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GUILT, BLAME, AND RESPONSIBILITY: THE EXPERIENCES OF PARENTS AND
CLINICIANS PROVIDING SERVICES TO ADOLESCENTS WITH CO-
OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE CHALLENGES

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University.

by

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DEDICATION

To the many parents working to help their children heal in the face of innumerable obstacles and to the clinicians who dedicate their working lives to aid in this seemingly never-ending process.

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Abstract

GUILT, BLAME, AND RESPONSIBILITY: THE EXPERIENCES OF PARENTS AND CLINICIANS PROVIDING SERVICES TO ADOLESCENTS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE CHALLENGES

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

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The purpose of this study is to understand and describe the experiences of parents of, and clinicians who provide services to, adolescents with co-occurring mental health and substance use challenges, particularly as they relate to issues of guilt, blame, and responsibility. The study is based in a theoretical framework derived from Symbolic Interactionism (Blumer, 1969), Attribution Theory (Heider, 1958), and Barrett's (1995) Theory of Guilt and Shame. The guiding question the study is: *What are the experiences of parents of adolescents with co-occurring mental health and substance abuse challenges and clinicians who provide treatment services around issues of blame, guilt, and responsibility, and how do those experiences shape their collaboration?* Twenty three participants engaged in in-depth interviews. The results have been analyzed using a phenomenological approach to qualitative research. The results of the study have been

organized within four domains. The first domain, Sources of and Impact of Guilt and Shame was comprised of three themes: (a) Parents experience of guilt related to their behaviors, (b) Parents' experiences of guilt has a serious impact on families, and (c) Guilt and shame felt by parents shaped the therapeutic process. The second domain, Being Blamed and Blaming Others, was comprised of two themes: (a) Feeling blame from every direction and (b) Parents blaming others. The third domain, Potential Pitfalls and Strategies for Success included three themes: (a) Anticipate issues of blame and guilt, (b) Inclusion and exclusion of parents in the therapeutic process, and (c) Clarify the process. The fourth domain is Training and Theoretical Orientation Issues, consisting of two key themes: (a) Theoretical orientation shapes practice with parents and (b) Importance of training specifically focused on working with families. Strengths and limitations of the study, along with implications for clinical practice, social work education, and future research, are discussed.

CHAPTER ONE

An Introduction

A decade ago, a federal report that relied on diagnostic criteria from the *DSM-IV* (American Psychiatric Association, 1994) indicated that 43% of adolescents who received mental health services were also diagnosed with a substance use disorder (Center for Mental Health Services, 2001). Experience suggests that there are even more adolescents who struggle with both mental health and substance abuse challenges but do not meet standard diagnostic criteria in both areas. The good news is that the President's New Freedom Commission on Mental Health (2003) found that early intervention and appropriate treatment for adolescents with co-occurring disorders can reduce the pain and distress that these youth experience. As will be explicated throughout this document, one concern in the delivery of appropriate treatment services in this area is the ways that issues of responsibility, blame, and guilt may interfere with the parent-clinician alliance that is essential in providing mental health and substance abuse services to youth. This study has gathered the voices of parents and clinicians around this issue in an attempt to inform the tailoring of social work practice and education so that they more effectively and compassionately serve adolescents with co-occurring mental health and substance abuse challenges and their families.

Definition of Key Terms

For the purposes of this research, it is essential to define a few key terms that will be used heavily throughout this proposal:

Responsibility in this study is conceptualized as the etiological factors that contribute to the development of co-occurring mental health and substance abuse

challenges among adolescents. It refers to the state of being accountable for the cause of a problem, in this case, mental health and substance abuse challenges in adolescents. This may include both biological and environmental factors for which there is extensive research that support their connection to these co-occurring problems. In his book, *Judgments of Responsibility*, Bernard Weiner (1995) argues that responsibility differs from blame in that it is affectively neutral. That is, one can be responsible for either success or failure, but blame is only assigned in a situation about which one has a negative emotional reaction.

In this study, *blame* will refer to a combination of the etiological responsibility discussed above, colored by a negative moral judgment from others, including but not limited to, society at large and treatment providers. This definition is derived not only from Weiner (1995) as mentioned above, but also from the work of Brewin and Antaki (1987), who while studying attributions, indicated that blame must require an attribution of responsibility along with a moral responsibility. Additionally, Weiner suggests that blame consists of a cognitive assignment of responsibility along with an emotional feeling of anger towards the one found responsible.

Guilt is a concept similar to blame as described above. However, instead of responsibility and a moral judgment made by others, guilt will include a negative moral judgment made about oneself. The closely related nature of these two concepts in especially event as guilt is sometimes referred to in the literature as self-blame (Moses, 2010). Barrett (1995) reviews multiple theories of shame and guilt and posits that most, yet not all, of these theories converge in an understanding that shame involves a understanding of oneself as 'bad' while guilt focuses instead on the badness of a

particular action or deed. Likewise, Jones, Kugler, and Adams (1995) highlight the need to distinguish between guilt and shame. They argue that while both emotions focus on both the subjective affective experience of an individual and an objective evaluation of an act or behavior, the results of shame and guilt differ. That is, when a person experiences shame, he or she feels compelled to hide themselves or conceal their behavior, whereas a person experiencing guilt feels driven to atone for mistakes or misdeeds. In Barrett's review of the theoretical literature regarding shame and guilt, she notes that while there are important differences between these concepts, they are often thought of as being part of the same family of emotions, and that many do not distinguish between these two emotions. Therefore, both of these concepts will be referred to as guilt for the purposes of this proposal, especially in the review of previous literature. That said, it is expected that the distinction between guilt and shame will prove important in the analysis phase of this research and the interview protocol has been designed with this distinction in mind. More detail on shame and guilt will be discussed in the theoretical underpinning section later in this chapter.

Also of note is the researcher's choice to use the terminology *challenges* as opposed to *disorders* when describing the substance abuse and mental health problems experienced by adolescents. This decision was made for two key reasons. First, the investigator, both in her research and in her clinical practice, prefers to focus on problems of living as opposed to pathologies whenever possible. This language choice serves as a reminder to herself, and hopefully her readers, that focusing on the humanity of an individual, as opposed to a label or diagnosis, is essential. Secondly, the researcher wants to include in this study parents of, and clinicians who work with, adolescents who

experience both mental health and substance abuse problems, many of whom may not be formally diagnosed with both a mental health and substance use disorder. That said, in the review of the etiological literature that occurs in Chapter Two, the term “disorder” is used to best reflect the research that was conducted.

