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Patienthood Meets Parenthood: Widening the Lens of Adult Psychotherapy

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Given the large number of adult psychotherapy clients who are parents, addressing the parenting role and child mental health within the adult psychotherapy context could magnify the benefits of therapy in numerous ways. For adult clients, the parenting role may be a source of concern and stress that is directly relevant to the focus of therapy. Thus, improvements in parenting skills, parenting cognitions, and management of emotions and behavior in parent–child interactions might translate into better mental health. Any such changes could, in turn, benefit the children of those adults in a variety of ways, including improving their well-being, reducing their risk of harm and psychological dysfunction, and enriching family functioning more generally. The thought-provoking article by Zalewski, Goodman, Cole, and McLaughlin (2017) highlights these opportunities and offers intriguing ideas regarding how adult mental health providers might pursue these aims with their clients who are parents, transcending the traditional insularity of child and adult mental health care. Zalewski et al. also provide a helpful summary of the literature on the association between parent and child psychopathology, effects of the experience of parenthood and child psychopathology on parent functioning, and an array of existing integrated treatment models targeting parents and children. Building on these contributions, we would like to comment on (a) the suggested practice recommendations within the context of the triadic model of family process (Schleider & Weisz, 2017), (b) maladaptive self-regulation in parents and their children as a potential target for intervention, and (c) the challenge of personalizing treatment within the clinical care context.

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UNPACKING ASSESSMENT AND INTERVENTION STRATEGIES: THE TRIADIC MODEL OF FAMILY PROCESS

Zalewski et al. (2017) recommend that clinicians screen parenting stress, satisfaction, and quality as part of their standard intake process for clients who are parents, and they note evidence on the substantial, though nonspecific, association between parent and offspring psychopathology. Because much of this association may be accounted for by shared biological and environmental risk, it is not entirely clear how much of the variance in child outcomes may be accounted for by variations in parenting behavior that could be addressed in therapy. One humbling set of meta-analytic findings suggests that the portions of variance in child mental health problems accounted for by various parenting dimensions (e.g., autonomy granting and warmth) are actually quite modest, with impacts that differ across child problem types (e.g., anxiety, McLeod, Wood, & Weisz, 2007—see Data S1, and depression, McLeod, Weisz, & Wood, 2007—see Data S1). Moreover, given the multidimensional and transactional nature of parent and child functioning and parent–child interaction, the research that does exist may not lead to simple or universal formulas for good parenting. This state of affairs may make it difficult for a clinician to know which parenting practices might be most fruitful to target for assessment and intervention in adult-focused psychotherapy.

The triadic model of family process (Schleider & Weisz, 2017) may provide a useful framework for clinicians who confront this challenge. This model identifies modifiable parent-level (e.g., parental mental health, interparent interaction), dyad-level (e.g., parenting practices and parent–child interactions), and

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family-level processes (e.g., family functioning, differential treatment of siblings) that have been shown to influence—and be influenced by—child internalizing difficulties. The model also outlines how child developmental period and gender might shape the effects of parent-, dyad-, and family-level processes—and how processes at all three levels might interact with one another to influence child difficulties, for example, when adult psychotherapy clients are struggling with mental health challenges that may interfere with their readiness to learn and their capacity to consistently implement new parenting strategies and skills. In terms of assessment and treatment applications, therapists might reference the triadic model as a "menu" of parent-, dyad-, and family-level constructs to assess during treatment, catalyzing the consideration of a given client's difficulties at the parent level, dyad level, and family level in the context of their children's characteristics. In addition to its focus on assessment, the triadic model suggests an agenda for future research on the potential of parent treatment to reduce risk of psychopathology in children. Schleider and Weisz's review of strategies that have improved parent-, dyad-, and family-level factors may help inform clinicians' approach to parent-directed therapy.

