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Promoting Parent Engagement in Child Psychotherapy: Therapists' Perspectives on Parent, Therapist and System-Level Barriers and Facilitators

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Abstract

Parental engagement in their child's therapy is increasingly recognized as a crucial component for successful treatment outcomes. However, various barriers at the levels of parents, therapists, and the broader system impede active participation and necessitate targeted therapeutic strategies. This study explores therapists' insights into the challenges of parental engagement in child therapy and the strategies employed to enhance it. An exploratory grounded theory approach was utilized, involving in-depth, semi-structured interviews with 15 therapists to gather data on their experiences in engaging parents. Data analysis was conducted using constant comparison, in vivo coding, and conceptual coding techniques. Our Findings indicate that parental engagement is influenced by barriers operating across three interconnected levels. At the parental level, failure to recognize their role in their child's difficulties, fear of being judged, and emotional burden were identified as significant barriers. At the therapist level, feelings of incompetence and negative emotions about parental disengagement often reduce therapists' efforts to involve parents in their child's treatment. At the systemic level, maintaining a balance between structured settings for parental meetings and necessary flexibility was identified as a key factor affecting engagement. The therapeutic alliance with parents emerged as a central element, both hindered by these barriers and capable of mitigating them to promote engagement. In conclusion, it is essential that training programs for child therapists include modules on recognizing barriers to parental engagement, developing skills to strengthen the therapeutic alliance, and designing a therapeutic setting that facilitates parents' engagement.

Highlights

• Parental engagement in their child's psychotherapy is critical for effective treatment, but its implementation remains challenging.

• This study found that parents' engagement is shaped by barriers and facilitating factors at the parent, therapist, and system levels.

• We propose a conceptual framework where the therapeutic alliance with parents mediates the relationship between barriers and parental engagement.

Introduction

Therapeutic work with parents is increasingly recognized as a vital component of child and adolescent psychotherapy. Contemporary practice acknowledges that children's difficulties and strengths, their attendance at therapy, and their progress in the therapeutic process are deeply intertwined with the parental environment (Novick & Novick, 2013). However, the level of parental involvement in their child's psychotherapy varies and can range from interventions focused solely on the child to those directed exclusively at the parents. Typically, models fall between these extremes, with the child remaining the primary client and parents participating through periodic consultations or collateral sessions (Haine-Schlagel & Walsh, 2015; Novick & Novick, 2013; Pine et al., 2024).

Engagement in the therapeutic process is a broad, multifaceted phenomenon that encompasses the client's efforts within and between sessions toward achieving change over the course of treatment (Bijkerk et al., 2023; Holdsworth et al., 2014). Parents' engagement in their child's treatment has been defined as including attitudinal and motivational components that reflect their perception that the treatment's benefits outweigh its costs. It also includes a behavioral component that involves seeking and initiating help, attending the service, and actively or meaningfully participating in it, both within sessions and by following through with treatment recommendations between sessions (Haine-Schlagel & Walsh, 2015).

Outcome research shows that parental engagement in their child's therapeutic process improves its effectiveness. A recent and comprehensive meta-analysis by Line et al. (2024) found that treatments involving parents were more effective in addressing children's mental health symptoms compared to those that did not involve parents. These results are consistent across various types of child mental health disorders (Haine-Schlagel & Walsh, 2015), in older child age groups (Pine et al., 2024), and in different therapeutic settings (Gardner et al., 2010). Furthermore, involving parents in therapy helps reduce the likelihood that children will drop out of treatment (Midgley & Navridi, 2007).

Although there is strong empirical support for the benefits of involving parents in their child's psychotherapy, much evidence suggests that parents' engagement remains a challenge (Baker-Ericze´n et al., 2013; Barnett et al., 2020; Haine-Schlagel & Walsh, 2015). Parents may struggle to engage in their children's psychotherapy due to various barriers. Kazdin and colleagues' (1997) Barriers-to-Treatment Model identifies various obstacles which parents encounter across the treatment continuum such as practical constraints to participation, perceptions of the treatment as demanding or irrelevant to the child's difficulties, and a weak therapeutic alliance. Consistent with this model, practical barriers, such as geographic distance, mobility issues, time constraints, and competing family responsibilities, are frequently reported in the empirical literature, particularly among parents from disadvantaged socioeconomic backgrounds or cultural minority groups (Gardner et al., 2010; Barnett et al., 2020).

Psychological barriers can also prevent parents from engaging in mental health treatments due to a variety of factors. These include negative and stigmatized perceptions of mental health services (Gardner et al., 2010), a reluctance to engage in self-reflection (Fawley-King et al., 2013), and a tendency to have a low internal locus of control, low self-efficacy and low motivation to change (Pereira & Barros, 2019). Additionally, fear of trusting a therapist and forming a close relationship, as well as concerns about being judged by them, can also deter parents from seeking help (Haine-Schlagel & Walsh, 2015).

Importantly, barriers to engagement are not limited to parents themselves but emerge across multiple levels, including the therapist and the broader service context (Barnett et al., 2020). While most child therapists recognize the benefits of parental involvement (Kurzweil, 2023; Line & Ray, 2024), many report frustration regarding parents' low levels of engagement and feel overwhelmed by the complexity of families' needs (Baker-Ericzen et al., 2013). Moreover, therapists' own levels of experience and self-

efficacy appear to be important, with more experienced therapists tending to involve parents more actively in their child's therapy (Haine-Schlagel et al., 2012; Line & Ray, 2024).

Additionally, organizational characteristics, including the level of training, supervision, and technical support provided to therapists, influence their ability to encourage parental engagement in treatment (Cooper et al., 2022). These findings suggest that therapist-level factors, such as their attitudes toward the importance of parental engagement, professional experience, and comfort in working with parents, play a crucial role in promoting parental engagement. However, these perspectives remain underexamined, underscoring the need for more detailed insights into the reasons behind therapists' reluctance or willingness to involve parents, as well as the strategies they use to promote engagement.