Statement of Context: History of Blaming Families

There is a long and unfortunate history in mental health services of blaming families, particularly mothers, for the problems that children encounter. The psychoanalyst Frieda Fromm-Reichman has been credited with creating the unhelpful term ‘schizophrenogenic mother’ (Hornstein, 2000), which refers to the idea that early interactions between a mother and child resulted in the child’s later developing serious mental illness. While this concept remained in the professional and popular imagination for decades, the state of the science evolved to a point where we came to understand the biological causes of schizophrenia and began to remove blame from the mother for causing this often devastating illness (Seeman, 2009). Unfortunately, the idea of the schizophrenogenic mother was replaced by blaming both parents and their suspected hostile attitudes and critical comments as bringing about periods of time in which an individual’s symptoms increased (e.g. Brown, Birley, & Wing, 1972; Vaugh & Leff, 1976).

Similar patterns of blaming parents were seen in the way that society in general, and the mental health profession in particular, viewed mothers of children diagnosed with autism. In their critique of pseudoscientific theories for the etiology of autism, Herbert, Sharp & Guadiano (2002) note that as early as the 1940’s, mental health professionals began to lay blame on parents, particularly mothers, for their child’s

autism. They draw attention to the work of Kanner (1946), for example, who indicated that interpersonally distant parents, in combination with biological factors, led to autism in children. Bruno Bettelheim (1967) took this idea one step further, disregarding the influence of organic causes for autism, and instead indicating that cold, unloving mothers were the cause of childhood autism. Indeed, Bettelheim, among others, encouraged a practice that children with autism be separated from their parents for long periods of time to promote healthy development (Gardner, 2000). Although researchers found no evidence significant personality differences between parents of children with autism and those whose children do experience this challenge (Allen, DeMeyer, Norton, Pontus, & Yang, 1971), some theorists, as Roser (1996) claims, continue to indict mothers as a causal factor in their child's autism.

While schizophrenia and autism maybe two of the extreme cases of mother-blaming in the history of psychology and its allied professions, there are certainly numerous other examples of the ways in which mental health professionals have blamed parents for their children's struggles. Researchers have accused mothers of children who stutter with having passive and negative personality traits (Yanagawa, 1973). Others have suggested that mothers of children displaying hyperactive behaviors have a high rate of sociopathy and hysteria (Morrison & Stewart, 1971). In the case of children exhibiting delinquent behaviors, scholars have gone as far as accusing parents of persuading, perhaps unintentionally, their children to act out their own impulses or desires (Johnson & Szurek, 1952).

Luckily, the prevalence of professional opinions that explicitly blame parents for their children's mental health problems has seemed to fade over the years (Seeman,

2009). Indeed, now it appears that mental health professionals acknowledge the burden experienced by family members of people with schizophrenia (Awad & Voruganti, 2008) and view parents of adult children with schizophrenia as coping as best they can in the face of ongoing difficulty (Riebschelger, 2002). However, it is within this historical context - that of mental health providers creating untold amount of damage to families who have a child facing significantly disabling conditions in the name of providing therapeutic services - that this study is situated.

Statement of the Problem: Perceptions of Guilt, Blame, and Responsibility Cloud the Relationship between Parent and Clinician

As will be described in detail in Chapter Two, parents often experience feelings of guilt and experiences of being blamed in regards to any significant challenges their child may experience, particularly those related to mental health or substance abuse problems. However, etiological research suggests that there are indeed some risk factors for mental health and substance abuse problems that parents can “transmit” to their children, either through heritable conditions or facets of the home environment. As clinicians strive to provide families with a full understanding of the problem at hand, discussions of responsibility may be colored by those experiences of guilt and blame.

This leads to challenges for the clinician, however, as, according to the literature that will be detailed later in this study, fostering a positive working alliance with an adolescent client’s parents is an essential component of effective treatment. Experience suggests that many clinicians are unclear how to best nurture this relationship in the face of therapeutic discussions between treatment providers and parents about etiological factors and parents experiences of guilt and blame, real or perceived.

Theoretical Underpinnings

This study uses three theories as a foundation for the research question, methodology, and analytic strategies. This section will detail the ways in which symbolic interactionism, attribution theory, and Barrett's theory of shame and guilt inform this research.

Symbolic Interactionism

Symbolic interactionism is drawn from the work of George Herbert Mead and later, his student Herbert Blumer. The theory posits that human behavior occurs in a mutually constructed social process and that the meaning individuals make of the things around them is essential in its own right. Blumer (1969) states the key propositions of symbolic interactionism: that individuals act based on their personalized meaning of a situation, that this meaning is developed through social interaction, and that meaning is modified by each individual through an interpretive process. In other words, there is not one meaning for each thing or encounter a person may experience; rather, each individual derives his or her own meaning from, or makes her or her own sense of, an experience.

The symbols referred to in symbolic interactionism are the constructions of meaning that individuals assign to different parts of their world. The theory emphasizes the importance of these symbols and the socially interactive process as motivators to human behavior and an explanatory factor for social phenomenon (Patton, 2002).

Because meaning emerges from social interaction and social context, in order to fully understand a phenomenon, one must understand the experiences and perceptions of the individuals involved in this interaction.

Additionally, it is important to note the key role of language in symbolic interactionism. Clearly, language is one of the key means by which human beings interact with one another. Indeed, George Herbert Mead, a sociologist upon whose work Blumer based much of symbolic interactionism, posited that individuals create their sense of self through communication with others (Mead, 1932). Language, therefore, becomes the key means of interpreting the world of the individual and engaging in the sense-making process.

In this study, symbolic interactionism will provide the rationale to consider not only the specific actions of parents and clinicians, but also the meaning-laden nature of the work they do to support children with mental health and substance abuse challenges along with the process they co-create through their interactions. Crotty (1998) argues that engaging in research grounded in symbolic interactionism requires that the investigator take seriously the individual perspectives of participants in regards to events, behaviors, and society. With this in mind, this researcher has chosen to utilize a phenomenological research design, which will be described in Chapter Three.

Attribution Theory

The key concepts and propositions of attribution theory (Heider, 1958; Weiner, 1986) have also contributed to the conceptualization of this research. Attribution theory suggests that people have an innate need to understand their environments, which leads them to develop casual explanations, or attributions, for their own and others' situations or behaviors. Lord and Smith (1983) indicated that attributions can serve two key functions that are relevant to this study: identifying the cause of an event and assigning responsibility for an event. The work of Weiner and colleagues (1971) suggests that

many attributions can be classified based on a key dimension, the locus of causality. The idea of the locus of causality refers to whether an individual believes the cause of an event was something internal (e.g., behaviors or beliefs) or external (e.g., societal forces, luck) to the person experiencing that event. Research suggests that typically, a person is held more accountable for a situation if the cause is perceived to be an internal attribute as opposed to an external one (e.g. Wadley & Haley, 2001).

For the purposes of this research, attribution theory informs the basic premise of the study – that parents and clinicians alike develop assumptions of the cause of an adolescent’s mental health and substance abuse challenges. Additionally, the focus of the theory on internal and external attributes may suggest factors that relate to parents experiences of guilt and blame.

