



Development and Validation of the Therapist Barriers to Engaging Parents (TBEP) Measure

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Abstract

Parent engagement is a well-documented challenge when delivering child and adolescent mental health treatments. Therapists' internal experiences, and how they respond to parents, may create a barrier to the parent engagement process. The current study developed the 13-item Therapist Barriers to Engaging Parents measure (TBEP) to assess providers' internal and external experiences that operate as barriers to parent engagement. The TBEP was completed by 148 child and family therapists across the United States. The TBEP demonstrated strong internal reliability (Cronbach $\alpha = .86$), and was negatively correlated with counselor efficacy, and significantly positively correlated with burnout, indicating convergent validity. Incremental validity of the subscales of the TBEP was also demonstrated. The TBEP appears to be a psychometrically sound measure of the internal barriers mental health providers experience when trying to engage parents.

Keywords Parents · Parent engagement · Therapists · Child mental health · Mental health services

Introduction

Mental health disorders in childhood and adolescence exact a toll on many families. Researchers estimate 20–40% of youth have a psychiatric disorder and likely need mental health services, while as few as half of children with a disorder actually receive services (Costello et al. 2011; Merikangas et al. 2010). Untreated childhood behavior problems have been shown to predict the development of unfavorable adolescent outcomes, such as early rejection by prosocial peers, academic difficulties and/or school dropout, out-of-home placement, criminal involvement, substance use, and teen pregnancy (Broidy et al. 2003; Webster-Stratton and Reid 2003). At the same time, internalizing problems in childhood, such as depression or anxiety disorders, can contribute to long-term impairments or even suicide (Copeland et al. 2014, 2017; Fergusson et al. 2005).

While childhood mental health disorders exert a cost at the individual, family, and societal levels, several promising evidence-based treatments exist. Parent Management Training (PMT) is a theoretically sound, empirically well-founded, and efficacious method for the treatment and prevention of externalizing behavior problems in children (Dretzke et al. 2009; Eyberg et al. 2008.; Webster-Stratton et al. 2011). Cognitive-behavioral therapies (CBT) are efficacious treatments for childhood internalizing disorders, which can include family-focused therapy or parent-focused portions of individual treatments in order facilitate positive treatment outcomes for the child (O'Neil et al. 2012; Wood et al. 2006). While the efficacy of parent-focused interventions across treatment modalities has been well documented, parent and service-provider variables related to treatment delivery and engagement may reduce the effective dissemination of these interventions in real-world practice settings. Half of youth who initially engage in mental health services discontinue treatment prematurely (Nock and Ferriter 2005; Pellerin et al. 2010, from; Becker et al. 2017). Specifically, McKay and colleagues (2001) found a third of families did not attend their requested appointments for mental health treatment, and families that were enrolled in services missed almost half of their scheduled appointments. It is clear that effective service delivery of any treatment involving parents depends on successful parent engagement and retention

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(National Institute for Health and Clinical Excellence 2006, 2009; Nock and Ferriter 2005; U.S. Department of Health and Human Services 2001, 2003).

There are multiple working descriptions of how to understand parent engagement, which have included parent attendance, participation in treatment, alliance with therapist, and attrition (Gopalan et al. 2010; Ingoldsby 2010; Staudt 2007 in Lindsey et al. 2014). Researchers are concluding that parent engagement is a construct with multiple factors including attitudinal, behavioral, facilitative, and socializing dimensions (Becker et al. 2017; Staudt 2007). Parent engagement is also a dynamic process throughout treatment in which practitioners play a primary role (Becker et al. 2017; Eames et al. 2010; Ingoldsby 2010; Koerting et al. 2013; Lindsey et al. 2014). Across studies, researchers have identified multiple behaviors of service providers that may *enhance* the parent engagement process, including: provider's overall assessment skills, and specifically assessing practical and psycho-social barriers for parents; psychoeducation about treatment, presenting problems, or service delivery; addressing parent perceptions about services; discussing with parents their beliefs about their children and themselves as parents; building a parent-therapist alliance; and evaluating a parent's stage of change and motivation (Becker et al. 2017; Eames et al. 2010; Ingoldsby 2010; Koerting et al. 2013; Lindsey et al. 2014).

