

**Participation Enhancement Intervention:
A Brief Manual for a Brief Intervention**

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Introduction

Treatment attendance and adherence are among the most basic necessities for therapeutic change in psychotherapy. This is particularly true for skills-based, cognitive-behavioral oriented approaches, which dominate current lists of evidenced based treatments (e.g., Kazdin & Weisz, 2003; Nathan & Gorman, 2002). With most psychosocial interventions focused directly on changing behavioral dysfunction, little attention has been given to developing procedures for increasing treatment participation. Toward this end, we developed and evaluated a brief intervention designed to enhance parent attendance and adherence to child therapy—the Participation Enhancement Intervention.

A recent review of the limited literature on participation enhancement interventions used in the context of child therapy reveals few approaches have been developed and evaluated (see Nock & Ferriter, 2005). Most existing programs have used a preparatory interview or orientation session to educate parents about the structure of therapy (e.g., Bonner & Everett, 1986; Day & Reznikoff, 1980; Wenning & King, 1995), or contingency contracting techniques to provide tangible rewards for ongoing participation (Aragona, Cassady, & Drabman, 1975; Eyberg & Johnson, 1974; Fleischman et al., 1979). Surprisingly absent from this literature is the use of motivational enhancement techniques, which are effective at increasing participation and outcomes in the adult psychotherapy literature (Miller & Rollnick, 2002). Also lacking is a focus on addressing barriers to treatment participation, which are related to poor attendance and premature termination (Kazdin, Holland, & Crowley, 1997).

Motivational enhancement approaches, particularly “Motivational Interviewing”—the most widely used motivational enhancement treatment package, have been effective in increasing participation and clinical change in adult psychotherapy with various populations (Miller & Rollnick, 2002). The guiding principles and specific techniques used in motivational enhancement approaches have been specified in manual form (Miller, Zweben, DiClemente, & Rychtarik, 1999). At the core, motivational enhancement approaches focus first on building motivation to change by highlighting the discrepancy between present behavior and desired outcomes, and subsequently on strengthening commitment to change by supporting the individual’s sense of self-efficacy regarding behavior change. This typically is done within the context of a brief, supportive therapeutic relationship lasting at least 30-60 minutes, with special attention given to expressing empathy and avoiding confrontation and argumentation. Within this overall framework, some of the specific techniques used to achieve and maintain increased motivation include eliciting self-motivational statements and generating an action plan using a change plan worksheet (Miller et al., 1999). The elicitation of self-motivational statements through verbal means as well as through use of the change plan worksheet, in which the client specifies what changes they will make, are among the hypothesized mechanisms of change in motivational enhancement approaches (Zweben & Zuckoff, 2002). Elicitations of self-motivational statements are theorized to increase motivation to change based on self-perception theory, which states that as an individual makes personal statements in support of a given point of view the individual becomes more committed to believing and acting in accordance with that view (Bem, 1967). For instance, when used to treat adult psychopathology, these techniques typically contrast current problem behaviors (e.g., substance abuse) with desired outcomes (e.g., good health) and elicit statements and specific plans centered on changing maladaptive behaviors to more adaptive ones (e.g., “I would like to stop using cocaine because it’s led to several medical problems for me...so I think it’s important that I get treatment for my drug problem.”).

Given the relations between parent motivation, barriers to treatment, and treatment participation, it is possible these motivational enhancement techniques can be used to increase parent motivation for child therapy, and thereby decrease barriers and increase actual treatment participation. In the application to child therapy, the focus would shift from increasing an individual's own motivation to change a problem behavior to increasing a parent's motivation to participate in treatment. One way to accomplish this goal is to identify and resolve potential barriers to treatment drawing from the structure and techniques specified by motivational enhancement approaches. For instance, the role of the therapist would be to elicit self-motivational statements about attending and adhering to treatment (e.g., "It's important that I participate in this treatment."), and about overcoming potential barriers to treatment participation (e.g., "If using the new skills I learn feels uncomfortable, I will continue to practice them and tell my therapist about any problems I have."). In addition, rather than addressing the modification of maladaptive behaviors, the change plan worksheet would focus on specific plans for attending and adhering to treatment as well as for overcoming potential barriers to treatment that might arise. To be sure, the application of only these specific techniques to parenting behavior varies significantly from Motivational Interviewing as commonly practiced, as it excludes several aspects believed to be central to this approach, such as the expression of empathy, rolling with the client's resistance, a non-directive stance, and the provision of specific feedback from the initial assessment. Nevertheless, this extension of these specific motivational enhancement techniques may provide important information about whether these selected techniques are efficacious in the absence of the full Motivational Interviewing package, and may offer a useful intervention for clinicians and researchers conducting child therapy.

