in terms of outcomes (e.g., whether or not strategies were effective), which was not the information this question was intended to gather. Findings may have been
different if a question such as “How culturally relevant were the treatment strategies?” or “How well did treatment strategies align with your parenting values?” had been asked instead.

Fourth, interviews were conducted by phone to allow participants a certain amount of anonymity. However, 10 out of 12 participants were caring for their small child(ren) within the home while the interview was being conducted. These participants were at times distracted by caretaking responsibilities; findings may have been different or more thoroughly articulated if participants had been alone while answering. Similarly, transcription was difficult at times due to background noise (e.g., young children yelling or crying) and it is possible in several cases participant data were lost as a result.

Fifth, all interviews were conducted by the PI, a White researcher. While the PI’s race was not formally disclosed to participants, participants may have exhibited justifiable mistrust of the researcher and may not have felt comfortable fully disclosing personal information to a person they had no relationship with over the phone. Responses may have been different if interviews had been conducted by a Black researcher.

Sixth, the PI conducted all interviews, led domaining, wrote all initial core ideas, and conducted the original cross analysis. Though this is standard procedure for a CQR dissertator, in a CQR study the work of domaining, developing core ideas, and conducting the cross analysis is normally shared more equally across all team members. While the team members contributed to all stages of the data analysis, they did by interacting with the data through the framework of the PI’s initial thoughts. Additionally, the PI worked with the auditor to make some changes to the final data table without eliciting feedback, as the team dynamics were no longer productive at that point in time.
Findings may have been different if data analysis responsibilities were divided equally across the team.

Finally, and perhaps most importantly, all participants completed EP and therefore displayed ongoing engagement with this BPT program. This study, therefore, provides no information on other Black caregivers who decided not to fully engage with EP treatment through this clinic, those who do not fully engage with other early childhood BPTs, or the particular factors may have influenced their decisions.

Implications

**Clinical Interventions to Improve Black Caregiver Engagement**

Study findings suggest several clinic interventions that may lead to increased ongoing treatment engagement from Black caregivers. Overall findings suggest spending time openly discussing caregivers’ ambivalence and mistrust about therapy and the therapeutic process may help to alleviate these and other hesitations and ultimately encourage ongoing engagement in this population.

First, clinicians should fully explain and emphasize the caregiver’s role in treatment sessions, including the caregiver being the target of most therapeutic interventions, a thorough explanation of why the therapist cannot work solely with a young child on behavior change, and the importance of consistent strategy implementation (Becker et al., 2015; Chacko et al., 2017, Kaminski et al., 2008). These conversations should not only take place during the referral stage, informed consent process, and intake appointments so caregivers feel fully informed about the type of therapy they are engaging in, but should also occur repeatedly throughout treatment
sessions in order to strengthen the caregiver-therapist alliance, improve adherence, and ultimately, improve outcomes.

Second, White clinicians should address cultural mistrust, early and often, as a way to build both therapeutic alliance and ongoing engagement (Acri et al., 2016; Asnaani & Hoffman, 2012; Coard et al., 2014; Santiago et al., 2013; Thurston et al., 2015) with Black families. Similar to conversations about the caregiver’s role in treatment, conversations about cultural mistrust should occur throughout treatment sessions. Though the clinic hired three diverse (e.g., Black, Latina, male) clinicians following study recruitment, the clinic should continue develop the cultural competence of all clinicians through targeting training and supervision in this area.

Third, openly address caregiver’s early concerns that treatment strategies may not be effective (Bamberger et al., 2014; Becker et al., 2014; Lindsey et al., 2019; Littell et al., 2001; Nock & Kazdin, 2005), as participants were open about these concerns despite completing the treatment program. Clinicians should continue to problem-solve and provide sufficient psychoeducation that modifying both the child’s behavior and the caregiver’s responses takes time and practice (Kaminski et al., 2008). Similarly, as fewer caregivers described ongoing use of child coping skills than behavior management strategies, clinicians could emphasize the use of coping skills in conjunction with the behavior strategies in order to increase efficacy. Though this study’s questions aimed at assessing caregiver’s perception of treatment strategies’ cultural relevance did not prove fruitful, it may help to solicit feedback in this regard during conversations related to both cultural mistrust and treatment effectiveness given each family’s unique context, and to
continue to explore ways of providing deep-level cultural adaptations to Black families (Ketch-Oliver & Smith, 2005; Meija et al., 2017; van Mourik et al., 2017).