Parent disengagement, non-adherence, or resistance (e.g., poor attendance, refusals to participate in discussions and activities, incomplete homework assignments; Wilson et al. 2015) during their child's treatment has been associated with negative practitioner attitudes and behaviors towards parents, which can *hinder* the engagement process (Wilson et al. 2015). Specifically, Patterson and Chamberlain (1994) and Patterson and Forgatch (1985) suggest that the barriers to parent engagement occur as a result of how therapists respond to and reflect upon the parent and their behaviors. For example, when the therapist perceives that the parent is not participating and externalizes the blame to the parent (i.e., sees the parent as "resistant" to therapy); the therapist may disengage or start to enter a coercive cycle. Based on the way in which therapists conceptualize parent "resistance" behaviors, therapists' emotional reactions to parent resistance behaviors, and actions therapists take in response to their internal reactions are aspects of the therapist's experience that can operate as barriers in the process of engaging parents. These negative attitudes and reactions to client behavior have been documented in therapists working with other difficult-to-treat client populations, such as individuals seeking treatment for Borderline Personality Disorder (Linehan et al. 2000).

In a review of literature on measuring parent engagement, only one measure was found that attempts to tap into a provider's experience with parent engagement process:

"Therapist Level of Engagement" by Orrell-Valente et al. (1999). Orrell-Valente and colleagues' (1999) created the "Therapist Level of Engagement" measure to assess therapists' beliefs about parents' behaviors, therapist self-reported responses to these behaviors, and self-reported abilities to remain empathic and supportive of parents when faced with parent disengagement or resistance during treatment (as suggested by Patterson and Chamberlain 1994). This measure was given to a sample of community-based child and family therapists implementing a specific PMT program and contained the following three subscales and corresponding reliability: Therapist's Beliefs about Parent Response ($\alpha = .91$); Therapist's Ability to Remain Empathic and Supportive ($\alpha = .85$); and Therapist's Ability to Remain Effective in Teaching and Confronting Parents ($\alpha = .86$). However this measure was designed for providers' level of engagement to be evaluated during the delivery of a specific intervention, and did not tap into a broader measurement of internal attitudes and reactions to parent behavior providers experience on a day-to-day basis while working with families.

While parents experience their own barriers to treatment engagement (Staudt 2007), it appears that a therapist's internal experiences and/or responses to challenges in working with parents may also present as a barrier to the parent engagement process. Practitioner behaviors could be a focal point for intervention in addressing parents' engagement-related behaviors. Therefore, measuring and addressing therapist internal barriers to parent engagement is essential in order to provide parent-focused evidence-based interventions that will positively impact children in need. However, no measure, to our knowledge, has been developed to assess clinicians' barriers to engaging parents. Thus, the purpose of this study is to develop a self-report measure, the Therapist Barriers to Engaging Parents measure (TBEP), which seeks to assess providers' internal and external experiences that operate as barriers to parent engagement.

Methods

Developing the Item Pool

The development of the Therapist Barriers to Engaging Parents measure (TBEP) consisted of conducting semi-structured interviews with community behavioral health clinicians about their perceptions of barriers to engaging parents, and comparing these findings to provider factors related to parent engagement and subscale content found in Orrell-Valente et al. (1999) Therapist Engagement measure. The qualitative results of these interviews provided further support for aforementioned elements of the parent engagement process and informed the factors represented in the TBEP.

Incorporation of Key Informant Perspectives

To capture relevant aspects of parent-engagement that had not yet been identified in the literature, and to assess how valid the concepts identified in the literature were to the lived experiences of clinicians, semi-structured interviews with key informants were conducted. Six key informants from three community behavioral health agencies in the North-west Ohio area completed the semi-structured interview. Each key informant is a supervisor of front-line staff that provide services within each of the programs they oversee.

Interviews lasted between 60 and 90 min, and were audio-recorded and transcribed. The semi-structured interview consisted of 18 open-ended questions. These questions were grouped into the following sub-sections: Conceptualization and Role of Parents; Services Offered to Parents; Agency Recruitment, Referral Processes, and Outreach to Parents; Staff Barriers to Parent Engagement; and Agency/Staff Perceptions of Parent Barriers. Importantly, within each sub-section key informants were asked to report on overarching agency policies (i.e., “Who/what organizations refer(s) parents/children to your organization?” and “Once a parent is in contact with your organization, how are they referred to a specific service within your agency?”) as well as aspects of their program’s services (i.e., “How are parents involved in this service/program?” and “For any of the services/programs you do with parents, do you use any pre-determined curriculum, manuals, or other pre-packaged materials?”). Additionally, key informants were asked to provide information on their staff’s experiences within the agency (i.e. “Tell me about any training opportunities you have for staff in terms of engaging and retaining parents in services.”) and their perspectives on the barriers their staff face when engaging parents (i.e., “What are some of the struggles your staff has faced when working with parents already involved in a specific service?”).