To date, relatively few studies have explored ways to enhance parents' engagement in their child's psychotherapy. Drawing on qualitative research literature reviews and clinical studies (Haine-Schlagel et al., 2018; Kuria & James, 2025; Kurzweil, 2023; Nock & Ferriter, 2005; Nocks & Kazdin, 2005), this emerging body of work highlights the benefits of incorporating targeted engagement strategies. Synthesizing these findings points to several approaches that appear particularly effective, including: (a) Collaborative goal-setting and clarifying the parents' role; (b) Ongoing psychoeducation about the child's issues and treatment; (c) Structuring active parent participation during sessions; (d) Regular review and feedback on homework; (e) Building a strong working alliance through warmth, validation and cultural adaptation; (f) Reducing barriers to accessibility; and (g) Adjusting interventions based on parents' mental health needs (Haine-Schlagel et al., 2018; Kuria & James, 2025; Kurzweil, 2023; Nock & Ferriter, 2005; Nocks & Kazdin, 2005).

Notably, most initiatives aimed at improving parental engagement have primarily focused on increasing attendance or have been studied on interventions designed exclusively for parents (Haine-Schlagel & Walsh, 2015). However, research findings from these parent-only interventions cannot be readily generalized to therapeutic models in which parents are involved alongside their child's therapy, given important differences in therapeutic settings, structure and goals (Kurzweil, 2023). Unlike interventions solely for parents, in such models, parents' roles in the process are often less clearly defined and more variable. Additionally, there may be ambiguity regarding the frequency of these sessions and whether both parents must participate. Moreover, the parenting component may take different forms, including dyadic parent-child sessions or separate meetings with parents. As such, this model may require tailored strategies to enhance and sustain parental engagement.

Furthermore, although a small number of studies provide broad, practical guidelines for enhancing parental engagement in children's therapy (Haine-Schlagel et al., 2018; Kuria & James, 2025; Kurzweil, 2023; Nock & Ferriter, 2005; Nocks & Kazdin, 2005), there is a notable lack of nuanced context-sensitive guidelines, grounded in therapists' insights from their direct personal experiences. This gap in detailed knowledge and recommendations may further contribute to therapists' avoidance of these challenges, thereby perpetuating difficulties in effectively engaging parents.

Taken together, these findings underscore the importance of implementing strategies to improve parental engagement in their child's therapy. However, given the complexity, ambiguity and variability of these models, alongside the limited research available, there is a need for more detailed, in-depth accounts of how therapists promote parental engagement, prioritize certain strategies, and navigate associated challenges across different clinical settings.

The current study

The current study aimed to address these gaps by exploring parental engagement within child-focused therapy. It adopts a grounded theory approach to explore therapists' perspectives and insights gained from working with children and their parents in community mental health services. The goals of this study were: (a) to investigate child therapists' perceptions of the barriers to parental engagement in the therapeutic process; (b) to examine factors at the therapist level that influence their efforts to engage parents; (c) to outline the approaches and methods therapists use to enhance parental engagement; and (d) to develop a conceptual framework of parental engagement which may help inform the development of contextually grounded interventions and practical recommendations for enhancing parental involvement.

Methods

Research Design

This exploratory study forms part of a larger mixed-methods research project examining barriers and facilitators to including parents in their child's mental health treatment. A mixed-methods approach is particularly well-suited to investigating a complex, multidimensional phenomenon such as parent-inclusive interventions, as it enables examination from both a broad, structured quantitative perspective and a more nuanced, inductive qualitative perspective that attends to emerging categories rather than relying solely on predefined ones. The present paper reports on the qualitative arm of the study, focusing on therapists' subjective experiences of working with parents and offering an in-depth exploration of the therapeutic process. In examining clinicians' experiences, we employed grounded theory, an inductive, iterative approach designed to identify concepts and build theory grounded in participants' own perceptions and concerns (Glaser & Strauss, 1967). Grounded theory is particularly useful for investigating psychosocial processes of behavior that emerge from participants' subjective experiences.

Participants

A total of 15 child and adolescent psychotherapists were recruited across 12 community-based mental health settings in Israel, including outpatient clinics, inpatient psychiatric departments, educational psychological services, and community and NGO-affiliated programs. The study's inclusion criteria required participants to be active child and adolescent psychotherapists working in public mental health

services and fluent in Hebrew. Among the participants were 11 psychologists, 1 social worker, and 3 art therapists, with professional experience ranging from 3 to 20 years. The sample consisted of 14 women and 3 men, aged 27 to 48 (M = 35.13, SD = 6.94). All participants held an academic degree, identified as Jewish, and were citizens of Israel.

Data collection procedures

Data was collected from November 2024 to February 2025. Participants were recruited through advertisements in mental health settings and professional online networks, asking therapists to take part in a study on the barriers and facilitators of parents' engagement in child mental health treatments. Interested individuals contacted the research team, which provided detailed information about the study's objectives and procedures. Data was collected through in-depth semi-structured interviews. The interviews were conducted online via Zoom and led by three research assistants who hold master's degrees in clinical psychology. The interview guide included broad, exploratory questions aimed at understanding clinicians' experiences with parental engagement in child mental health treatment, including perceived barriers and facilitators, strategies used to promote engagement, emotional responses, clinical dilemmas, and coping strategies. For example, clinicians were asked: "Describe what you tend to do when parents are reluctant to take part in their child's therapeutic process". Each interview lasted approximately 45 minutes. All interviews were audio-recorded and transcribed verbatim.

Analysis

Analysis of interview transcripts was informed by a modified grounded theory approach (Glaser & Strauss, 1967), integrating both deductive and inductive coding strategies. Each round of data collection was followed by interim analysis, which generated hypotheses and shaped subsequent data collection (Glaser & Strauss, 1967). The research team first engaged in repeated readings of the transcripts to become familiar with the data and generate initial codes. Three members of the research team, psychologists in training, independently coded 10 transcripts, line by line. We first applied a small number of conceptual codes identified *a priori* as analytically important, such as "therapeutic alliance," which was expected to be central based on the literature. We then applied *in vivo* codes, codes that participants themselves use to divide the world, to remain close to the data. Following open coding, the team engaged in a second analytic phase resembling axial coding, in which initial codes were clustered into higher-order categories based on conceptual similarity, analytic significance, and their relationships to one another (Glaser & Strauss, 1967). At this stage, discrepancies were discussed with the principal investigator, and category definitions were iteratively refined until consensus was reached.