**Future Research**

This study’s findings also suggest several areas of future research into the ongoing engagement of Black caregivers in early childhood BPTs. Specific to EP or other home-based treatment protocols, a similar study could be conducted when or if agencies fully return to in-home treatment following the Covid-19 pandemic. As the existing engagement literature on in-home early childhood therapy is grounded in child welfare populations (e.g., Lewis et al., 2018) and this study was unable to recruit a sample that only participated in home-based treatment sessions, research should continue to explore the unique implications of in-home therapy on Black caregiver engagement (Damashek et al., 2012).

As all participants reported their therapist made an effort to form a positive working alliance with them, future engagement research could focus entirely on the caregiver-therapist alliance within early childhood BPTs. Given how the current study’s results were consistent with Karver et al.’s (2005) Theoretical Model of Common Process Factors in Youth and Family Therapy, and given the general overlap between factors influencing alliance and those influencing engagement, one possible study could involve an interview protocol specifically designed around this model. Such a study could explore whether Black caregivers who complete early childhood BPTs experience the model’s common process factors as key to both their alliance with their child’s therapist and their overall engagement with the treatment program.
Similarly, more explicit qualitative research into cultural understanding within the therapeutic alliance of cross cultural caregiver-therapist dyads or cultural relevance of particular treatment strategies remains needed, particularly within early childhood BPTs (Acri et al., 2016; Alegria et al., 2010; Axford et al., 2012; Damashek et al., 2012; Halliday-Boykins et al., 2005; Kazdin et al., 2006; Lakind et al., 2018’ Morawska et al., 2011; Mulvaney-Day et al., 2011). Researchers should ask directly about cultural relevance, perhaps by first exploring participants’ parenting values and practices and then having participants compare and contrast these cultural factors with BPT treatment recommendations. Protocols should be piloted with potential participants and modified based on caregiver understanding and feedback. Studies could employ a Black researcher in the hopes of reducing potential masking of responses by participants with a White researcher as may have occurred here. Specific to EP, a future study could investigate differences in alliance and cultural understanding between Black caregivers and White therapists or the diverse clinicians now employed by the clinic.

Finally, investigations into factors that influence Black caregivers’ ongoing engagement will not be complete without including the perspectives of those who do not complete BPT treatment. Obtaining these perspectives often proves difficult due to a loss of contact with these caregivers. Researchers should continue to pursue ways to conduct research with caregivers who miss sessions early in treatment or those who explicitly communicate the desire to end treatment prematurely, perhaps through anonymous survey research. These types of studies will likely provide additional information pertinent to informing effective engagement interventions with Black caregivers specific to early childhood BPTs.
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APPENDIX A

Informed Consent

MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS

Understanding Factors That Influence Black Caregivers’ Ongoing Engagement in Behavioral Parent Training Programs (BPTs)
Jennifer L. Tomlin, MS, LPC
Department of Counselor Education and Counseling Psychology

You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please ask questions about anything you do not understand before deciding whether or not to participate.

PURPOSE:

• The purpose of this research study is to better understand how relational and cultural factors influence Black caregivers’ ongoing engagement (i.e., participation within therapy sessions and use of strategies between sessions) in their child’s treatment through the Behavior Clinic at Penfield Children’s Center.
• You will be one of approximately 10-15 participants in this research study.

PROCEDURES:

• You will be asked to complete one 45-to-60-minute interview with study investigators.
• You will receive the interview questions prior to the interview so that you may be familiar with both the general topics of the interview as well as specific questions you will be asked to answer during your interview.
• You will be asked questions regarding what expectations you had for your child’s treatment at the Behavior Clinic, your role during treatment sessions, your relationship with your child’s therapist, and how, if at all, cultural factors influenced your participation within sessions and your use of treatment strategies outside of therapy sessions. You’ll also have an opportunity to make suggestions for how the Behavior Clinic can better serve Black families.
• The interview will take place via phone at a mutually agreeable time.
• You will be audio recorded during the interview portion of the study to ensure accuracy. The tapes will later be transcribed. Digital recordings will be erased upon completion of the study. The electronic files of the
recording transcriptions will be kept and destroyed after 3 years beyond the completion of the study.

- For confidentiality purposes, your full name will not be recorded and any name references will be removed during transcription.