The triadic model also suggests a strategy for evaluating efforts to modify family processes in the context of adult psychotherapy. The model posits that parent-, dyad-, and family-level factors can influence child internalizing distress, specifically by shaping child-level processes (e.g., child perceptions of control, attributional style, or cognitive biases) that operate as mechanisms underlying psychopathology, or mechanisms thought to underlie psychopathology. Assessing whether parent-focused psychotherapy shifts these intermediate, child-level mechanisms could magnify its potential to improve child outcomes, even among well-functioning children with subclinical symptoms. Indeed, this intervention evaluation strategy is consistent with the National Institute of Mental Health's current Strategic Research Plan, which emphasizes mechanism-targeted approaches to developing and evaluating novel treatments—for example, testing whether interventions shift well-established risk factors for the development or maintenance of psychopathology (National Institute of Mental Health, 2016; Zalta & Shankman, 2016—see Data S1). Thus, the triadic model of family process is one example of a theoretical model through which clinicians and researchers might think through a synthesis of adult, adult–child, and family emphases within the context of adult psychotherapy.

SELF-REGULATION IN PARENTS AND THEIR CHILDREN

The triadic model identifies emotion regulation as one of the child processes affected by dyad-level factors. Self-regulation, more broadly construed, can be conceptualized as the activation and implementation of a goal to modify one's behavior, emotion, or thoughts. Although self-regulation has been the subject of many studies examining child functioning, it has received relatively less attention within the context of parenting practices. Some studies have conceptualized self-regulation in terms of the amount of emotion, cognition, or behavior being regulated and the amount of effort being used to regulate it, but the adaptiveness of self-regulation also depends on the variety of strategies used and their functionality across different situational contexts. That said, the literature indicates that some strategies—like reappraisal, acceptance, and problem solving—are often linked to adaptive functioning, whereas other strategies and tendencies—like rumination and suppression—are linked to a host of negative outcomes (e.g., depression, anxiety, social dissatisfaction). This suggests certain self-regulation skills that can be particularly helpful targets in adult psychotherapy for clients who are parents.

In addition to building self-regulation skills in parents themselves, self-regulation skills may be encouraged in children through their parents. There is evidence that maladaptive emotion regulation in parents may be an underlying transdiagnostic process in the etiology of child psychopathology, by way of child emotion regulation and other intermediate processes, as discussed in the triadic model. Poor parent emotion regulation has been rather consistently linked to children's maladaptive emotion regulation—and to a lesser extent, to internalizing and externalizing symptoms. Contemporary learning theories of anxiety (Mineka & Zinbarg, 2006—see Data S1) and developmental theories of emotion regulation (Thompson & Meyer, 2007—see Data S1) suggest that children pick up maladaptive tendencies

(avoidance of threat and uncertainty, in the former case, and the use of specific emotion regulation strategies, in the latter) in part because these tendencies are modeled for them by parents.

As previously discussed, it is critical to take into account the child's developmental period when implementing Zalewski and colleagues' (2017) recommendation to evaluate parenting quality at the start of adult psychotherapy. From a prevention standpoint, clients who are parents of infants and very young children and whose motivation for treatment includes a wish to improve themselves for their children's future well-being can be provided with psychoeducation on adaptive self-regulation skills and encouraged to develop these skills. Most of the work in this area has examined infancy and early childhood, and less research has explored parental influences on children's emotion regulation in middle childhood and adolescence. However, we know that both middle childhood and adolescence are marked by more intense social, emotional, and cognitive demands than early childhood. Adolescence in particular is a crucial period in the development of emotion regulation in which problematic patterns of emotion regulation can increase risk for a wide range of negative psychological outcomes (McLaughlin, Hatzenbuehler, Mennin, & Nolen-Hoeksema, 2011). Clients with adolescent offspring, for instance, might benefit from an emphasis on improving adaptive emotion regulation skills. As one example, in dialectical behavior therapy for adolescents—which has led to improved emotion regulation, decreased depressive symptoms, and reduced suicidal and self-injurious behaviors in adolescents with bipolar disorder—youths and their parents learn and practice emotion regulation skills through weekly multifamily groups (Goldstein, Axelson, Birmaher, & Brent, 2007—see Data S1). In addition to emotion recognition and labeling, these skills include emotion regulation strategies that are change based (e.g., opposite action) and acceptance based (e.g., mindfulness and radical acceptance). Adults who attend therapy as collateral treatment of their children's problems may also benefit from psychoeducation about skills that are useful for handling the challenging and negative emotion-triggering circumstances surrounding their children's problems.