The research team then convened to develop a codebook, which was then applied to the full dataset. Themes were generated by systematically identifying patterns, similarities, and differences across interviews and by examining convergences and divergences among categories. Analysis proceeded iteratively, moving between coding and interpretation, with ongoing comparison of codes and emerging

categories within and across interviews. This constant comparative process enabled the refinement of categories and attention to relationships between them, including how therapists described conditions, responses, and perceived consequences within the therapeutic process. In the final analytic stage, the team met to resolve discrepancies, further refine the thematic structure, and articulate the key theoretical linkages that grounded the study's conceptual framework

Ethical considerations

All procedures were reviewed and approved by the Institutional Review Board of {masked}, IRB#243. All participants provided written informed consent for participation and publication prior to enrollment in the study. To protect the therapists' identities, the research team used pseudonyms and omitted potentially identifiable information.

Findings

Three distinct yet interconnected themes related to clinicians' experiences of engaging parents in their child's psychotherapy were constructed through the analytic process. The first theme focuses on factors shaping parents' difficulties in engaging in the therapeutic process. including attitudinal, emotional and contextual influences. The second theme examines therapists' avoidance of working with parents. The third theme focuses on therapeutic processes and system-level factors that enhance parental engagement.

1. Parental variables associated with low engagement in the therapeutic process

All therapists described in detail situations in which parents were hesitant to take an active role in the therapeutic process. Analysis of therapists' responses reveals numerous factors contributing to low parental engagement, including parents' attitudes towards treatment, parents' emotional difficulties in engaging in therapy, challenges related to parental mental health, as well as broader psychosocial and situational influences.

1.1. Low parental engagement related to parents' attitudes toward treatment

A central theme emerging from the data was that low parental engagement was often rooted in parents' underlying beliefs about mental health, treatment, and their own role within it. Therapists described engagement as shaped by a fundamental misalignment between their clinical framework and parents' expectations, whereby treatment was often viewed as unnecessary or as externally focused on "fixing" the child, rather than involving parents as agents of change. Participants reported, for example, that some families referred to therapy expressed skepticism regarding the need for psychological treatment, either for their child or for themselves as parents. Notably, this stance was almost always attributed to fathers. For example, D described:

I had one father who really dismissed me, basically telling me, ‘You have nothing to talk to me about,’ and another father who thought he didn’t need me to treat [his child] at all. As if everything was fine with the child, that it would pass, so what if they diagnosed him with this or that? (D., intern in educational psychology, female, age 28).

A common explanation for parents’ low engagement was their limited understanding of their role in the child’s therapy and their potential influence on the process. According to therapists, many parents do not initially understand their contribution to the child’s difficulties, nor do they recognize their capacity to bring about change through modifications in their parenting: “…parents don’t really understand why they are coming. They don’t really see how they are connected to the child’s difficulties, they don’t really see how they can help or influence it.” (G. clinical psychologist, male, age 38).

Another common explanation concerned parents’ expectations of treatment. Therapists described parents who sought concrete, practical guidance, similar to medical advice, rather than engaging in deeper exploration of parenting patterns and their relationship with their child. This gap, between the therapists’ goal of fostering parental understanding and mentalization, and the parents’ expectation of practical guidance, was perceived by the therapists as contributing to resistance and avoidance of treatment V. explained: “Many times it feels like they come with a very concrete mindset, to receive tools, to be told what to do or what to say.” (V., clinical psychologist, female, age 44).

In line with this, a significant number of therapists used the metaphor of a “garage” to describe parents’ expectation that the therapist would fix their child, rather than seeing themselves as agents of change. A. said:

There are parents who don’t want to go through changes themselves, and from their perspective, they send their child to a ‘repair shop’ kind of therapy. Then, when I meet with them, there’s resistance to change on their part, and I sometimes encounter some aggression […]. (A., intern in clinical psychology, male, age 30).

V. added: “And there are parents who mainly use me as a kind of extension in front of the child… to tell the child things, explain things to the child, educate them.” (V., clinical psychologist, female, age 44).

1.2. Emotional motives underlying parents’ difficulties in engaging in therapy

Many therapists noted that parenting-focused treatment component can be challenging for parents, as it may confront them with painful emotions and troubling self-perceptions, including self-blame, guilt, self-criticism, and a sense of failure. Within this context, parents' desire to deflect responsibility for their child’s psychopathology may have contributed to their reluctance to engage actively in treatment. As G. explained:

Coming to receive help from someone else often means acknowledging a challenge and difficulty in parenting, and I think that is very hard for many parents.” Relatedly, many therapists attributed parents’ avoidance to fears of being criticized or judged by the therapist: “There is often a reluctance toward an

external figure who comes in, looks at you, says things, and perhaps examines, and perhaps judges. (G., clinical psychologist, male, age 38).

In addition, therapists described how some parents were deterred from engaging in treatment due to the complex psychological processes involved in caring for a child with a mental illness, including reactions of disbelief and denial in response to the child's diagnosis, as well as grief, pessimism, and fear regarding its anticipated implications for the child's future. Z described parents who declined to meet with him after he suggested their child may have a psychiatric diagnosis:

There was a lot of resistance, and the meetings with them gradually became less frequent. It was simply an elephant in the room that they didn't want to talk about. They were not yet emotionally prepared to discuss it. (Z., intern in educational psychology, female, age 30).

Within this context of emotional vulnerability, therapists also described how treatment can unsettle parents' sense of their role and competence in relation to their child. In some cases, this took the form of perceived competition with the therapist over who better understands or connects with the child. Therapists reported that some parents felt threatened by the developing bond between the therapist and child. As A. noted: "I experienced situations where parents somewhat sabotaged the therapy because it was hard for them to see their children getting along with the therapist but not with them." (A. intern in clinical psychology, male, age 30).

In addition, therapists emphasized that parents' own mental health challenges often limited their capacity to engage in treatment. Therapists provided numerous examples demonstrating that, when parents face such challenges, their ability to reflect on their parenting and to be emotionally available to the child may be significantly constrained. Z., for example, described a case involving divorced parents, in which the father was coping with PTSD and the mother had a history of relational instability and abandonment, both of which affected their involvement in the child's treatment:

She (the mother) is very preoccupied with her love life and personal life, and less with the child's life. The father is also occupied with his own pain and feelings, and in fact, he works in a job that recreates his post-trauma, so he is in a very, very complex situation, and it is hard for him to make time and space for the child. (Z, intern in educational psychology, female, age 30).