Barrett’s Theory of Shame and Guilt

While there is literature that refers to Shame and Guilt Theory, a careful reading of these pieces of research lead this writer to recognize that there is not a cohesive theory, but instead multiple ones (e.g., Piers & Singer, 1971, Schorre, 1991, Nathanson, 1987, Buss, 1980) that converge in some areas and diverge in others. From these, Barrett’s theory of shame and guilt (1995) has been selected to guide this research as it encapsulates several useful ideas contained in other related theories. The basic principles of this theory that are relevant to this study are as follows:

1. Shame and guilt are social emotions. These emotions emerge out of social interactions, to the extent that they can be considered social constructions, and are directly related to a particular society’s rules and norms.
2. Shame and guilt serve important functions. Shame distances the person

experiencing this emotion from others, particularly the one who may be evaluating or judging them. Guilt, on the other hand, motivates a person to repair the damage caused by a misdeed.

3. Shame involves the sense that some person, or the society at large, is viewing the person experiencing the emotion as a bad person, while guilt refers to the sense that one has behaved in a way that is contrary to their own, or society's, standards.

For the purposes of this study, these concepts from Barrett's theory of shame and guilt shaped the questions asked during data collection along with the data analysis process. While much of the literature on parental experiences of guilt do not highlight the distinction between shame and guilt, these differences may be connected to the ability of a clinician and parent to work towards forming a successful partnership. This study attempted to tease out these differences and their relationship to the parent-clinician alliance.

Significance of the Study

This study is intended to lend voice to both the parents of, and the clinicians who work with, adolescents with co-occurring mental health and substance abuse challenges, particularly in regard to their experiences of blame, guilt, and responsibility. In a recent article, Sheridan, Peterson and Rosen (2010) argue that only a handful of studies have focused their attention on the perceptions of parents of adolescents in family therapy. While there is an adequate amount of quantitative and qualitative research that discuss parent perceptions of blame and experiences of guilt related to their children's mental health and/or substance abuse difficulties, as will be seen in Chapter Two, there is a

dearth of literature that highlight the interactive process around these issues within the parent-therapist alliance. Additionally, there seem to be no studies that provide information to suggest how parents and clinicians can best work together to overcome these issues in order to form a successful working alliance. This study seeks to describe the experiences of the parents and clinicians related to their professional relationship, particularly as it is shaped by issues of blame guilt and responsibility.

By gathering rich, descriptive data from both parents and clinicians, it was a hope of the investigator that this research project would begin the work of filling in that gap in the literature of the voices of parents and clinicians around this topic. When their stories are not told in the literature, it is easy for professionals to minimize and marginalize the importance of their experiences. It was expected that the interviews conducted in this study would shed light upon the experiences of these participants and would have implications for both clinical practice and professional education around fostering effective parent-clinician alliances.

Relevance to Social Work

The Bureau of Labor Statistics, a component of the U. S. Department of Labor (2010) reported that in recent years, approximately 45 percent of social workers were employed in child, family, and school settings, with another 21% working primarily in the mental health and substance abuse field. Additionally, employment projections indicate that jobs are expected to be added in these areas over the next decade (U. S. Department of Labor). As social workers provide a majority of the mental health services that are delivered in this country (National Association of Social Workers, 2010), we should be particularly concerned with our ability to provide more effective

services to youth through improving our alliances with their parents. Indeed, the Family-Centered Care philosophy, which calls for professionals to respectfully include family members as partners in the treatment and caregiving of individuals with mental health challenges, has been an important influence on mental health service for the past several decades (Johnson, 2000). That said, there is clearly more work to be done to encourage professionals to partner effectively with parents and other family members, as current research highlights a persistent and unmet need of family members to receive more information, collaboration, and support (McNeil, 2013). Furthermore, this research relates to several specific core values of social work as delineated in the Code of Ethics of the National Association of Social Workers (2008):

Social Justice – Social workers are called to challenge social injustice, and at their core, the issues of responsibility, blame, and guilt are social justice issues. As will be demonstrated in Chapter Two, blame and guilt interfere with an adolescents' ability to receive appropriate, effective treatment. As social workers, we have a responsibility to work to change some of those societal forces, particularly those that may impact our own professional work.

Likewise, there is a gap in knowledge regarding the lived experiences of parents and clinicians as they strive towards forming a productive working alliance. Without these stories, parents may remain voiceless in the literature. Adding their voice reminds consumers of the literature of their utmost importance in service delivery to adolescents and allows their experiences to shape the course of future research and improve social work services to families.

Importance of Human Relationships - Social workers recognize the importance

of human relationships as a vehicle for change. Indeed, social work practitioners who work with children strive to foster collaborative relationships between the clinician, parents, and other service providers. If nothing else, this study is about human relationships, particularly the way guilt and blame can negatively affect the parent-clinician relationship and the successes that the participants have had as they moved past those issues to more effectively leverage a relationship for positive change. Likewise, this study provides the opportunity for social workers to better understand the needs of the families they serve, and through that understanding, be more able to develop and maintain the empathy that is essential for work to be successful.

Competence – Social workers are expected to develop professional expertise, yet there is little literature to guide these professionals in developing such proficiency in the formation of positive working alliances with the parents of adolescents with co-occurring disorders. In order to continue to develop professional competence, social work practitioners need additional information regarding strategies for overcoming conflict that results from issues of responsibility, blame, and guilt. It is the hope of this researcher that this study will provide such needed knowledge.

The following chapter seeks to highlight the literature explicating what we know about the causes of co-occurring mental health and substance abuse challenges in adolescents, the experiences the parents of these adolescents have with guilt and blame, and the importance of the relationship between parents and clinicians providing services to these young people. Chapter Three will detail the research methodology for this investigation, followed by a discussion of the results and implications in Chapters Four and Five.

CHAPTER TWO

Literature Review

Building from the theoretical content discussed in Chapter one, this chapter will highlight key research that further informed this project. First, there is a review of the importance of the relationship between parents and clinicians in child and adolescent treatment services, which grounds the focus of this study on the clinician-parent alliance. This is followed by a discussion of the literature regarding the etiology of co-occurring disorders, including both biological and environmental factors. This information is central to this study in that it is expected that the experiences related to guilt, blame, and responsibility of both parents and clinicians alike will be related to these causative factors. Next, the research related to parental experiences of guilt and blame is delineated. This literature highlights that these emotions are widespread among parents of children with mental health and substance abuse challenges, pointing to the relevance of this study. Finally, the chapter concludes with the research question for this study.