Thematic analysis by two transcript reviewers revealed two major themes occurring across interviews related to barriers to parent engagement. The first theme was that staff members’ conceptualization and reactions to parent behavior emerged as a barrier to engaging parents. Key informants reported their staff expressing negative emotional responses when confronted with a lack of parent participation or other parent “resistance” behaviors. The second theme was that clinicians’ conceptualizations of the sources or intentions of parents’ behavior influenced their negative emotional responses. In general, the emotional responses of staff were indicated as a barrier to staff being able to work with and engage parents effectively. This theme is also illustrated by key informants reporting on staff difficulties addressing mental health problems that parents may experience. Key informants suggested staff characteristics, such as the length of time they have been practicing in their field or the

relationship they have built with that parent, may influence this barrier for staff when trying to engage parents. These qualitative results provide a real-world illustration of these empirically-supported concepts, with key informants reporting across agencies that the way their staff conceptualize and respond to parent behaviors within the therapeutic process creates a barrier for staff to engage parents effectively.

Based on the review of the literature, relevant measures, and the semi-structured interviews, items were developed for the Therapist Barriers to Engaging Parents (TBEP) measure. First, six items from the Orrell-Valente et al.’s measure “Therapist Level of Therapeutic Engagement” were modified to apply to a sample of therapists implementing a variety of parent-focused services. Then, the elements of therapists’ internal experiences identified from the pre-existing literature, and the themes generated from the qualitative key-informant study, informed the creation of 10 additional items (for a total of 16 items). The measure used a 5-point Likert scale, ranging 1 = Never to 5 = Almost Always, with higher scores indicating more internal barriers to effectively engage parents.

Validation of the TBEP

Procedure

To examine the reliability and validity of the TBEP, participants were recruited through a random selection of hospitals, outpatient clinics, and community behavior health centers (CBHCs) across the United States, drawn from the national list of mental health treatment facilities available through the Joint Commission directory. The Joint Commission website provides a list of accredited organizations by state, and every fifth agency on each state’s list was randomly selected to be contacted for recruitment. One hundred and ten agencies were recruited via phone or email and 22 agencies agreed to participate (20%). Similar response rates were found in other studies that sent recruitment emails to recruit a national sample of substance abuse counselors (20%, Davis and Rosenberg 2013; 10%; Rosenberg and Davis 2014). This study was unable to calculate a specific therapist response rate because the number of therapists employed at each agency that agreed to participate was unknown. Therefore, it is impossible to determine how many therapists were provided with the study’s recruitment email, and chose not to participate.

An email was sent to directors and upper-level administration employed at the randomly selected agencies, which provided a brief explanation of the study, the benefits of having that agency’s clinicians participate, and a description of employees who are eligible to participate in the study. Administrators who agreed to allow their agency to participate were sent an invitation email to be forwarded to employees who meet the eligibility criteria. This invitation

email briefly summarized the study, and included a hyperlink to click if the staff member was interested in completing the study or learning more information. Participants were also recruited through advertisements posted on social media websites (Facebook, LinkedIn, etc.). All participants were provided with the opportunity to be entered into a random raffle where they could win 1 of 4 \$50 Amazon gift cards or 1 of 2 \$100 Amazon gift cards. This study was approved by the authors' university institutional review board.

Sample

A total of 149 child and family therapists completed the online survey. One participant was not included in final data analysis because they completed less than 50% of the survey items (see Table 1 for demographic characteristics). Of the 148 participants used for the final sample, 29% ($n=43$) were recruited through advertisements posted on social media websites (Facebook, LinkedIn, etc.).

Measures

The following measures were also administered in addition to the TBEP.