1.3. Parental low engagement due to psychosocial and contextual difficulties

One of the most salient barriers perceived by therapists for parents' low engagement in treatment was related to the practicalities of access and financial difficulties stemming from psychosocial circumstances, life conditions, or the general burden of parents' daily lives. Some therapists linked parents' heavy daily burdens to a survival-oriented stance that prevented them from fully engaging in treatment. In these cases, low engagement did not necessarily reflect resistance or avoidance in the conventional sense, but rather a protective strategy aimed at maintaining day-to-day functioning in the

face of overwhelming demands. For example, Z. described a mother's reluctance to engage in treatment in the midst of war:

This was a parent consultation process that began in October (the beginning of the war in Israel). Umm… it was very, very difficult for her [the mother]. She was very much in survival mode, and I believe that taking a moment to confront her pain and to discuss it disrupted her survival mechanism, because she was the one who ran the entire household; she did everything. It's hard for her, hard for her to stop and talk. […] Because… what will happen? She can't collapse right now; she's afraid it will make her collapse. (Z., intern in educational psychology, female, age 30).

While psychosocial barriers were clearly significant, some therapists also questioned whether, in certain cases, these constraints functioned as a form of camouflage or justification for avoiding active participation in treatment. As H. further explained:

He works most hours of the day, but even when I offered them afternoon hours and was flexible with scheduling, he had all kinds of excuses. I mean, of course, there's work, but even when there was an option to change things at work, there wasn't much willingness. (H., intern in clinical psychology, female, age 30).

2. Therapists' avoidance of working with parents

Interestingly, therapists' accounts suggest that avoidance of parenting-focused sessions is not limited to parents; therapists themselves may also hesitate to engage in this work. Their accounts revealed situations in which they were reluctant to engage in parenting interventions for various reasons, including feeling inadequate in their ability to work with parents, experiencing inferiority compared to them, and facing negative emotions when parents resist or avoid treatment.

2.1. Therapists' feelings of incompetence and inferiority in working with parents

A considerable proportion of therapists reported feeling a lack of competence in working with parents, which often discouraged them from including them in the therapeutic process. Some therapists attributed this feeling to inadequate knowledge and training in parenting-related therapeutic work. They recognized that the therapeutic approach for parental interventions often differs from that used in individual therapy with adults or children, necessitating specific skills. T. shared her reluctance in shifting from focusing primarily on the child to including the parents in the treatment:

Yes, I felt inexperienced, perhaps also lacking knowledge. How do you approach such a conversation? What mindset should a therapist hold? I am eager to engage in the process, but also I am anxious, and try to avoid it. (T., Intern in developmental psychology, female, age 27).

Young therapists, particularly those without children, noted that age and life-experience differences can create a sense of professional incompetence when working with parents, whom they perceived as having more life experience than themselves. For example, D., a 28-year-old therapist, described feelings

that her expertise was being questioned or undermined, which affected her motivation to engage parents: “In my case, because I’m young, it feels like I’m not being taken seriously; they see me as someone who is still learning.” Y., a 27-years old female therapist, added:

The difficult part for me is when they start asking me questions: Are you married? Do you have children? … In those moments, I suddenly become unsettled… Who am I to tell them what to do? After all, I don’t have children myself…These moments make me shrink a little.

2.2. Therapists’ negative emotions toward unengaged parents

In almost all interviews, therapists described feelings of anger and disappointment toward parents when they avoided or evaded participating in treatment. The negative emotions described were often intense and experienced as a significant challenge that complicates, and at times even undermines, the therapeutic alliance and process. Y.A. described the difficulty of persisting in work with parents who do not attend meetings:

Dealing with endless attempts to court them [the parents]; these take a huge amount of time […] I feel that the parents don’t appreciate the time or what is being given to them, and kind of let it dissolve or keep putting it off with excuses… Those are places that are less pleasant for me, and they even evoke frustration and anger, which can also harm the treatment. (Y.A., Intern in clinical psychology, female, age 32).

The therapists also described strong negative emotions in reaction to parents’ defensive or defiant approach towards them, which affected their willingness to maintain regular meetings with parents. Z. described her work with the mother of a girl with serious behavioral problems:

She [the mother] is very resistant, very defensive; she touches on things and then pulls away. Sometimes she even ridicules me, or the situation, and it is very, very hard for me to deal with her… It’s like a dismissal of my capability. You feel that you’re not progressing anywhere, and then it feeds itself, you try to fight it, but it doesn’t succeed, and it’s hard. (Z., Intern in educational psychology, female, age 30).

3. Therapeutic mechanisms that enhance parents’ engagement

Interviews indicated that therapists employed a range of strategies to mitigate parents’ reluctance to engage in parental interventions. These strategies reflect broader therapeutic processes and mechanisms that therapists identified as central to promoting engagement, particularly those related to the therapeutic alliance and the structure of the therapeutic setting.

3.1. Ongoing work on the therapeutic alliance with parents

The therapeutic alliance between a therapist and a client is often described in literature as being rooted in the development of a strong, supportive relationship. It also relies on a mutual agreement regarding

the goals of therapy and the methods used to achieve them (Bordin, 1979). All interviewees consistently emphasized these elements as crucial in involving parents in treatment.

Among the alliance components, most therapists cited the therapeutic relationship as the central factor in increasing motivation for parenting-focused work and overcoming resistance. Therapists reported that when they responded to parents' emotional needs by providing emotional containment and supporting emotion regulation, they were able to increase parents' engagement in treatment. They consistently emphasized that a strong relationship helped parents feel comfortable, reduced their fear of being judged, and enabled them to open themselves up to the therapeutic work. Y.G. said:

It's all about trust and feeling safe. They must sense that the person they're talking to genuinely cares about them and is willing to move at their pace. The fear of being judged just fades away as the relationship grows. (Y.G., clinical psychologist, female, age 40).