Review of Literature Suggesting Importance of Parent-Clinician Relationship

Importance in the Delivery of Mental Health Services

Alexander and Morrisson-Dore (1999) argue that there is a growing literature that indicates that the relationship between parents and clinicians is of key importance in the delivery of mental health treatment services to children. Discussion in the literature about the importance of this alliance is not new; indeed, it has been present in the literature for the past twenty years. Clinicians have been encouraged to view families as valuable allies as opposed to a problem to be overcome in treatment (Modrcin & Robison, 1991) and to understand that both clinicians and parents have important knowledge, experience, and abilities that can be helpful to the child receiving treatment

(Hunter & Friesen, 1996). The active participation of parents in their child's therapy is considered a crucial aspect of effective treatment (Nevas & Farber, 2001, Horvath & Greenberg, 1994). In fact, the relationship between parent and clinician has been viewed to be of equal importance to the client-therapist relationship (Naidu & Behari, 2010).

A growing body of literature provides empirical support to these ideas. In a study of 25 children, their parents, and their therapists, designed to investigate the impact of therapeutic alliance in the treatment of childhood obsessive compulsive disorder, Keeley and colleagues (Keeley, Geffken, Ricketts, McNamara, & Storch, 2011) found that parent-clinician alliance, as rated by both the parent and the therapist, was a significant predictor of positive treatment outcomes for the child. In a larger study of 181 children and their parents who were receiving services for behavioral problems in publically-funded community mental health clinics, it was found that the strength of the parent-therapist relationship, as reported by parents four months after services began, was predictive of the family's attendance rate for scheduled sessions (Garland, Haine-Schlagel, Accurso, Baker-Ericzen, & Brookman-Frazee, 2012). Similarly, Kazdin, Whitley and Marciano (2006) investigated the role of therapeutic alliance in evidence-based treatment for children referred for mental health services after displaying a pattern of oppositional and aggressive behaviors. In this study of 77 children and their families, the researchers found that the quality of the parent-therapist relationship predicted both improvements in parenting practices and positive changes in children's symptoms and functioning.

The aforementioned studies clearly indicate the importance of the parent – therapist relationship as a component of child and adolescent mental health services.

The following literature highlights the growing understanding of the complexities involved in investigating parent-clinician alliance. Lerner, Mikami, and McLeod (2011) observed parent-therapist alliance in a group of 27 parents receiving psychoeducation and parent-training services aimed to help their children with attention-deficit/hyperactivity disorder improve their social competency. In this intervention, which had no child-focused component, it was found that an early alliance between the therapist and a parent predicted improvements in both parenting skills and child outcomes. This is a key finding in that it emphasizes that even without contact between the therapist and the child who is experiencing challenges, a positive parent-therapist relationship can lead to changes in a child's social functioning. Flicker, Turner, Waldron, Brody, and Ozechowski (2008) investigated the role of therapeutic alliance in retention in a functional family therapy program for adolescents who abuse substances. They found that not only was the parent-therapist alliance important in treatment outcomes for youth, but that among the Latino families in their study, a balance between the parent-therapist alliance and the adolescent-therapist alliance was essential. In other words, Hispanic families in which parents reported differing levels of engagement with the therapist when compared to their children were more likely to drop out of treatment prematurely. This, however, did not hold true for the Anglo families in the study, suggesting that cultural differences must be taken into account when evaluating parent-therapist relationships. Finally, Hawley and Weisz (2005) studied both child-therapist and parent-therapist alliances among 65 youth receiving outpatient mental health services in a community mental health setting. They found that the parent-therapist relationship was significantly related to family participation, attendance, and therapist-

family agreement around the timing of treatment termination, while the youth-therapist alliance was related to both child and family reports of symptom improvement. The findings from this study suggest that both child and parent relationships with the therapist are essential to effective treatment, but that they may play different roles in, and have a different impact on, the therapeutic process.

Guilt and Blame in the Parent-Clinician Relationship

There are many causes for a poor relationship, one that does not advance or even hinders a child's progress towards treatment goals, to develop between treatment providers and client's parents. That said, issues of guilt and blame repeatedly emerge both in the literature and this researcher's professional experience as one of those factors. In a conceptual article, Judith Fox (2011) argues that stigma held by both parents and clinicians related to the root causes of children's mental health problems inextricably shapes the parent-therapist relationship, thereby altering the therapeutic process for the child. This idea appears to be supported by the empirical literature. In a 2005 study, Harden found that parent's relationship with the child's therapist was strained by the parent's experience of guilt and perception of blame from provider. Alexander and Morrison-Dore (1999) indicate that when therapists hold negative beliefs about parents, effective partnership-based practice is unsuccessful. Similarly, it appears that parents who perceive that they are being blamed by the therapist for their child's problems may be more likely to terminate treatment prematurely (Kuehl, Newfield & Joaning, 1990, Mason, Watts, & Hewison, 1995). In fact, preliminary findings suggest that when *any* statements blaming parents are made by therapists, there is an increased likelihood of the family dropping out of treatment (Wolpert, 2000). Conversely, parents

have suggested that a therapist who provides a nonjudgmental, nonblaming stance increased their comfort level in therapy (Sheridan, Peterson & Rosen, 2010).

Barriers to Meaningful Parental Participation

Although the importance of family involvement in services is clear, parents often experience barriers to effective participation in their child's therapy. In many cases, this may be a result of systemic or bureaucratic features of an agency, such as rules that explicate who should participate in treatment planning and the sessions themselves, that stand in the way even when parents express a desire to participate in treatment (Huffine & Anderson, 2003), but the personal relationship between parent and clinician also has an impact in this area. A negative relationship between parents and clinicians leads to negative clinical outcomes for the children receiving services. For example, when parents experience blame by others for their child's challenges, it may limit their ability to engage in the therapeutic process through being active in family therapy sessions or responsive to a therapist's request to participate in the difficult emotional work that treatment services sometimes require (Furlong & Young, 1996). Likewise, a parent's perception of a poor relationship with the therapist is linked to premature termination of services (Kazdin, Holland, & Crowley, 1997) and a strong parent-therapist relationship is significantly related to fewer cancelled sessions and no-shows (Hawley & Weisz, 2005). Indeed, the quality of a clinician-parent relationship is a predictor of treatment outcome in youth (Horvath & Symonds, 1991).

Feinstein, Fielding, Udvari-Solner and Joshi (2009) argue that the professional literature provides limited specific suggestions to clinicians about how to develop effective parent-therapist alliances. If this is the case in the broader sense, then it

certainly holds true for the problem of developing such effective relationships in the face of the complicating issues of responsibility, blame, and guilt.

Review of Literature Related to Etiology of Co-Occurring Disorders

Nature versus Nurture

As argued by Anastasi (1958), during the first half of the twentieth century, those attempting to understand psychological functioning began engaging in the “nature vs. nurture debates” in which academics took positions as to whether issues as diverse as personality, intelligence, psychopathology, and happiness were determined by heredity or environmental influences. Some believed in the theory of *Tabula Rasa* – that we are all “blank slates” when we are born and that our environment shapes our development. Others, believed that our lives were predestined by our genetic makeup. Indeed, undergraduate students in psychology continue to be exposed to the nature vs. nurture controversy in their introductory coursework (Kalat, 2010; Myers, 1995). In the past several decades it has become accepted by most social science theorists, if not society at large, that both nature *and* nurture contribute to psychological outcomes, and in fact, this is the foundation for the multidimensional approach to practice taught in social work programs around the country. Therefore, it is essential that we understand not only the individual biological and environmental factors at play, but also the interaction between these forces of nature and nurture in the development of adolescent co-occurring mental health and substance abuse disorders.

