The Effects of Parent Participation on Child Psychotherapy Outcome: A Meta-Analytic Review
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Overview of Child Psychotherapy Research
- 8-12% of young children and 15% of adolescents within the general population experience clinically severe emotional and behavioral difficulties (Roberts, Attiksson, & Rosenblatt, 1998)
- Throughout childhood and adolescence, approximately 10% of youths (ages 3-17) will have received some form of psychological intervention for behavioral or emotional problems (U.S. Congress, 1991)

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Overview of Child Psychotherapy Research
- Kazdin (2000) estimated over 500 different therapies currently in use for children
- 80% of surveyed clinicians indicated that they routinely include children as well as parents as treatment participants (Kazdin, Siegel, and Bass, 1990)
- To date there is little empirical evidence comparing treatments that include parent participation to those that primarily involve youths

Overview of Child Psychotherapy Research
- Kazdin (2003) evidence based treatments:
  - Depression: CBT*, Coping with Depression course, Interpersonal Psychotherapy
  - Anxiety: Systematic Desensitization*, Modeling*, Reinforced Practice*, CBT*
  - ODD/CD: MST*, Problem-Solving Skills Training*, Parent Management Training*
  - ADHD: Stimulant Medication, Parent Management Training*, Classroom Contingency Management Programs

Previous Child Psychotherapy Meta-Analyses
- Most studies have found child psychotherapy to be effective (ES = .7) compared to no treatment controls
  - Limitations:
    - Based on studies that often used tightly controlled clinical samples
    - Publication bias (more likely to have significant results)
    - Findings smooth over possibly unique differences between treatments and populations
**Previous Child Psychotherapy Meta-Analyses**

Hazelrigg, Cooper, & Borduin (1987)

- 7 studies pub. 1966-1984 compared individual to family therapy for children/adolescents
- Family therapy was more effective than individual therapy on measures of family interaction and behavior ratings.
- Limitations:
  - Findings not very robust (fail safe N = 10)
  - Most studies were based on behavioral disorders

Shadish et al. (1993):

- 9 studies compared family to individual therapy for children/adolescents
- Family therapy was less effective than individual treatment (ES = -.28)

**Current Study**

- Psychotherapy defined as: “any intervention intended to alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior through counseling, structured or unstructured interaction, a training program, or a predetermined treatment plan” (Weisz et al., 1995)

**Current Study**

- Exclusions (following Weisz et al., 1995):
  - Drug therapy
  - Bibliotherapy
  - Relocation of children
  - Prevention programs
  - Mental retardation
  - Learning problems
  - Medical problems

**Current Study**

- Inclusion criteria:
  - Compared individual treatment to a treatment group that included significant parent participation (either combined parent/child or parent only treatment)
  - Contained pre and post-treatment data
  - Random assignment or matching group equivalency
  - Minimum N = 5
  - Target of treatment < 18 years of age
  - Target child experienced clinically significant distress

**Current Study**

- A priori identified moderator variables:
  - Difference in number of therapy sessions
  - Therapy orientation (behavioral/nonbehavioral)
  - Presenting problem (internalizing/externalizing)
  - Mean sample age
  - Methodological quality of study
  - Type of outcome measure (specific vs. global)
Results

- 42 original psychotherapy studies, N = 4,189
- Mean age = 11.66, 64% male subjects
- 26% elementary, 38% adolescent
- 57% externalizing problems, 24% internalizing, 5% abuse, 7% other
- Cognitive behavioral most common orientation (63-100%)
- 65% Caucasian, 21% African American, 26% Other subjects

Results

- Significant test of homogeneity of variance
  Q (7) = 15.175, p < .05
  Q (40) = 138.75, p < .05

There is greater variability among effect size estimates than sampling error alone. Must adjust weighted mean effect size and look for significant moderators.

Results

- Child only vs. combined treatments: d = .25 (range 1.86 to -.77) N = 41
- Child only vs. parent only treatments: d = .13 (range .78 to -.76) N = 8
- Child only vs. controls: d = .44 (range 3.34 to -.45) N = 19
- Combined treatment vs. controls: d = 1.03 (range 4.6 to -.76)
- Fail safe N = 50

Moderator Analysis for Child Only to Combined Treatments

- Entered into regression analysis as individual predictors, only child treatment orientation was marginally significant. R = .286, F (1,39) = 3.49, p = .069
- Cognitive behavioral child only treatment was closer in effectiveness to combined treatments
- Stepwise regression: no significant moderator variables were identified.

Discussion/Implications

- D = .25 is consistent with Grissom’s (1996) meta-meta-analysis median probability of effectiveness when comparing two treatments.
- Findings support the incorporation of both parents and children in treatment.
- No difference between child only and parent only treatments.

Discussion/Implications

- Findings are preliminary but seem to support the family systems model of treatment, inclusion of multiple family members is most beneficial
- The addition of parent participation in treatment is more beneficial, regardless of child’s age, presenting problem, method of outcome assessment
Limitations

- Lack of homogeneity of variances
- Samples mostly comprised of tightly controlled efficacy-style studies
- Uneven distribution of treatment orientation and presenting problem
- Psychometric properties of outcome measures

Future Directions

- Examining other potential moderators of effect size: level of therapist training, level of initial severity of presenting problem, culture/race, outcome informant
- Examining under what context is parent participation most beneficial

Thank you for your attention

- Comments?
- Questions?
- Concerns?
- Compliments?
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