Similar to other therapeutic contexts, a positive therapeutic relationship was described as including validation, empathy, a compassionate view of the parent, and a genuine wish for the parent's well-being. B. described her attempts to validate the parents' negative feelings:

They need a space to let out their frustration and anger, and sometimes you just have to be there with them in that anger. It's also about being there for them when they're scared, like when they worry that their child doesn't love them or that nothing will come of it. 'That's true; it's super scary'. (B., bibliotherapist and arts therapist, female, age 48).

Several characteristics of a positive relationship that appear somewhat unique to work with parents also emerged in the therapists' accounts. These included communicating with parents "at eye level", working collaboratively and reciprocally, and maintaining a high level of availability to parents. H.'s words illustrate how she positioned herself in a collaborative and reciprocal stance in her work with parents:

…I like the joint work, the joint thinking, consulting with them. I think there's also a kind of humble understanding that I can offer something, but they are the experts on their children; they know them, and they know what it's like for them. (H., intern in clinical psychology, female, age 30).

High availability to parents was also described as a distinctive aspect of the therapeutic relationship. D. illustrated this with the following example:

What helps parents persist? […] I think creating ongoing contact with parents. Not only in the session, but also on WhatsApp. I had a mother who said, 'D., can I talk to you on the phone for a second?' I said, 'Yes, I'll call you in about an hour.' She called, and we talked […]. Our relationship made her respect me, you know? She really took the therapy seriously. (D., intern in educational psychology, female, age 28).

Therapists noted that a strong therapeutic alliance relies on agreement with parents regarding treatment goals and tasks. This agreement develops as therapists carefully explore and understand parents' needs at each stage of treatment, enabling them to tailor interventions effectively and set realistic, feasible

goals. In line with the parents' attitudinal barriers described in the first theme, therapists observed that many parents struggle to cooperate due to a lack of understanding of their role in treatment. Therapists emphasized the importance of explaining the rationale behind parental involvement to facilitate agreement on goals and tasks. For example, G. shared:"…I think that clarifying to them how the parent guidance sessions are connected to the child's well-being and to their treatment is important, and I think that this is not always clear enough." (G., clinical psychologist, male, age 38).

Relatedly, therapists described a common situation where the therapist's goal to delve deeper stood in contrast to parents' desires and treatment goals. B, for example, recognized that she must first address the parent's needs to ensure their treatment goals were aligned.:

A lot of the parents who come to our center really aren't ready to dig into the deeper, unconscious meanings behind their actions or their emotional struggles… When I listen to their questions, they often boil down to wanting practical advice on what to do and how to handle things... I must really pay attention to where they are and what they need in that moment. (B., bibliotherapist and arts therapist, female, age 48).

In their interviews, therapists emphasized that establishing a strong alliance with parents is crucial not only in the early phases of treatment but also during ongoing challenges, especially after alliance ruptures. Such ruptures can arise from misunderstandings or disagreements between therapists and parents about treatment goals, often leading to negative emotions and reduced parental cooperation. Therapists highlighted the importance of open dialogue during these moments to shift from perceiving unengaged parents as resisting to understanding their underlying concerns. For instance, Y.G. described how an open dialogue with the mother of a girl with selective mutism helped her perceive the mother's low engagement more empathically:

This week, the mother told me: 'I come here, and I feel like a child who didn't do her homework.' Because she couldn't carry out the speech-exposure tasks. She did nothing; she couldn't do it. Not out of neglect or anything like that, but simply because it was too difficult for her. And we were able to talk about that difficulty, and about how it confronts her with the fear of placing additional burdens on her daughter, of creating more tension, and of her daughter having to cope with failure. (Y.G., clinical psychologist, female, age 40).

H. noted how this process led to a better attunement to parental needs: "In the end, what mainly helped was listening, really listening and trying to understand what her need actually was, and to refine it. Overall, that improved the following meetings." (H., Intern in clinical psychology, female, age 30).

Alongside successful strategies, therapists also identified approaches that were less effective in repairing alliance ruptures. In particular, attempts to confront, persuade or pressure parents to participate were often described as counterproductive, at times intensifying resistance rather than reducing it. Y.Z. described his unsuccessful efforts to persuade a father to attend parent sessions:

I repeatedly tried to persuade him and explain the importance. I also tried to call him several times and explain that I really needed him to come to the next parents' session. I tried explaining the importance of both parents being in the room together, that I needed to hear from both of them and see both of their perspectives on the child…it only worked for the next two or three sessions, and then he would disappear again. (Y.Z., Intern in clinical psychology, female, age 34).

Another therapeutic approach that several therapists described as unhelpful in repairing alliance ruptures was using interpretations of the parents' low engagement. For example, Y.A. reflected:

Many times, because we are psychologists and therapists, we rush to interpret everything. So, before I say, 'Okay, you were late because I made you angry,' I try to pause for a moment and think before I respond… Sometimes I realize that perhaps I simply wasn't sufficiently there for him. (Y.A., Intern in clinical psychology, female, age 32).

3.2. The therapeutic setting – clear boundaries versus flexibility

Another key strategy that emerged from the interviews involved attention to the therapeutic setting. In response to parents' low engagement and resistance, therapists emphasized the importance of establishing clear expectations and boundaries regarding parental involvement. At the same time, they described a tension between maintaining these boundaries and remaining flexible in order to facilitate engagement.

Therapists stressed the need for clear boundaries and a well-defined setting in therapy to boost parents' engagement. They advocated for a therapeutic contract that outlines parental involvement from the start, as clear boundaries can enhance parents' motivation. G. said:

There were cases where I told parents that to keep their child's treatment going, we must meet regularly. For some parents, it works. They respond well. They may not like it, but in the end, it helps them organize their efforts. (G., clinical psychologist, male, age 38).

Despite recognizing the need to establish firm boundaries, several therapists also spoke candidly about the difficulty of doing so. For example, Z. shared:

If I'm really honest with you and with myself, I think that a lot of it depended on my own assertiveness… It's also on me. It's not exactly that I set meetings and they just kept skipping them endlessly. No, that's not the story. (Z., Intern in educational psychology, female, age 30).