PERSONALIZING TREATMENT WITH THE CLINICAL CARE CONTEXT

Any clinician seeking to build on the good ideas of Zalewski et al. (2017) will confront a central challenge of psychotherapy in this age of evidence-based practice: blending the evidence derived from research on groups with the uniqueness of each individual parent and child, and the uniqueness of each parent–child relationship (Ng & Weisz, 2016—see Data S1). Frameworks such as the triadic model can provide empirically informed guidance for assessment and intervention in relation to parenting, including a focus on building parent self-regulation skills in order to improve both parenting practices and child self-regulation. These ideas, taken together with the recommendations provided by Zalewski et al. (2017), can certainly help inform clinical practice, but ideally in combination with a clinician's focus on what makes each case distinctive. For example, once therapists have assessed clients' parent-, dyad-, and family-level strengths and difficulties, as per the model, next steps may include (a) identifying maladaptive processes most relevant to the specific parent's and child's functioning, (b) modifying treatment to target those processes using approaches tailored to the particular parent and child, and (c) monitoring (ideographically, as in the Weisz et al., 2011, "top problems assessment" approach—see Data S1) parent and child response throughout the intervention.

As Zalewski et al. (2017) note, even such a simple step as providing psychoeducation on how parent psychopathology impacts child functioning could have undesirable consequences in some cases. Some parents could interpret this information as a sign that the therapist disapproves of their parenting, and this could undermine the therapeutic relationship. Similarly, providing psychoeducation on how child psychological functioning impacts parent functioning could be problematic in some contexts. For example, clients experiencing high levels of parenting stress might make causal attributions to their child when provided with this information, and this could undermine the parent–child relationship. The point is that even simple psychoeducation may not be so simple that it can be applied uniformly—research may suggest options for how it can be performed, but selection of the specific form and content will need to reflect some degree of clinical

judgment by a thoughtful clinician, ideally in combination with ongoing evaluation of the impact on parent and child.

The same perspective applies to the selection of intervention components. As one example, behavioral training programs often encourage parents to increase the frequency and specificity of praise for positive behaviors by their children, but often with little guidance on calibration. Praise can take a variety of forms and levels, and some levels—for example, "You made an amazingly beautiful drawing!"—may not be a good fit for all children, even if clearly labeled and action-specific, as encouraged in parenting interventions. Although children with average to high self-esteem may respond positively (or neutrally in some findings) to inflated praise, the same statements have been found to discourage children with low self-esteem, who may worry about their ability to continue meeting such high parental standards (Brummelman, Thomaes, Orobio de Castro, Overbeek, & Bushman, 2014).

Intervention goodness of fit may also depend on parenting style. For a parent–child dyad characterized by permissive parenting and child externalizing behavior problems, research may suggest teaching the parent behavior management skills, such as effective instructions and the use of time-out. For a parent–child dyad characterized by authoritarian parenting and child problem behavior, on the other hand, research may suggest a focus on the parent's relationship-building skills, emphasizing one-on-one time or child-directed play combined with positive attention and praise. In either case, regardless of how empirically informed a clinician's judgment might be in intervention selection, ongoing assessment of parent or child response would be needed to evaluate whether the strategies selected actually generate the intended result or need to be reconsidered and further personalized.

In sum, the ideas proposed by Zalewski et al. (2017) highlight significant challenges in relation to assessment, intervention design and content, and monitoring of treatment response when clinical care is provided to adults who are parents. One challenge is that of blending a focus on parent-, dyad-, and family-level factors within a single adult therapy episode. Another challenge is identifying and addressing self-regulation issues that can impact functioning at all three levels. A third challenge is personalizing treatment, arguably a requirement for effective clinical care—that is, fitting research-derived principles and procedures to the distinctive characteristics and needs of adult clients and the children whose lives they touch.

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SUPPORTING INFORMATION

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Data S1. Online References.