Therapist Efficacy for Engaging Parents This 20-item measure was created by the authors to measure participants' self-efficacy for the specific occupational task of engaging parents in their child's treatment services (Cronbach's $\alpha=.93$). Previous research has demonstrated that specific job tasks are important in assessing efficacy expectations (Rooney

and Osipow 1992) and that the appropriate level of measurement of occupational self-efficacy is the task-specific level (Bores-Rangel et al. 1990; Matsui and Tsukamoto 1991; Lent and Brown 2006). Responses to these items were rated on a 6-point Likert scale of 1=I would not do this, 2=Very Low Confidence, 3=Low Confidence, 4=Moderate Confidence, and 5=High Confidence. The creation of this measure was informed by research conducted in the area of parent engagement and service-providers' role in the parent engagement process (Kazdin et al. 1997; Nock and Kazdin 2001; Nock and Photos 2006; Staudt 2007). The creation of this measure is consistent with the creation of other job-related efficacy measures (Bodenhorn and Skaggs 2005; Kranz 2003). The sum of these 20 items was calculated for each participant, and a higher score reflected greater confidence in parent engagement skills. The rationale for creating and including this measure is that most research has examined counselors' beliefs about their overall counseling abilities, rather than task or client-specific aspects of CSE (Lent et al. 2003). For example, child and family therapists may experience varying levels of efficacy for engaging parents effectively in their child's treatment, performing counseling behaviors with children individually, or providing counseling services to an entire family unit. If a therapist is frequently presented with parent resistance or disengagement that they cannot successfully navigate, an accumulation of these experiences may decrease their feelings of professional efficacy when it comes to engaging parents. Therefore, researchers have suggested that it may be beneficial to study task-specific CSE, such as parent engagement, in rela-

Table 1 Participant demographics

	n	Percent	Mean (SD)
Age			37.05 (11.43)
Years practicing in field			8.01 (8.49)
Gender			
Female	129	87%	
Male	19	13%	
Education			
Bachelor's in social work or psychology	6	4%	
Master's in social work	44, 12	30% licensed, 8% unlicensed	
Master's in clinical counseling	45, 12	31% licensed, 8% unlicensed	
Licensed marriage/family therapist	7	5%	
Doctorate in psychology or social work	15	10%	
Employment			
Community Behavioral Health Center	96	65%	
Outpatient Clinic	21	14%	
Hospital/residential facility	10	7%	
Other (schools, juvenile justice, in-home and hospice care, board of developmental disabilities, private practice)	19	13%	

tion to general CSE and under circumstances that resemble real-world counseling relationships (Lent et al. 1998).

Burnout The Maslach Burnout Inventory–Human Services Survey (MBI–HSS) was used to assess the participants’ report of burnout (Maslach and Jackson 1981; Maslach et al. 1996). The MBI–HSS 22 items measure three dimensions of burnout (emotional exhaustion, depersonalization, and reduced personal accomplishment subscales). Items were scored on a 7-point scale ranging from Never to Every Day (1 = Never, 4 = A Few Times a Month, 7 = Daily). The measure has good internal consistency and test–retest reliability (Maslach and Jackson 1981; Gibson et al. 2009; Kim et al. 2011; Rosenberg and Pace 2006). In the current sample, the subscale alphas ranged from .71 to .88. It was important to include this measure because providers’ negative internal and external experiences that operate as barriers to parent engagement could be influencing, or be indicators of, dimensions of burnout. Researchers have suggested that mental health professionals experiencing burnout can engage in behaviors that negatively impact the care they give to their clients, such as making faulty judgments or exhibiting inflexible thinking by adopting a rigid stance toward problematic situations (Wallace et al. 2010).

Overall Counseling Efficacy Participants’ overall or general therapist efficacy was measured using a shortened version of the Counseling Self-Estimate Inventory (COSE) designed by Larson, et al. (1992). The original COSE consists of 37 statements with 6-point Likert-type responses on a scale of 1 (strongly disagree) to 6 (strongly agree). This study utilized the seven items from the “Difficult Client Behaviors” subscale and the 10 items from the “Process” subscale to provide a general measure of therapist efficacy (Cronbach’s $\alpha = .81$ in current sample). Higher total summed scores denote stronger self-perceptions of one’s overall counselling self-efficacy. This measure was included because overall counseling efficacy could prevent or ameliorate a therapist from experiencing negative attitudes or reactions to client behavior, because a therapist with higher confidence in their counseling abilities could be able to separate a parent’s behavior from their own therapeutic or interpersonal skills.

General Self-esteem Participants’ general level of self-esteem was measured using The Rosenberg Self-Esteem Scale (RSE, Rosenberg 1965; Cronbach’s $\alpha = .89$ in current sample). The RSE consists of 10 items with 4-point Likert-type responses on a scale of 0 (Strongly Disagree), 1 (Disagree), 2 (Agree), and 3 (Strongly Agree). The measure has good internal consistency, convergent and divergent validity (Robins et al. 2001). Higher total summed scores denote higher levels of overall self-esteem. A validated measure of self-esteem was included in this study’s survey in order to

be able to control for the positive effects one’s self-esteem could have on one’s professional confidence and ability to navigate internal barriers to engaging parents. Researchers have indicated that positive self-esteem is associated with greater ability to manage stress—which could impact therapists’ experiences of internal barriers to parent engagement (Kogler et al. 2017; Lee et al. 2013).