Due to the difficulties in establishing boundaries, many therapists relied on the frameworks provided by the clinics/organizations in which they worked or expressed a need for mechanisms. Rather than viewing boundary-setting as an individual responsibility, therapists emphasized the importance of systemic support, including structured approaches to monitoring treatment no-shows and clearer criteria for treatment termination. G. said:

…I think we need some kind of systemic mechanism of how to act when parents do not attend… parents sometimes… basically understand that even if they don't come, the child's treatment will continue… So… we need to think about some way to create commitment. (G., clinical psychologist, male, age 38).

Alongside establishing boundaries, therapists frequently reported acting flexibly to keep parents engaged in the therapeutic process. They provided many examples of how they adjust the therapeutic setting, including flexibility in meeting scheduling and frequency, shifting to online formats, meeting with only one parent, and more. B highlighted the importance of being flexible, especially when parents are facing numerous challenges in their lives: "I try to accommodate them [the parents], check what time works best for them, see how I can adjust my schedule. After all, they have a billion responsibilities, I understand that." (B., bibliotherapy and arts therapy, female, age 48).

Therapists frequently expressed the expectation that the systems in which they operate should be sufficiently flexible to meet parents' needs, rather than leaving such adaptations solely to individual clinicians. H. said: "If there were an option to work in the evening, it could make it easier to encourage parents to come after their working hours." She also highlighted the advantages of flexible service delivery models that reduce the burden on parents attending clinic-based sessions, instead bringing services closer to them:

…For example, the clinic has a wonderful home-based therapy program, where therapists come to patients' homes when it is difficult for them to get to the clinic. The clinic strives to ensure that its services are accessible to everyone. There is also a project providing treatment in daycare centers or kindergartens. It can make it easier for some parents to meet at the kindergarten rather than at the clinic. (H., Intern in clinical psychology, female, age 30).

At the same time, therapists often described how accommodating parents' needs can come at the expense of the depth and quality of treatment. For example, Z. explained that while her online therapy sessions with a mother were a convenient alternative to traditional in-person sessions, they affected the therapeutic relationship and ultimately the effectiveness of the intervention:

I feel that physical presence creates emotional closeness, and I feel that on Zoom, at least in my experience, there's less potential to reach deeper layers, less potential for closeness. It's more about getting things done. (Z., Intern in educational psychology, female, age 30).

A specific aspect of the therapeutic setting that several therapists paid special attention to was the frequency of meetings. Therapists emphasized that there is a direct connection between meeting frequency and parents' willingness to persist in treatment, the ability to deepen the therapeutic work, and the capacity to repair ruptures in the therapeutic alliance. V. discussed the challenges of building a meaningful relationship with parents when meetings are infrequent.:

Often, it feels like the work with the parents is not deep enough. It's related to frequency: if parents' meetings were once a week, then perhaps it would be different. But often that's not the case. Even once

every two weeks is hard to maintain. And then the work becomes more superficial…we don't dive deeply enough into each parent's inner world. (V., clinical psychologist, female, age 44).

A. described how meeting frequency affects the ability to repair ruptures in the therapeutic relationship, and how this, in turn, influences parental engagement:

With one mother, at the first meeting after the intake, I somewhat hurt her feelings. Now, when there is ongoing treatment, and I meet the person regularly and with relatively high frequency, I have an opportunity to repair these kinds of ruptures. But here, there was a rupture, and when I called to schedule her next appointment, after two or three months…From her perspective, the rupture had not been repaired. The longer the time passes, the harder it becomes to repair it. So, I think that the low frequency of meetings harms the parents' ability to cooperate. (A., Intern in clinical psychology, male, age 30).

Discussion

Parental engagement in their child's psychotherapy has long been recognized as a critical component of effective treatment. However, its implementation remains challenging, and the existing literature offers limited guidance on how to facilitate engagement. To address these knowledge and practice gaps, this study sought to better understand therapists' perspectives on the barriers to parental engagement in their child's therapy and the strategies they use to promote it.

Three key findings emerged from the study. First, our findings indicate that parental engagement is shaped by barriers operating at three interconnected levels: those related to parents, those related to therapists, and those arising from the therapeutic setting and the broader systemic context. Second, our evidence suggests that there are reciprocal and circular influences between these three barrier domains. For example, parents who arrive with mistrust or resistance may evoke feelings of criticism, frustration, or incompetence in therapists. In turn, therapists who experience negative emotions toward parents may become less proactive, less empathic, or more critical, thereby weakening parents' willingness to participate. Systemic conditions may intensify these processes by limiting opportunities to establish continuity, trust, and emotional safety within the therapeutic relationship. Third, within this dynamic process, the therapeutic alliance emerged as the central organizing construct. Strong alliances may buffer the impact of barriers across all three domains, whereas weakened alliances may amplify cycles of avoidance, mistrust, and disengagement.

Based on these findings, we propose a conceptual framework that positions parental engagement not as an individual parent characteristic but as an emergent relational and systemic phenomenon shaped by ongoing interactions among parents, therapists, and the therapeutic setting. Figure 1 presents this framework, illustrating how the therapeutic alliance with parents mediates the relationship between barriers and parental engagement.

Barriers at the parents' level

At the parent level, negative perceptions of parenting-focused interventions, including misunderstandings of the intervention's objectives and the parents' role in their children's psychotherapy, were frequently cited as barriers to parental engagement. Therapists noted that parents who do not recognize their role in their child's difficulties, who expect the therapist to be the primary agent of change, or who are open only to concrete guidance by the therapist, often feel disappointed with the parenting intervention and become disengaged. These findings align with prior research identifying parents' perceptions of the treatment as unhelpful or irrelevant as barriers to engagement (Burney et al., 2024; Kazdin et al., 1997; Waid & Kelly, 2020). It highlights the importance of including a psychoeducation component in parenting interventions to increase agreement with treatment goals and techniques, thereby strengthening the treatment alliance.