Based on this model, we conducted an initial study (Nock & Kazdin, 2005) with the goals of: (1) developing a brief intervention using selected techniques from the motivational enhancement approach to increase parents' motivation to participate in child therapy, and (2) performing a randomized, controlled evaluation of this intervention. Similar to some previous applications of motivational enhancement approaches (but in contrast to "pure" Motivational Interviewing), the current intervention was delivered in several small doses (i.e., during three 5-15 minute periods) during the early stages of treatment.

Brief Overview of the PEI

The PEI is a brief, adjunctive intervention incorporating selected motivational enhancement techniques and aspects of the barriers to treatment participation model designed to increase parents' treatment motivation and to identify and problem-solve potential barriers to treatment participation. Therapists elicited self-motivational change statements by asking parents what changes, if any, they would like to see in their child's behavior, and regarding their plans for various therapy-related behaviors, such as attending sessions and adhering to the treatment regimen (e.g., practicing parent skills at home and in sessions, working collaboratively with the therapist, etc.). In cases where parents reported a current or potential barrier to treatment participation (e.g., lack of support from others, treatment perceived as too demanding or irrelevant), therapists inquired about specific plans to overcome each barrier. Therapists elicited self-motivational statements from parents during supportive verbal exchanges and through the completion of a Change Plan Worksheet focused on attending and adhering to treatment. In addition, parents in this condition received information about the importance of attending and adhering to treatment and the efficacy of the treatment in the form of handouts, as well as monthly calendars to help remember scheduled appointments and homework assignments.

These problem-solving discussions lasted approximately 5-15 minutes (depending on the quantity and complexity of the barriers involved in each case) and were implemented in the first clinic visit, and during the third and fifth therapy sessions.

Parents in the PEI condition did not receive more time or attention than those in the non-PEI (i.e., Standard Clinical Treatment; SCT) condition. Rather, families in the SCT condition participated in clinical interviews or engaged in regular therapeutic activities during the time the PEI component was delivered. Also, all parents (i.e., PEI and SCT) benefited from pre-existing clinic procedures aimed at increasing treatment participation, such as: between-session phone calls from therapists, the dissemination of homework binders to organize between-session tasks, free child care during therapy sessions, and a sliding fee scale that ensures affordability for all families presenting to the clinic. Thus, the initial study evaluated the efficacy of the brief PEI above and beyond current clinic procedures.

Administration of the PEI

In this section I describe the manner in which the PEI was administered in our initial study (Nock & Kazdin, 2005). In doing so I describe what was done with all parents (i.e., those in both the PEI and SCT condition) given that many of these procedures are likely to have a positive influence on participation, as well as what was unique to the PEI condition in order to clarify what specific elements were associated with the effects observed in our initial study.

Upon entering the clinic for the very first visit, clinicians conduct a Pretreatment Introduction and Orientation. This is outlined in great detail in Alan E. Kazdin's recent book, *Parent Management Training* (2005; see pages 257-262 for details). In short, clinicians:

- Welcome the parents and provide introductions to the clinic and treatment
- Collect information about parent and family issues and concerns (using an Introduction Form)
- Summarize parents' description of the problem
- Describe the treatment approach(es) that will be used (e.g., Parent Management Training [PMT], Child Problem-Solving Skills Training, etc.)
- Describe the assessment methods that will be used over the course of treatment to evaluate clinical change and related constructs
- Describe the importance of treatment attendance

Parents in the PEI condition received all of the above, with a slightly more thorough description of the importance of treatment attendance and adherence. This consisted of a brief handout describing the relation between parent participation in treatment and treatment outcome (this can be easily generated or tailored for any treatment approach given studies have demonstrated such a relation), and the following speech from the clinician:

“As effective as this program is, it sometimes doesn't work because families stop coming or don't try the skills at home that we go over. Now I know this treatment seems a little demanding to some parents, and I'll ask you to do some things in very specific ways that might not seem natural to you at first, and I'll help you with this. But in order for this to work, it's important for you to do your best to come to session each week and to try out the skills that we go over. Most of the “treatment” of your child occurs between you and your child at home, at the store, wherever you are. If you come each week, really practice the skills we will go over together, and really use them with your child, you will

maximize your influence over (child's name), and you will see positive changes. If something doesn't work the first time, there are things we can do to change them, but I want to make sure you give the treatment a fair chance. Otherwise it might not work. So if you have any problems getting to treatment or any doubts or concerns about any aspect of treatment, please don't hesitate to tell me.