Analytic Plan

The variables of age, gender, degree/licensure, work setting, a general measure of self-esteem, and length of time practicing in the field of mental health treatment were also included in correlational analyses to determine which of those variables should be included as covariates in remaining analyses. An Exploratory Factor Analysis (EFA) was conducted to examine the factor structure of the TBEP and to aid in item reduction. To test internal reliability, Cronbach’s alphas were calculated on the resulting subscales of the TBEP. To examine convergent validity, correlational analyses were conducted to examine the associations between the TBEP and therapist PE efficacy, general counseling efficacy, and burnout. Incremental validity was also examined using regression analysis to investigate whether the TBEP predicted clinician emotional exhaustion, one of the three dimensions of burnout, over and above counseling efficacy, while controlling for indicated covariates. All authors certify responsibility for the manuscript, and there are no known conflicts of interest with any of the authors of this study.

Results

Preliminary Analyses

Before conducting analyses, the current sample was screened for univariate outliers (defined as more than three standard deviations from the mean); one participant was identified as an outlier on the TBEP measure, and three participants were identified outliers on the Depersonalization (DP) subscale of the burnout inventory. These participants’ total raw scores were trimmed to one above the next-highest value. The TBEP, Therapist Efficacy for Engaging Parents, and the three subscales of Burnout (Emotional Exhaustion, Personal Accomplishment, and Depersonalization) were assessed for skew and kurtosis before conducting hierarchical regressions, and the Burnout subscales were found to be highly skewed. Therefore, these variables were log transformed for use in the main analyses. Three participants were missing more than 50% of items on a given measure, therefore, the mean of the participant’s responses was used to provide responses on remaining missing items. Because participant age and years of experience practicing in the field were

significantly correlated with the burnout subscales, these variables were used as covariates in the incremental validity analysis.

Item Reduction and Factor Structure

After removing items (3) due to low inter-item correlations, the final 13 items were entered into an EFA, (using Oblimin rotation). An examination of the scree plot revealed a three-factor solution, with items loading above .40 on each factor. Seven items loaded onto the first factor, and represented therapists' perceptions and emotional experiences related to parents in treatment (*Therapist Emotional Experiences*). Two items loaded onto a second factor and represented therapists' blaming and negative judgments towards parents (*Therapist Judgments*). Four items loaded onto the third factor, and represented therapist reactions in treatment and ways parents' behavior in treatment can influence therapist behaviors and decisions (*Therapist Reactions in Treatment*). The EFA for the final set of TBEP items is presented in Table 2.

Reliability and Convergent Validity of the TBEP

Internal reliability for the overall TBEP was strong (Cronbach $\alpha = .86$). Acceptable internal validity was also found for each of the three subscales: Therapist Emotional Experiences, Cronbach $\alpha = .76$; Therapist Judgments, Cronbach $\alpha = .74$; Therapist Reactions in Treatment; Cronbach $\alpha = .78$.

The TBEP overall measure, and the three subscales, were significantly negatively correlated with therapist levels of parent engagement efficacy, and significantly negatively correlated with overall counselor self-efficacy (see Table 3), supporting convergent validity. Further, TBEP and its three subscales were significantly positively correlated with the Emotional Exhaustion and Depersonalization subscales of Burnout, and significantly negatively correlated with the Sense of Personal Accomplishment subscale of Burnout, also indicating convergent validity of the TBEP (see Table 3).

Incremental Validity of the TBEP

Three linear regressions were conducted to test the incremental validity of each subscale of the TBEP in predicting therapist burnout. In the first regression, the Therapist Emotional Experiences subscale significantly predicted emotional exhaustion, over and above counselor efficacy ($B = .35, p < .01$; see Table 4). In the second regression, the Therapist Emotional Experiences subscale also predicted depersonalization, over and above counselor efficacy ($B = .42, p < .01$). Similarly, the Therapist Emotional Experiences subscale predicted sense of personal accomplishment ($B = -.20, p < .05$). Similar findings emerged for the other subscales of the TBEP, further supporting incremental validity of the TBEP subscales (see Tables 5, 6).