Parental disengagement was also attributed to the emotional discomfort experienced by parents while acknowledging their disadvantages and negative experiences in parenthood. This discomfort is particularly heightened by the fear of being criticized by their therapists. Our findings support previous research identifying parents' reluctance to self-reflect and fear of being judged as central barriers to parental engagement (Baker-Ericze´n et al., 2013; Haine-Schlagel & Walsh, 2015; Kuria & James, 2025). Furthermore, in accordance with previous studies (Kazdin et al., 1997), we found that parents who struggle with their own mental health issues or who are burdened by challenging life circumstances tend to disengage more from the therapeutic process due to a lack of emotional and physical resources. Our findings on these parent-level factors can help therapists view parents' disengagement as an avoidant coping strategy rather than mere treatment resistance. This perspective may foster a more compassionate therapeutic approach, thus strengthening the therapeutic alliance.

Barriers at the therapists' level

Our findings also reveal factors at the therapists' level which contribute to parents' disengagement in their child's treatment. Therapists often reported feeling incompetent when working with parents, which led to reduced efforts to engage them in the process. These feelings were linked to inadequate training in parenting work or, for some, to perceptions of themselves as inferior to parents, such as being younger or not having children of their own. These findings add to previous studies that have linked therapists' efforts to engage parents to their professional experience and self-efficacy (Haine-Schlagel et al., 2012; Line & Ray, 2024). This finding may be explained by the idea that, in the unique interaction between child therapists and caregivers, both parties may struggle to maintain their self-esteem and manage feelings of being judged. Potentially, this could reflect an underlying rivalry between them over who is the more benevolent figure in the child's life.

Another major setback to engaging parents was the therapists' cyclical reaction to the parents' disengagement. Consistent with previous findings (Baker-Ericze´n et al., 2013; Line & Ray, 2024), therapists often described the negative feelings that arise when parents avoid or refuse treatment, as well as the burnout effect. It appears that to break this vicious cycle, ongoing support and consultation are essential to help therapists manage these intense negative feelings and to establish a strong alliance with the parents.

Mechanisms at the setting and the system level

Some mechanisms influencing parents' engagement were identified at the level of the therapeutic setting and the broader system. This revealed an interesting tension between two poles. On the one hand, therapists emphasized the need for clear boundaries regarding parental involvement and a consistent setting. On the other hand, they acknowledged the importance of flexibility, which is affected by factors such as their organization's working hours and the available treatment modality (Burney et al., 2024; Wide & Kelly, 2020).

Clear boundaries were viewed as ensuring parents' continuous attendance at sufficient frequency, allowing the establishment of a strong therapeutic alliance, repairing ruptures in this alliance, and achieving greater depth and quality in the intervention. Previous findings indicated that when parents' regular attendance was ensured, their participation in session activities, discussions, and/or homework was greater (Haine-Schlagel & Walsh, 2015) and that therapeutic work with them reached greater depth (Whitefield & Midgley, 2015). Flexibility was primarily described by the therapist as a remedy for parents' logistical barriers. These findings align with Becker and Chorpita's (2023) conclusion that certain procedures work best for different aspects of engagement (e.g., appointment reminders improve attendance, while cultural sensitivity strengthens the relationship).

The therapists emphasized that navigating the tension between structure and flexibility requires a delicate balance that enables meaningful therapeutic work while accounting for the parents' logistical barriers. It seems that the complexity of this challenge, together with therapists' difficulty being assertive in setting boundaries, leads them to expect the system to manage this tension, suggesting a need for more thorough training and continuous supervision.

The therapeutic alliance as a mechanism facilitating parents' engagement

A positive therapeutic alliance with parents was the most frequently mentioned mechanism for facilitating parents' engagement. In accordance with accepted definitions of the therapeutic alliance, therapists referred to its three components: the therapeutic bond, agreement between the therapist and the client on the treatment goals, and the means (or tasks) to achieve them (Bordin, 1979). They observed that building a positive therapeutic relationship with parents involves validating their feelings, showing empathy, and maintaining a compassionate perspective - essential qualities in any positive relationship. However, several unique aspects of the therapeutic relationship with parents also came to light. These include communicating with parents "at eye level," collaborating with them, and being highly available to meet their needs.

These findings suggest a specific therapeutic approach that may help build a strong relationship with parents, even when they are not primary clients and do not necessarily seek treatment for themselves (but rather for the child). By creating a safe, warm environment, therapists can help parents confront difficult feelings about their child or about themselves as parents. A collaborative "eye-level" relationship

allows parents to feel less misunderstood or judged by the therapist (Kuria & James, 2025), and maintaining a high level of between-sessions availability (e.g., text messaging, emails, phone calls) makes the therapist a significant and relevant figure in the parents' lives, thereby promoting alliance and engagement. However, such between-session contacts should be carefully considered and defined to minimize risks such as parents' over-dependency on the therapist or blurred boundaries (Mishna et al., 2012).

The therapeutic alliance with parents is also established and maintained by discussing and agreeing with them on the goals of therapy and the means to achieve them. This included not only the objectives for the child's therapy but also for the parents' own process. The therapist worked to reach agreement on the parents' level of involvement in treatment, the specific issues they wanted to address, and the methods of achieving their goals. These discussions took place both at the beginning of treatment and throughout the therapeutic process, especially during times when the therapeutic alliance faced challenges. The therapist emphasized that open, direct and non-confrontative communication about the parents' concerns, expectations, and needs is essential to actively engage them in the process and to overcome the inclination towards disengagement. Such an approach may reduce parents' misunderstandings, frustrations and dissatisfaction with the treatment (Baker-Ericze´n et al., 2013) and assist the therapists in navigating the session's focus from daily, concrete issues related to the child to the parents' internal world, childhood histories and unconscious material (Whitefield & Midgley, 2015).

Our qualitative findings align with the results of a meta-analysis of quantitative data, indicating that the parent-therapist alliance is related to improved treatment engagement (de Greef et al., 2017). It emphasizes the importance of treating the therapeutic relationship with parents as equal to, rather than subordinate to, the relationship with the child, and of employing therapeutic strategies to strengthen it.

Limitations

This study has several limitations that should be considered when interpreting its findings. First, the study was constrained by its small sample size and unique contextual factors, which may limit the transferability of the findings to other cultural settings. For example, the public services in Israel are free of charge, which might explain why, unlike in previous research (Wide & Kelly, 2020), issues related to treatment costs or complex insurance authorization procedures did not emerge as significant barriers for parents. Additionally, our findings rely solely on clinicians' perspectives, and parents' views are not included. Parents' accounts may reveal additional barriers or facilitators influencing their engagement, such as cultural factors or the child's age, which have been identified as obstacles in previous studies (Kuria & James, 2025; Wide & Kelly, 2020).