Biological Factors

Numerous biological factors have been associated with the development of adolescent substance use challenges. It is important to note that heritability for addiction

varies with substance choice, age, and biological sex (Edwards, Svikis, Pickens & Dick, 2009). For example, one investigation that utilized data gathered by the Virginia Twin Study of Adolescent Behavioral Development found that genetic forces seem to be a predominant risk factor for adolescent substance use among girls, while boys' substance use seems to be shaped more by environmental factors such as association with deviant peers and family disengagement (Silberg, Rutter, D'Onofrio & Eaves, 2003).

Additionally, a cross-sectional study of 5,769 10-15 year olds found that those who experienced early onset puberty had higher levels of youth substance abuse when compared with their later-maturing peers (Patton et al, 2004).

Given the evidence that addictive disorders have a considerable heritable root, efforts have been underway to identify the specific genes involved in addiction. However, as Edwards, Svikis, Pikens, and Dick (2009) argue, these efforts are complicated, and much is yet unknown, as substance dependence is genetically complex and it is believed that there are multiple heritable factors that influence both the onset of addiction and the variation in addictive behaviors. That said, it appears that at least two genes involved are in alcohol metabolism, alcohol dehydrogenase 1B (ADH1B) and aldehyde dehydrogenase 2 (ALDH2) (Edwards, Svikis, Pickens & Dick) and that the presence of the allele ADH1B*2, as is common among people of East Asian descent, or the allele ALDH2*2 are protected against the development of alcoholism (Edenberg, 2007). Conversely, variations on GABRA2 and GABRG1, two receptor genes, seem to be associated with a greater susceptibility to alcohol dependence (Edenberg, et al., 2004; Enoch, Hodgkinson, Yuan, Albaugh, Virkkutien & Goldman, 2009). These differences in GABRA2 also appear to be related to an increased risk of dependence on illicit drugs

(Dick, 2007). Additionally, variations on genes that are related to dopamine receptors, particularly DRD2, have been associated with dependence to heroin (Xu, et al., 2004), nicotine (Radwan, El-Setouhy, Mohamend, Hamid, Azem, Kamel, Israel & Lofreddo, 2007), and alcohol (Yang, Kranzler, Zhao, Gruen, Luo & Gelernter, 2008).

Likewise, biological influences appear to have an impact on the development of mental health challenges among adolescents. Heritable factors appear to be critical in the development of adolescent depression (Andersen & Teicher, 2008). As with addiction, variations in GABA and the dopamine system, are correlated with depressive and anxious behavior (Birzniece et al., 2006). Indeed, another twin study, this one focused on adolescent girls, found that about 40 percent of the variance of risk of major depressive disorder was accounted for by additive genetic factors, that is, the sum of the variance of genetic differences on a variety of alleles (Glowinski, Madden, Buckholz, Lynskey & Heath, 2003). As striking as that finding may be, other mental health disorders appear to have even a greater genetic basis. For example, it has been estimated that 70-91% of the risk of developing ADHD comes from genetic factors, specifically those related to variations in dopaminergic pathways located on DRD4, DRD5 and SLC6A3 (Thapar, O'Donovan, & Owen, 2005). Additionally, a sizeable amount of risk may also arise from environmental factors experienced *in utero*, such as complications during labor and delivery that may cause early brain trauma (Ben Amor, et al., 2005). While these perinatal risk factors can be classified as environmental, they may also be considered biological risks due to the physical changes that may occur in a child's brain.

The aforementioned research highlights the impact of genetic and other biological factors on the development of mental health and substance abuse challenges. This

information is important for the purposes of this study, as parental experiences of guilt and exoneration may relate to these factors, as will be described later in this chapter.

Environmental Factors

Along with genetic influences on the development of substance abuse challenges, many environmental factors have been noted to contribute to this problem. In a study that compared risk and protective factors for adolescent substance use among teens in the United States and Australia, researchers found that poor family management, which refers to an inability to provide consistent supervision and rules to their children, and family history of substance use predicts substance use among young people cross-nationally (Beyers, Toumbourou, Catalano, Arthur & Hawkins, 2004), while another study, which surveyed 134 Native American adolescents, has found that strong family communication patterns related to parent-child discussions about values, behaviors, and problem solving, among others appears to be protective against teen substance use (Beebe, Vesely, Oman, Tolma, Aspy & Rodine, 2008). Additionally, adolescents living in a single parent home are more likely to begin using alcohol and marijuana than those in a two-parent household (Loneczak, et al., 2007; Guxens, et al., 2007) It has also been demonstrated that levels of caregiver substance use, regardless of biological ties between the caregiver and child influence adolescent substance use (Walls, et al., 2007).

In the mental health literature, it is clear that early experiences such as abuse and neglect are critical in the development of adolescent depression (Andersen & Teicher, 2008). Additional environmental risk factors for depression in children and adolescents include traumatic life events such as abuse or neglect, adverse family environments including maternal depression, parental criminality, or parental substance abuse, family

conflict, and poor relationships with parents (Birmaher, et al., 1996; Zalsman, Brent, & Weersing, 2006). Likewise, adolescents who live in a family environment that is marked by conflict are more likely to experience repeated major depressive episodes than their peers with a history of depression who live in a home where there is less conflict (Asarnow, Tompson, Hamilton, Goldstein, & Guthrie, 1994). Additionally, environmental influences may account the 20-30% of risk of ADHD that is not heritable, according to Ben Amor and colleagues (2005). For example, structural equation modeling used in a study of 203 elementary school-aged boys and their mothers demonstrated that poor parenting behaviors, such as inconsistency or the use of coercive discipline, and adverse family environments characterized by frequent conflict or marital dissatisfaction were predictors of depressive symptoms among youth with ADHD (Drabick, Gadow & Sprafkin, 2006).