Table 2 Exploratory factor analysis (EFA) with Oblimin rotation of 13-item therapist barriers to parent engagement measure

Component			
Item	1	2	3
I feel the parents I work with do not respect what I have to offer ^a	.570	-.180	.113
Most parents I work with are unmotivated ^b	.069	-.898	-.110
I see most of the guardians I work with as a barrier to their child's success ^b	.155	-.480	-.233
I take it personally when a parent is not making an effort in therapy ^b	.414	.207	-.184
I find it difficult to maintain a friendly and open attitude towards some parents ^a	.640	-.055	-.074
It is difficult for me to feel caring and interest for some parents I work with ^a	.564	.062	-.078
It is difficult for me to give some parents the respect I would like to ^a	.655	.030	-.012
I find it difficult to understand the feelings and experiences of some parents ^a	.447	.031	-.027
I feel the parents I work with trust me and are honest with me ^a	.465	-.130	-.018
When I'm frustrated with a parent, it's difficult for me to keep working with them ^b	-.036	-.046	-.748
I have honestly not felt like trying anymore with some guardians, that it was hopeless ^b	.257	-.057	-.528
It's hard for me to continue trying to involve a parent if it seems like they don't want services ^b	.122	.077	-.550
I am hesitant to continue involving a parent if they become defensive or angry with me ^b	-.036	-.124	-.689
% of Variance	37.41%	10.01%	8.26%
Eigenvalue	4.86	1.30	1.07

Oblimin with Kaiser Normalization rotation method used requesting Eigenvalues > 1.0. Highest factor loadings. Correlations between the item and the factors per item are bolded

^aItem adapted from Orrell-Valente et al. (1999) measure

^bItem created by author

Table 3 Convergent validity of the therapist barriers to parent engagement measure (TBEP): correlations between TBEP total score and subscales and therapist efficacy and burnout

Variable	1	2	3	4	5	6	7	8	9
1. Barriers to parent engagement (total score)	–								
2. Therapist emotional experiences subscale	.90**	–							
3. Therapist judgments subscale	.65**	.43**	–						
4. Therapist reactions in treatment subscale	.86**	.61**	.44**	–					
5. PE efficacy	–.57**	–.51**	–.36**	–.50**	–				
6. Counselor self-efficacy	–.48**	–.42**	–.28**	–.47**	.63**	–			
7. EE	.43**	.39**	.25**	.36**	–.35**	–.25**	–		
8. DP	.52**	.51**	.30**	.42**	–.39**	–.36**	.49**	–	
9. PA	–.39**	–.38**	–.26**	–.30**	.56**	.52**	–.31**	–.29**	–
Mean (SD)	2.25 (0.45)	2.07 (0.45)	2.85 (0.68)	2.27 (0.63)	1.94 (0.05)	4.46 (0.70)	1.48 (0.13)	1.01 (0.15)	1.68 (0.50)
Range	1.23–3.69	1.14–3.43	1.00–4.50	1.00–4.00	59.00–100	1.47–6.00	1.04–1.74	0.78–1.40	1.51–1.76

PE parent engagement, EE emotional exhaustion, DP depersonalization, PA personal accomplishment

** $p < .01$

Discussion

The purpose of this study was to develop and test the reliability and validity of a measure of therapists' internal barriers to engaging parents in a national sample of child and family therapists. The effective treatment of childhood mental health disorders requires a therapeutic alliance with parents that facilitates their engagement in parent-focused interventions (Danko et al. 2016; Kazdin and Whitley 2006; Kazdin et al. 2006; Nock and Ferriter 2005). Therapist internal barriers to engaging parents likely contributes, at least in part, to the high dropout rates found when implementing evidence-based treatments for youth behavior problems (Koerting et al. 2013; Lindsey et al. 2014; Orrell-Valente et al. 1999; Patterson and Forgatch 1985; Patterson and Chamberlain 1994). Thus, creating a measure to detect such therapist experiences could be used to enhance the effective delivery of evidence-based treatments in real-world settings, and may be essential for the achievement of successful outcomes with parents and children.