Conclusion and Implications for Practice, Policy, and Research

Our study offers a distinct contribution to the literature by generating a practice-based conceptual understanding of how parental engagement is established, negotiated, and sustained within child-

focused therapy. To inform policy, clinical practice, and future research, we recommend the following.

Dedicated training in parenting interventions. Overall, our findings highlight the need for more comprehensive and dedicated training for child psychotherapists in parenting work, as well as ongoing supervision, not just as a supplement to training in child psychotherapy, but as a unique discipline (Whitefield & Midgley, 2015). Such training should acknowledge the unique challenges of engaging parents when the child, rather than the parent, is considered the primary patient and provide therapists with a conceptual framework for navigating these complexities. A clear working model can support therapists' sense of competence (Leibowitz & Silverman, 2024), thereby leading to greater tolerance and a more compassionate view towards the parents' disengagement and preventing emotional burnout.

Our findings do not support the superiority of any specific therapeutic approach (e.g., psychodynamic or cognitive-behavioral therapy) in engaging parents, despite the diverse methods used by the therapists in our study. Instead, our results highlight essential components that should be included in therapist training, regardless of the specific therapeutic techniques they learn. These include: (a) Deepening therapists' familiarity with parents' emotional barriers (e.g., fear of criticism, difficulty in acknowledging guilt and other negative feelings) and technical obstacles to engaging in their child's treatment. (b) Learning the unique aspects of the therapeutic alliance with parents, including the therapeutic relationship and the importance of reaching an agreement on the goals and methods of the parenting-focused component. (c) Learning methods to manage resistance in treatment and overcome ruptures in the therapeutic alliance.

Ongoing consultation for therapists. Ongoing consultation can assist child therapists, especially younger ones, in building warm, close relationships with parents and in overcoming negative feelings towards them, such as anger, feelings of incompetence, criticism, and feelings of inferiority.

A treatment model that facilitates the therapeutic alliance with parents. A suitable treatment model and setting are necessary to facilitate the creation of a strong therapeutic alliance with parents. For instance, including a series of frequent sessions with parents at the beginning of treatment, followed by regular sessions, may help achieve this goal. Additionally, a treatment model that includes a clear therapeutic contract, covering the frequency of parents' sessions, who participates in them, and the parents' dual role as facilitators of the child's treatment and as the focus of treatment themselves, is another means to promote agreement and understanding between the parents and their child's therapist.

Structured, yet flexible therapeutic setting. Our findings highlight the importance of balancing a structured setting (such as having constant scheduled sessions and consequences for missed appointments) with the flexibility needed to improve treatment accessibility. Parents' logistical challenges can be addressed by various means, such as offering flexible treatment hours and modalities, creating a supervised waiting area for their other children, and providing convenient public transportation and parking options (Waid & Kelly, 2020).

Special attention to parents who struggle with mental issues or stressful life circumstances. Our study found that parents' mental health issues and stressful life circumstances significantly hinder their ability to engage in their child's therapy. It also suggests that, up to a moderate level of these challenges, a child's therapist can support parents by providing a space for them to discuss their concerns and help them regulate their emotions. However, when parental psychopathology is at a high level, it is necessary to refer the parent for treatment and to offer more flexibility in scheduling parenting meetings.

Taken together, these recommendations underscore the necessity for clinical, organizational, and policy frameworks that enhance clinicians' skills and the effectiveness of their interventions, while also addressing the specific challenges faced by parents. Future research should further investigate these issues from the perspectives of parents, children, and policymakers.

Declarations

Author Contribution

M.S. contributed to the study conception and design. Material preparation, data collection and analysis were performed by M.S. and S.B.F. The manuscript was written by M.S. and M.F. All authors read and approved the final manuscript.

Data Availability

The data supporting this study's findings are restricted to protect participants' privacy and anonymity. It can be accessed only upon request from the authors.

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Figures

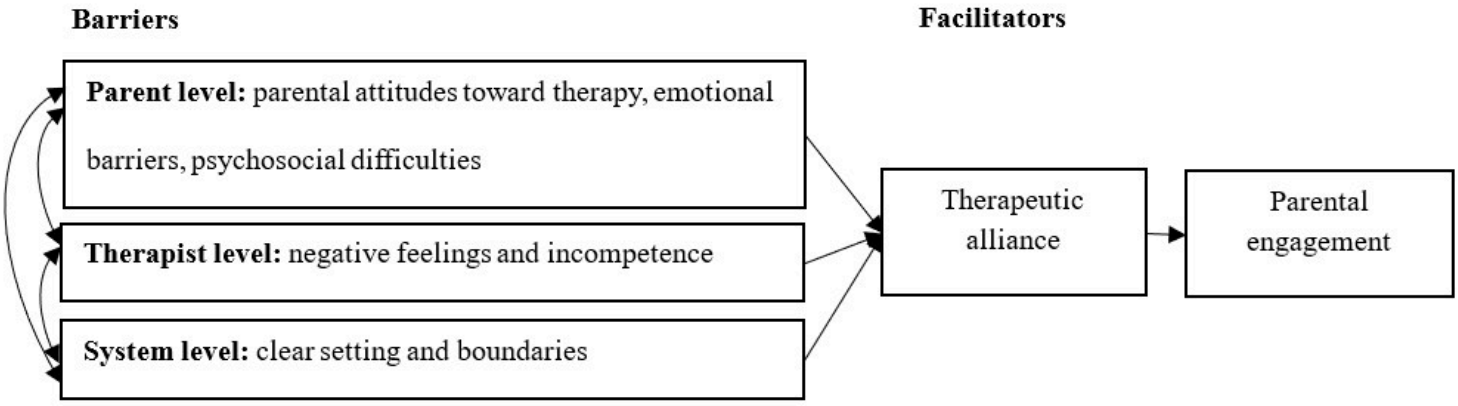


Figure 1

Conceptual framework of barriers and facilitators to parental engagement