Comorbidity

As attribution theory suggests that parents and clinicians alike will be developing causal theories as to the relationship between the development of mental health and substance abuse problems among adolescents who experiences challenges with both of these issues, it is important to gain an understanding of the current state of the literature in this area. While some scholars posit that early experiences of mental health challenges bring on substance use in adolescents, and others suggest that substance abuse in the early teen years may be a causative factor in later mental health symptoms, it is important to note that these are not the only possibilities. Rather, twin studies have been conducted that indicate that common genetic factors undergird the development of both addiction and internalizing and externalizing mental health disorders (Kendler,

Prescott, Myers & Neale, 2003). It has become increasingly clear that neither adolescent substance use nor youth mental health challenges develop in a vacuum. For example, research demonstrates that experiencing internalizing disorders, in which symptoms are most often experienced intrapsychically such as depression or anxiety, is a risk factor for marijuana use among adolescents (Brook, Brook, Arencibia-Mireles, Richter, & Whiteman, 2001; Brown, Lewinsohn, Seeling & Wagner, 1996; Dierker, Vesel, Sledjeski, Costello & Perrine, 2007; Wittchen et al., 2007). Other research suggests that experiencing externalizing problems, which refers to outwardly apparent behavioral symptoms, such as aggression or defiance, in early or mid childhood is a predictor of adolescent substance abuse when the adolescent's drug of choice is alcohol (Boyle, Offord, Racine, Szatmari, Fleming, & Links, 1992; Costello, Sung, Worthman, & Angold, 2007; Pardini, White, & Stouthamer-Loeber, 2007; White, Xie, Thompson, Loeber, & Stouthamer-Loeber, 2001;), marijuana (Boyle et al.; King, Iacono, & McGue, 2004; White et al), or other illicit drugs (Cohen, Chen, Crawford, Brook, & Gordon, 2007; Fergusson, Horwood, & Ridder, 2007).

Likewise, the literature appears to support the idea that early substance abuse is a predictor of challenges related to depression and anxiety in early adulthood. However, there have been mixed results in the studies that attempt to discover the order of onset of these problems. For example, Brown, Lewinsohn, Seely, and Wagner (1996) conducted a cross-sectional survey of a sample of 1,709 community adolescents and found that early cigarette smoking seems to increase the likelihood of later episodes of major depression. However, in their study of 1,039 6th-10th graders, Griesler, Hu, Schaffran, and Kandel (2008) found that psychiatric disorders frequently preceded an adolescent's

first use of substances. Another study found that diagnoses of conduct disorders often preceded substance abuse in girls and boys, but that girls experiences of depression often frequently led to later substance use (Silberg, Rutter, D'Onofrio & Eaves, 2003).

Additionally, another study utilizing path analysis found that the presence of Posttraumatic Stress Disorder in adolescent males contributes to the later development of cannabis use disorders (Cornelius, Kirisci, Reynolds, Clark, Hayes & Tarter, 2009). An understanding of the professional thinking around the ways in which mental health and substance abuse challenges may co-develop in an adolescent is an important foundation for this study. Attribution theory asserts that people seek to develop an understanding of the causative factors for difficult circumstances. For the professionals, particularly, in this study, it is expected that some of this knowledge base will shape their positions.

Interactive forces

Of course, it is insufficient and simplistic to presume one can highlight the primary cause of mental health or substance abuse challenges experienced by youth to be either biological or environmental forces. Rather, it is now quite clear, and experience suggests widely accepted among clinicians, that these difficulties are the result of the interaction of multiple risk factors. For example, evidence suggests that many cases of depression in adolescents and young adults may arise from the confluence of genetic factors, such the presence of polymorphism in the 5-HTT gene, interacting with environmental incidents, such as abuse or neglect, that occur within a developmentally vulnerable period of time (Caspi, et al., 2003). In this case, it seems not to be just the combination of biological and environmental factors that is of importance, but also the timing of those events during an individual's lifetime. For example, an individual who

experiences physical abuse in early childhood may be more likely to have negative mental health or substance abuse outcome in adolescents, than one who experiences the same severity of abuse in middle childhood after they were able to reap the benefits of some environmental protective factors. Likewise, while highlighting both genetic and social influences on the adolescent mood disorder outcomes, Andersen and Teicher (2008) are quick to acknowledge that both heritable factors and early experiences are critical in the development of youth depression. For this study, these findings may contribute to the attributions of responsibility assigned by clinicians, in particular, many of whom would have had access to this information over the course of their professional education and training. Indeed, it is assumed by the researcher that the complexity of causative factors in the development of mental health and substance abuse challenges may be related to the complexity of the experiences of guilt, shame, and blame among parents and clinicians.

Review of Literature Related to Parental Experiences of Guilt

Genetic Causes and Guilt

Experience suggests that parents of children who experience mental health and substance abuse challenges frequently experience feelings of guilt and self-blame. Although an argument has been put forth that an increased focus on the biological causes of these disorders may validate and relieve parents of feelings of guilt, this does not seem to play out in the literature. Instead, it appears that some parents find that the increased focus on biological factors as a root cause of behavioral disorders to be exonerating. Meiser, Mitchell, McGirr, Van Herten, and Schofield (2005), posit that other parents who believe that biological forces are the root cause of their child's

challenges, experience guilt related to passing on “bad genes.” In a qualitative study of parents of children with Attention Deficit Hyperactivity Disorder, Klasen (2000), found that many parents felt relief when they were told that their child’s behavior was a result of a diagnosable illness. Another qualitative study, this one of families that experience a high rate of bipolar disorder, found that participants reported that a genetic explanation for bipolar was likely to decrease the stigma associated with the disease. Conversely, in a narrative-based qualitative study of 11 mothers of children with ADHD, women have reported blaming themselves for their child’s diagnosis, focusing their guilt on genetic factors that they may have passed along to their children (Peters & Jackson, 2008). Indeed, in a mixed methods study designed to examine parents self-blaming thoughts and behaviors, Moses (2010) has found that parents often report feeling guilty about causing their child’s mental health problems, regardless of their understanding of the causation of those struggles.

Parental Behaviors and Guilt

Of course, parental feelings of guilt do not only focus on the biological roots of their child’s problem. Indeed, many parents seem to experience guilty feelings due to their understanding that their child’s difficulties may have arisen or been exacerbated by their parenting behaviors (Peters & Jackson, 2008). Other parents indicated a belief their child’s mental health problems were a result of their failure as parents (Harden, 2005) or their failure to identify problems or seek services early enough to prevent a problem from worsening (Moses, 2010), poor decisions they made as parents (Moses) or difficult family circumstances (Moses). Parents of adolescents in family therapy reported feelings of inadequacy related to their ability to effectively parent their children

(Sheridan, Peterson, and Rosen, 2010). Likewise, in a qualitative study that aimed to describe the lived experiences of parenting an adolescent who uses illicit drugs, parents discussed feelings of intense guilt that their failure as a parent led to their children's substance abuse (Usher, Jackson, & O'Brien, 2007).

At least one study suggests that there does not appear to be a relationship between conceptualization of the problem and parent's feelings of guilt (Moses, 2011). That is, feelings of guilt do not appear to vary with a parent's belief or opinion about the causes of their child's mental health challenges. It is, however, important to note that parents of children with substance use disorders were more likely to experience self-blame than those with other mental health diagnoses (Moses, 2010). This finding is essential for this study, as it suggests that parents who have children with co-occurring mental health and substance abuse challenges may be more likely to experience guilt than those parents who have a child that struggles with mental health problems, but does not abuse substances.