The Therapist Barriers to Engaging Parents (TBEP) measure was developed based on existing theories in the literature (Orrell-Valente et al. 1999; Patterson and Forgatch 1985; Patterson and Chamberlain 1994) and qualitative interviews with key informants employed at community behavioral health agencies. The TBEP and its' three subscales evidenced strong psychometric properties. Further, the TBEP demonstrated adequate incremental validity, with the TBEP subscales independently predicting therapists' level of burnout, over and above a general professional efficacy. These findings provide further supporting evidence

for theories proposed by Patterson and colleagues (Patterson and Forgatch 1985; Patterson and Chamberlain 1994), which suggested that therapist barriers to parent engagement occur as a result of *how* therapists reflect upon and respond to the parent, their relationship with the parent, and the parent's behaviors. The preliminary validation of this measure sheds light on the internal experiences of mental health providers, and provides legitimacy to the construct of internal barriers therapists can experience when trying to work with parents. This study's results also demonstrated associations between the way providers think and feel about parents, and how efficacious they feel about their parent engagement skills and their overall counseling abilities. Results from Tables 4, 5 and 6 revealed that therapist emotional experiences and judgements they make about parents can uniquely contribute to their levels of emotional exhaustion and depersonalization. These findings elude to an important connection between certain internal attitudes and responses providers can have, and possible broader consequences of higher burnout rates and poorer professional efficacy. Becker and colleagues (2017) synthesized 40 years of engagement research in children's mental health services, and suggested that "the field would benefit from further alignment of research operations with the conceptualization of engagement as a dynamic, multidimensional, and transactional construct." The TBEP could add depth and dimension to future investigations of parent engagement, as it assesses a transactional portion of the engagement process and appears to have significant relationships with provider outcome variables like professional efficacy and burnout.

Table 4 Incremental validity of the therapist emotional experiences subscale

Predictors	ΔR^2	β
Emotional exhaustion		
Step 1	.03	
Age		-.10
Years of practice		-.09
	$F(2,137) = 1.96$	
Step 2	.05	
Age		-.03
Years of practice		-.08
Counselor self-efficacy		-.23*
	$F(3, 136) = 3.57^*$	
Step 3	.10	
Age		-.02
Years of practice		-.09
Counselor self-efficacy		-.08
Therapist emotional experiences		.35**
	$F(4, 135) = 7.08^{**}$	
Depersonalization		
Step 1	.09	
Age		-.37**
Years of practice		.21
	$F(2, 137) = 6.40^{**}$	
Step 2	.10	
Age		-.28**
Years of practice		.23*
Counselor self-efficacy		-.33**
	$F(3, 136) = 9.99^{**}$	
Step 3	.15	
Age		-.26**
Years of practice		.21*
Counselor self-efficacy		-.15
Therapist emotional experiences		.42**
	$F(4, 135) = 16.38^{**}$	
Sense of personal accomplishment		
Step 1	.04	
Age		.14
Years of practice		.08
	$F(2, 137) = 2.84$	
Step 2	.23	
Age		-.01
Years of practice		.05
Counselor self-efficacy		.51**
	$F(3, 136) = 16.62^{**}$	
Step 3	.03	
Age		-.02
Years of practice		.06
Counselor self-efficacy		.42**
Therapist emotional experiences		-.20*
	$F(4, 135) = 14.57^{**}$	

* $p < .05$, ** $p < .01$

Table 5 Incremental validity of the therapist judgments subscale

Predictors	ΔR^2	β
Emotional exhaustion		
Step 1	.03	
Age		-.10
Years of practice		-.09
	$F(2,137) = 1.96$	
Step 2	.05	
Age		-.03
Years of practice		-.08
Counselor self-efficacy		-.23*
	$F(3, 136) = 3.57^*$	
Step 3	.03	
Age		-.01
Years of practice		-.05
Counselor self-efficacy		-.19*
Therapist judgments		.18**
	$F(4, 135) = 3.84^{**}$	
Depersonalization		
Step 1	.09	
Age		-.37**
Years of practice		.21
	$F(2, 137) = 6.40^{**}$	
Step 2	.10	
Age		-.28**
Years of practice		.23*
Counselor self-efficacy		-.33**
	$F(3, 136) = 9.99^{**}$	
Step 3	.05	
Age		-.26*
Years of practice		.26*
Counselor self-efficacy		-.28**
Therapist judgments		.23**
	$F(4, 135) = 9.82^{**}$	
Sense of personal accomplishment		
Step 1	.04	
Age		.14
Years of practice		.08
	$F(2, 137) = 2.84$	
Step 2	.23	
Age		-.01
Years of practice		.05
Counselor self-efficacy		.51**
	$F(3, 136) = 16.62^{**}$	
Step 3	.01	
Age		-.02
Years of practice		.04
Counselor self-efficacy		.48**
Therapist judgments		-.11
	$F(4, 135) = 13.08^{**}$	