DURATION:

- Your participation will consist of one 45-to-60-minute telephone interview.

RISKS:

- The risks associated with participation in this study are minimal, although it is possible that you may experience some feelings of discomfort upon reflecting on your experience treatment with child. We will provide you with the research questions prior to your interview, helping you to be prepared for the types of questions included in the interview.
- Although your privacy is very important, if you talk about actual or suspected abuse, neglect, or exploitation of a child or elder, or if you talk about hurting yourself or others, the researcher or other study team member must and will report this to the Bureau of Milwaukee Child Welfare, the Wisconsin Department of Children and Families Services, or law enforcement agency.

BENEFITS:

- There is the potential benefit to you of being reminded about the positive parenting strategies you learned during treatment.
- In addition, this research may benefit society by informing clinicians how to better serve Black caregivers engaging in this type of behavioral treatment with young children.

CONFIDENTIALITY:

- Data collected in this study will be kept confidential.
- All your data will be assigned an arbitrary code number rather than using your name or other information that could identify you as an individual.
- The principal investigator will maintain an electronic copy of the key linking participant names and codes. This key will be stored separate from the data on a password protected computer in the principal investigator’s Marquette University office. Once the data analysis has been completed and the manuscript is written, the file linking names and codes will be deleted.
- Digital recordings of telephone interviews will kept on the principal investigator’s password protected computer until the completion of the study, at which time they will be electronically erased.
• All transcriptions will be de-identified and assigned a code by the principal investigator before transcripts are shared with research team members.
• Transcripts will be stored on a password-protected computer in the principal investigator’s office at Marquette.
• The data collected in this study will not be used or distributed for future research even if they have been deidentified.
• The data will be destroyed by shredding paper documents and deleting electronic files 3 years after the completion of the study.
• When the results of the study are published, you will not be identified by name.
• Direct quotes from interviews may be included in reports or publications but your name will not be attached to any quotations.
• Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

COMPENSATION:
• You will receive one $25.00 gift card upon completion of the research interview.

VOLUNTARY NATURE OF PARTICIPATION:
• Participating in this study is completely voluntary and you may withdraw from the study and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled.
• If you withdraw from the study, your data will be destroyed and will not be used.
• You may skip any questions you do not wish to answer.
• Your decision to participate or not will not impact your relationship with the investigators or Marquette University, or the Behavior Clinic.

ALTERNATIVES TO PARTICIPATION:
• There are no known alternatives other than to not participate in this study.

CONTACT INFORMATION:
• If you have any questions about this research project, you can contact Jennifer Tomlin, M.S., LPC (jennifer.tomlin@marquette.edu), or Dr. Alan Burkard, Ph.D., (alan.burkard@marquette.edu).
• If you have questions or concerns about your rights as a research participant, you can contact Marquette University’s Office of Research Compliance at (414) 288-7570.
I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

____________________________________________
(Printed Name of Participant)

Verbal Consent Obtained: Yes No __________________________

(Date)

____________________________________________
(Printed Name of Individual Obtaining Consent)

____________________________________________
(Signature of Individual Obtaining Consent) Date
APPENDIX B

Demographic Form

Demographic Information:

Relationship to child(ren) who received Behavior Clinic services: ________________

Race/Ethnicity: ___________ Gender: _______________ Age: _________________

Does caregiver view treatment as successful?  Yes ______ No ______

Number of sessions attended:  Intake = ____________
                              Treatment = ____________

Number of sessions scheduled: __________

Was treatment completed?  Yes ______  No ______

Number of therapists on case: __________

Therapist(s) race/ethnicity: __________

Does therapist view treatment as successful?  Yes ______  No ______

Contact Information

Name: ________________________________________

Phone number: ________________________________________

Email address: ________________________________________

Best days/times for an interview: ________________________________________

Mailing address (to send gift card after interview):

________________________________________________________________________

________________________________________________________________________
APPENDIX C

Interview Protocol

Introduction:
This study is interested in how Black caregivers experience and engage in therapy at the Behavior Clinic. These questions will focus on you and how you approached this therapy with your child. We are interested in your perspective about participating in this therapy before, during, and after therapy, recognizing that your perspectives may have changed throughout the course of treatment. Our goal through this project is to understand and better meet the needs of Black caregivers who participate in therapy with their children at our clinic.