Review of Literature Related to Parental Experiences of Blame

Not only do parents report experiencing feelings of guilt around their child's mental health and substance abuse symptoms, but the literature also indicates that they frequently experience the judgment of others and perceive that many facets of society, including educators, health care providers, friends, and family members, hold them responsible for their child's difficulties. In a qualitative study of the experiences of 11 parents of children with ADHD, mothers report feeling scrutinized for being both too strict and too lenient with their children (Peters & Jackson, 2008) in that when their children act out in public, the parents are considered to be poor disciplinarians, but when

they set limits, others judge them as being too harsh with their kids. Indeed, mothers, in particular, seem to experience the blame of the wider community when their child has a mental health disorder. Litt (2004) conducted a qualitative inquiry into the caregiving experiences of low-income mothers of children with ADHD. Among many other themes that are more tangentially related to this study, one quite pertinent finding emerged; many mothers reported that teachers and physicians often blamed them for their children's poor behavior. Another qualitative inquiry, this one focusing on mothers of young children with developmental delays and their attempts to receive services, found that some mothers felt blamed by health care providers for their child's behavior. In particular, single mothers experienced the health care providers as believing they are 'poor mothers' and mothers of young boys often heard their concerns dismissed outright (Williams, 2006). Additionally, in a phenomenological study of 18 parents of children who abuse substances, participants reported experiencing not only judgment from the wider society, but also feeling blamed by their child for the consequences that arise from their use (Usher, Jackson, & O'Brien, 2007).

While the blame placed on parents by the wider society is distressing, perhaps more concerning is the blame and judgment that parents perceive from the professional to whom they have turned for help. Parents of children who abused substances expressed that they felt that they were held responsible and judged by health care providers (Usher, Jackson, & O'Brien, 2007). Mothers, in particular, report sensing blame from professionals in the health care arena. In another qualitative inquiry, this one focusing on the experiences of parents of adolescents with a diagnosed psychiatric condition and their interactions with health care providers, some participants described experiencing a

sense of humiliation when they perceived that they were held responsible for their child's problems by a mental health provider (Harden, 2005). In the same study, other themes of parents not being listened to by medical professionals and doctors dismissing the expertise of parents arose.

A careful and critical reading of the literature provides some hints as to why parents may perceive such blame by the very professional who are supposed to be helping and supporting them. One study found that when therapists sense that a parent blames their child for their mental health problems, as is not uncommon, particularly for children with externalizing disorders, the clinician may have the tendency to shift focus of blame from a specific child onto the family as a whole (Reimers & Street, 1993). In the face of these experiences of blame that have been voiced by parents, there is some good news. One exploratory study of ten families receiving mental health treatment was designed to investigate the tendencies of therapists to lay blame or exonerate individual family members for the presenting problem in therapy. The study found that overall, therapists tend to exonerate, rather than lay blame. However, when these clinicians made blaming statements, they tended to focus this blame on the mothers of their clients (Wolpert, 2000).

Research Question

Given the literature that indicates the variety of etiological forces at play in the development of adolescent co-occurring mental health and substance abuse challenges, the evidence that suggests guilt and blame are common experiences for parents of these adolescents, and the essential importance of the parent-clinician relationship, it is clear that further investigation of the intersection of these forces is necessary. Therefore, a

qualitative study seeking to give voice to the experiences of parents and clinicians around these issues was conducted. The following research question served as a basis for the study: What are the experiences of parents of adolescents with co-occurring mental health and substance abuse challenges and clinicians who provide treatment services around issues of blame, guilt, and responsibility, and how do those experiences shape their collaboration?

CHAPTER THREE

Methodology

Paradigmatic Framework and the Interpretive Paradigm

Burrell and Morgan (1979) provide a framework for understanding differing approaches to social science research. This framework is based on the assumption that the philosophy of science, and therefore, various research methodologies can be organized by placing their perspectives along two separate continua. The first continuum, subjectivity versus objectivity addresses the researcher's ontological position, that is, the way in which they view the nature of reality. Research conducted from the subjective side of this continuum presumes that each participant may have a different perspective on reality, whereas a more objective stance asserts that there is an identifiable truth that can be discovered through the research process. The second continuum, regulation versus change, highlights the emphasis of the researcher on investigating the way things are or pushing for social change.

This study has been conducted in the interpretive paradigm as described by Burrell and Morgan (1979). That is, on the two continuums described above, this study falls on the side of subjectivity and regulation. A key philosophical assumption that grounds this research is that reality is subjective; there is not one truth that can be generalized to the wider population, but instead there are as many realities as individual participants. Additionally, this study has not been designed to provoke change among its participants, but rather to describe the way things are. That said, this does not preclude the possibility that change will occur as a result of the reporting of this research and its implications for changed practice. Indeed, it is the belief of the investigator that the

findings of the study may lead to future work that shapes the interaction between parents and clinician and that providing a voice to the participants in this study is important in the advancement of social justice and social work practice. However, it remains that the goal of the methodology that has been used is to describe the current phenomenon as opposed to raising the consciousness of participants in order to facilitate change.

Research Design

A phenomenological research design has been selected for this study for two key reasons. First, the methodology of phenomenological inquiry is consistent with the epistemological and ontological assumptions of the interpretive paradigm and is therefore well suited for this study. Secondly, phenomenology is an appropriate approach to utilize when investigating individuals' experiences of a shared phenomenon (Creswell, 2007), as has been done in this study.

Creswell (2007) outlines the defining features of phenomenological inquiry. First, the primary task in this type of research is an attempt to uncover deep understanding of a phenomenon. In this study, the investigator has worked to gain such an understanding of the relationship between parents and clinicians when it comes to issues of guilt, blame and responsibility. Secondly, the researcher should set aside any assumptions or judgments about the topic at hand. In this case, while collecting the data and during the initial phase of analysis, the researcher attempted to set aside her experiences as a clinician in this arena. Thirdly, the reality, or truth, of a situation is linked to one's understanding of it. Finally, that reality is only understood within the context of the experience of an individual. The interpretive perspective of this work, and its grounding in symbolic interactionism, reflects these last two features of

phenomenological research.

Two main traditions have arisen in phenomenological inquiry: transcendental phenomenology and interpretive phenomenology. In a transcendental phenomenological approach, the researcher sets aside his or her own presuppositions and assumptions about the topic at hand and attempts to view the topic with fresh eyes (Moustakas, 1994). This is done by learning little about the subject prior to the collection of data, by the non-use of a theoretical framework to guide the research process, and by the researcher bracketing her assumptions or beliefs about the topic throughout the research process (Lopez & Willis, 2004). In interpretive phenomenology, also referred to as hermeneutic phenomenology, it is assumed that conducting value- and bias-free research is impossible. Rather, the experiences of the researcher may prove to be a valuable way to focus the inquiry and a theoretical framework can help guide data collection and the presentation of findings (Lopez & Willis, 2004). Nonetheless, it remains essential to the research process that the investigator clarify and articulate their own assumptions regarding the phenomenon at hand (Lopez & Willis). Additionally, the hermeneutic approach emphasizes the importance of social and cultural forces on the phenomenon.