* $p < .05$, ** $p < .01$

Table 6 Incremental validity of the therapist reactions in treatment subscale

Predictors	ΔR^2	β
Emotional exhaustion		
Step 1	.03	
Age		-.10
Years of practice		-.09
	$F(2, 137) = 1.96$	
Step 2	.05	
Age		-.03
Years of practice		-.08
Counselor self-efficacy		-.23*
	$F(3, 136) = 3.57^*$	
Step 3	.08	
Age		.02
Years of practice		-.11
Counselor self-efficacy		-.08
Therapist reactions in treatment		.32**
	$F(4, 135) = 6.00^{**}$	
Depersonalization		
Step 1	.09	
Age		-.37**
Years of practice		.21
	$F(2, 137) = 6.40^{**}$	
Step 2	.10	
Age		-.28**
Years of practice		.23*
Counselor self-efficacy		-.33**
	$F(3, 136) = 9.99^{**}$	
Step 3	.06	
Age		-.24*
Years of practice		.20*
Counselor self-efficacy		-.20*
Therapist reactions in treatment		.28**
	$F(4, 135) = 10.72^{**}$	
Sense of personal accomplishment		
Step 1	.04	
Age		.14
Years of practice		.08
	$F(2, 137) = 2.84$	
Step 2	.23	
Age		-.01
Years of practice		.05
Counselor self-efficacy		.51**
	$F(3, 136) = 16.62^{**}$	
Step 3	.01	
Age		-.03
Years of practice		.07
Counselor self-efficacy		.46**
Therapist reactions in treatment		-.11
	$F(4, 135) = 12.94^{**}$	

* $p < .05$, ** $p < .01$

There were limitations of this study that should be addressed in the future. The cross-sectional design precludes inference of causal relationships between variables of interest. Further, missing variables may be important to further explore findings regarding the influence of therapist barriers to parent engagement and parent engagement efficacy. For example, this sample did not include a measure that specifically assessed parent disengagement. Therefore, the mechanisms by which therapist barriers to parent engagement influence parent engagement efficacy are unclear. This study is a preliminary validation of the TBEP measure and future research is needed to confirm factor structure and validity with other relevant measures such as parent-report of therapeutic alliance, supervisor ratings of barriers to parent engagement expressed by supervisees, parents' attendance or "show rate" in treatment, and parent and child treatment outcomes. Another limitation is that the sample size was relatively small and participants were not asked to report their race/ethnicity; thus, the findings may not generalize to all therapists from different ethnic backgrounds.

The current study supports the TBEP as a psychometrically sound measure of the internal barriers mental health providers experience when trying to engage parents. Future studies should confirm the factor structure of the TBEP and validity in a larger sample of therapists. This study has provided preliminary support for the importance of assessing and addressing therapist internal barriers to engaging parents. This study has also offered a possible method for future research efforts investigating the transactional nature of parent engagement. Specifically, the TBEP could be used as a tool by supervisors in mental health treatment settings to better understand and support their providers by identifying areas of their work with parents that are challenging. Supervisors could also have providers complete the TBEP in a systematic fashion, and higher TBEP scores could provide a possible explanation, or addressable component, of providers' lack of patient engagement or poor attendance rates for services. Further, these initial findings suggest that interventions could be used with practitioners to positively impact the parent engagement process, protect therapists' professional efficacy, and possibly decrease premature treatment termination. Possible interventions could include: identifying and managing providers' interpretations and reactions to parent behaviors through perspective taking and self-reflection exercises, psychologically processing problem cases to determine what it is about a parent that is making it difficult for the provider to engage them, and re-adjusting treatment approaches to fit a family's engagement needs once obtaining clarification around the provider's attitudes and reactions to parent engagement issues. Providers and supervisors/managers could utilize these interventions within the context of supervision for providers in training,

or ongoing clinical management meetings conducted with licensed providers in mental health treatment settings. Additional trainings for providers could include: developing provider self-awareness around internal barriers to engaging; increasing providers' skills that facilitate the parent engagement process already identified in previous research (Becker et al. 2017; Lindsey et al. 2014; Staudt 2007), possibly decreasing the severity and frequency of providers' developing internal barriers to engaging parents; how to engage parents with community outreach by conducting appointments in locations easily accessed by families (e.g. family home, library, community center); and cultural sensitivity training that includes understanding of how to navigate cultural barriers. These interventions could also increase the likelihood of retaining quality counselors in the field of mental health treatment while improving overall client outcomes.

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