For example, research has shown that the more parents use the techniques they learn in this program, the better their child gets—the less they use them in real life, the less change they see. It's like if your child has an infection and your doctor gives you antibiotics. If you only give them to your child once, it's not going to cure the infection. In this case, this treatment is like the antibiotics and (child's name) needs to get an adequate dose before we know whether or not it's working and before his behavior can change. For this reason, our program requires a commitment of about 4-6 months. This is actually shorter than most other treatments and you may know people who have been in therapy for many years, but we've found that this is long enough to cause a lasting change in the child's behavior, although if you don't complete the program, it is not as effective in helping your child. So do you think you'll be able to commit to the entire 4-6 months? Great!"

The primary focus of the PEI is on completing a Change Plan Worksheet (CPW) with the parent. We modeled this worksheet after those used in motivational enhancement techniques, but this one was created specifically for parents presenting for treatment for their child or adolescent. The CPW begins with three questions and ends with one additional question designed to elicit self-motivational statements about changing the child's behavior and participating in treatment (see CPW for actual items). It includes six other questions that require the parent to identify and attempt to resolve potential barriers to treatment participation that may arise over the course of treatment. The clinician sits side-by-side with the parent and works through the CPW, with the parent writing in answers to each item. There is a box for each response and a brief prompt to help parents generate responses in case they are having difficulty doing so. In addition, each potential barrier is rated on a 0 to 4 scale in order to provide the clinician and parent with immediate information about the likelihood of that barrier interfering with treatment, as well as to evaluate changes in barriers over time with repeated administrations. The clinician begins the CPW by stating:

“If you're going to commit to 4-6 months of treatment, I want to make sure that you are happy and that you are seeing the changes in (child's name) that you would like to see. In order to keep us focused on what these problems are and on how we are going to work together to solve them, I always fill-out a Change Plan Worksheet with parents so that we can be sure we agree on the game plan. I was hoping we could take a few minutes to fill this out.

First, we've already talked about what changes you would like to see in your child, and about the fact that you are willing to try out some new parenting techniques to help this to occur. Write those into #1.

Second, what would you say are the most important reasons you want to make these changes now?

“Third, you’ve already taken the biggest and toughest step, which is coming in for help in the first place, and again you should be congratulated on doing that! Now based on what we were just talking about, what steps can you take to help change (child’s) behavior?”

Great! Next, we know from seeing so many families that things can sometimes get in the way of parents coming to sessions or using the skills they learn, that’s understandable. So what we do now is try to identify potential problems before they occur and think of different ways around them to make sure you are able to keep coming to treatment and that you get the most out of this program.”

In the next section, the clinician inquires about the presence of each potential barrier, has the parent rate how much each potential barrier is likely to interfere with treatment (0-4), and responds accordingly. That is, if the parent reports the barrier is unlikely to interfere with the treatment, the clinician responds by rephrasing and praising (e.g., “Great, so you will be able to find a way to the clinic each week! That is wonderful!”) and then by asking the parent to generate a solution to that barrier should it become a problem (e.g., “So we know this isn’t a problem now, but what can you do if this becomes a problem in the future?”).

We considered a response of 0 or 1 as indicating the barrier was not a problem, and a response of 2, 3, or 4 as indicating the barrier was a problem. To help the clinician with CPW administration, we placed a vertical line between the 1 and 2 on each response selection as a reminder of the cut-off (Note: items 8-10 are reverse coded). After completing the entire CPW, the clinician makes a photocopy for their records and gives the original to the parent. The clinician then tells the parent:

“Great, so we have our goals. Along the way it’s important that we stay connected, so will you tell me about any concerns you have about any aspect of how things are going? Also, please let me know what you find useful or helpful along the way.”

We completed a new CPW with parents at the end of sessions 1, 5, and 7. Clinicians were encouraged to revisit the CPW with the parent if they observed any barriers arising.

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