Opening questions:
These first questions ask about what you thought and felt prior to starting therapy. I want to get an idea about what you were anticipating or expecting would happen during treatment.

1. Why did you first seek Behavior Clinic services for your child?

2. Before therapy started, how did you feel about participating in therapy with your child?

3. What did you think therapy would be like? What did you think the therapist was going to do in the sessions?

4. What did you expect your involvement in the therapy would look like? How did you see yourself playing a role in the therapy?

Engagement in therapy:
Now we are going to talk about how you participated in sessions with your therapist.

5. As the therapist was working with your child, what did you do? How did you also participate?

6. What, if any, hesitations did you have about participating in therapy?

7. What did the therapist do to help involve you in the therapy?
   a. What aspects, if any, were helpful and encouraged your participation in sessions?
   b. What aspects, if any, were unhelpful and discouraged your participation in sessions?

8. In addition to involving you in the session, what, if anything, did the therapist do to create a positive relationship with you?
The next few questions ask about cultural influences on engagement, knowing that you and your therapist were of different cultural backgrounds.

9. What, if anything, did the therapist understand about your experience as a Black caregiver?
   a. How did you know the therapist understood your experience?
   b. How, if at all, did the therapist’s understanding of your experience affect your buy-in/participation in the therapy sessions?
   c. What, if anything, did you do differently in therapy because of how your experience was addressed?
   d. How, if at all, did this understanding affect the way you worked with the therapist?

10. What, if anything, did the therapist not understand about your experience as a Black caregiver?
    e. How did you know the therapist did not understand your experience?
    f. How, if at all, did this lack of understanding affect your buy-in/participation in the therapy sessions?
    g. What, if anything, did you do differently in therapy because of this lack of understanding?
    h. How, if at all, did this lack of understanding affect the way you worked with the therapist?

11. What else, if anything, influenced how or why you participated in therapy sessions?

Engagement between sessions:
We are also interested in how you applied the therapy to your daily life. These next questions ask about how you used the strategies from therapy on your own with your child.

12. Describe your use of treatment strategies between sessions.
    i. How did you use the treatment strategies between sessions?
    j. What, if anything, helped you use strategies between sessions?
    k. What, if anything, interfered with your use of strategies between sessions?

13. How, if at all, was therapy useful in your daily life? How was it relevant?

Closing Questions:
14. What suggestions, if any, do you have for the Behavior Clinic in order to better involve Black caregivers during treatment?

15. Is there anything else related to your overall engagement with therapy that I haven’t asked that you would like to share with me?
Dear <Name> 

My name is Jennifer Tomlin and I am a third-year doctoral student in counseling psychology at Marquette University. I am looking for volunteers to assist in my dissertation research exploring factors that may influence how Black caregivers engage in their young child’s mental health services. I am hoping to interview Black caregivers who have completed the Behavior Clinic’s treatment program within the last six months.

For this study, engaging in your child’s therapy means participating during sessions and using treatment strategies in between sessions. Questions will focus on you and how you approached this therapy with your child as well as how the therapist worked to involve you in sessions. I am really interested in your perspective about participating in this therapy before, during, and after therapy, recognizing that your point of view may have changed throughout the course of treatment. I am also interested in how you viewed your work with your child’s therapist, knowing you were of different cultural backgrounds. My goal is to understand and better meet the needs of Black caregivers who participate in therapy with their children at our clinic.

Caregivers who volunteer to participate in this study will be asked to participate in a phone interview (typically 45 to 60 minutes). Interview questions and procedures will be sent to you ahead of time so you can review them before the interview.

In appreciation for your time and participation, caregivers who complete the research interview will receive a $25 gift card.

If you are interested in learning more and potentially participating in this study, please contact me at jennifer.tomlin@marquette.edu or let your clinician know and I will contact you via phone to follow-up.
Dear <Name of Participant>,

Thank you for participating in our study examining the treatment experiences and engagement of Black caregivers at the Behavior Clinic at Penfield Children’s Center. You have made a valuable and important contribution to our research.

As a token of our appreciation, please accept the enclosed gift card. We are grateful for your time and participation in our project.

Sincerely,

Alan Burkard, Ph.D., and Jennifer Tomlin, M.S., LPC
Dept. of Counselor Education and Counseling Psychology
College of Education
Marquette University Milwaukee, WI 53201
414/288-3434
Alan.Burkard@marquette.edu