The researcher has chosen to utilize interpretive phenomenology for this study. It is her belief that truly setting aside her assumptions and viewing the subject naïvely is not possible, particularly given her experiences as a clinician who has addressed the issues at hand in her practice and because theory and previous research has played an important role in shaping this study. Instead, the investigator has taken steps to monitor her own beliefs and will discuss them along with the presentation of findings from this study in Chapter Four. Additionally, the philosophical foundations of interpretive

hermeneutic phenomenology are aligned with symbolic interactionism in that the social context of a phenomenon must be addressed in order to understand the true meanings at play.

Participants

Sampling

The sample for this study included two separate subgroups: parents of adolescents with mental health and substance abuse challenges and clinicians who provide treatment services to these adolescents. Purposive sampling combined with convenience sampling techniques has been utilized to recruit participants from treatment facilities that provide services to adolescents with mental health and substance abuse challenges. Sample size was determined during data collection, as interviews were conducted until saturation is reached, which is defined in the qualitative literature as the point at which no new themes are emerging from the data (Morse, 1995). It was expected that 10-15 participants in each subgroup may allow the researcher to obtain saturation.

A total of 23 participants were interviewed for this study, including 14 clinicians and nine parents. Clinicians included individuals with master degrees in Social Work, Rehabilitation Counseling, Counseling Psychology, and Marriage and Family Therapy or doctoral degrees in Clinical Psychology. Therapists were employed in outpatient community mental health clinics, residential treatment facilities, psychiatric hospitals, schools, and juvenile detention facilities. The clinician subgroup consisted of three men and eleven women and included individuals who identified as Caucasian, African-American, and Latino/a.

Parents who participated in the study included those who had children who had received treatment services at schools, in outpatient community mental health centers, community-based intensive treatment programs, therapists working in private practice, psychiatric hospitals, residential treatment facilities, and therapeutic wilderness programs. Parent participants include biological parents, stepparents, and foster parents. The treatment services received by the children of these participants were funded through Medicaid, private health insurance, and out-of-pocket costs. The parent subgroup consisted of three men and six women and included individuals who identified as Caucasian, African-American, and Latino/a.

Inclusion/Exclusion criteria

In order to be included in the study, parents had to have an adolescent age 13-19 who was either currently receiving treatment services for mental health and substance abuse challenges, or who had received those services within the past year. It was not necessary for the adolescent to carry an official diagnosis of both a mental health and a substance use disorder; simply experiencing challenges in both of these areas, as reported by the clinician, was sufficient for inclusion in this research. As research has indicated that biological parents of children with mental illnesses seem to experience more guilt and self-blame than non-biological caregivers (Moses, 2010) and therefore may have a different experience with regards to the question at hand, the researcher considered excluding foster parents, custodial grandparents and other relatives, and other non-biological parental figures. However, given the desire in qualitative research for maximum variation within the sample, all custodial caregivers were eligible to participate in the study.

In order for a clinician to be included in the study, they must have been either currently providing services to an adolescent age 13-19 who experienced co-occurring mental health and substance abuse challenges, or have provided such services within the past year. In order to maintain some homogeneity within this group, all clinicians must have a master's or doctoral degree in social work or an allied helping profession such as psychology, rehabilitation counseling, or counselor education.

Procedure

Recruitment

Participants were recruited through local agencies, both public and private, that provide mental health and/or substance abuse services for adolescents. Participants were connected with 14 agencies in Virginia, Maryland, North Carolina, and Oregon. Clinicians were provided with recruitment flyers that could be distributed to parents of current or past clients and were encouraged to consider participating in the research themselves. Additionally, clinicians shared the recruitment information with colleagues who they believed may be interested in participating. As an incentive, and in acknowledgement of the time it takes to participate in a qualitative inquiry, participants were provided with a \$10 gift card at the completion of the interview. The researcher had gift cards from several stores, including Target, Walmart, and Starbucks, available so that participants were able to choose the incentive that they found most desirable.

Data Collection

Data was collected through audio-recorded, semi-structured, individual interviews, as is common in phenomenological research (Wertz, 2005). While some phenomenological investigators choose to utilize unstructured interviews to allow the

conversation to go in any direction (Moustakas, 2004), the use of prompts in semi-structured interviews allowed the interviewer to focus the participant on their lived experiences in the context of this study (Wertz). The questions and prompts that were asked of participants were developed by integrating the concepts of symbolic interactionism with many of the key findings from the literature related to the parent-clinician alliance and the influence of guilt, blame, and responsibility. A copy of the interview protocol is attached. Appendix A describes the questions that guided the interviews conducted with parents, while Appendix B outlines the interview questions used with clinicians.

All interviews were conducted at a location that was convenient to participants and agreed upon by the researcher. As the researcher has provided home- and community-based treatment services for numerous years, she was comfortable conducting interviews in participant's homes, offices, or other community locations, provided that some private space could be secured. On occasion, a participant preferred to meet the researcher in a neutral location; in those situations, interviews were conducted in a university office building or in a private therapy practice office space.

Prior to the beginning of the interview, the researcher discussed the potential risks and benefits of participating in the research along with an explanation of confidentiality and asked the participant to provide informed consent. The interviews were digitally recorded and the recordings were transcribed by a transcription service. Additionally, the researcher wrote field notes following each interview in order to capture the context of the setting and to protect the data in the case of a technological malfunction with the recording device. Interviews varied in length from approximately 20 to 75 minutes.

Risk to Human Subjects

Participants in this study experienced no more than minimal risk. It is possible that some questions asked during the interview may have caused the participant to experience upset or to revisit difficult times in their lives. In the unlikely circumstance that a participant experienced more than minimal distress, the interviewer, who is a licensed clinical social worker and has extensive training and experience in crisis management, was prepared to provide appropriate referrals to community resources; however, this was not necessary during data collection. Additionally, care was taken to provide an incentive to participants that honored their time, yet was not of such a value that it was likely to coerce participation. Virginia Commonwealth University's Institutional Review Board approval was obtained prior to the onset of data collection.

Data Management

Consent forms and hard copies of data have been stored in a locked filing cabinet. Electronic data, whether audio recording or transcripts, have been kept in password protected files on the researcher's personal computer.

Data Analysis

Thematic analysis grounded in the literature regarding phenomenological methods was used in this study. Several authors provide details on the process of data analysis in phenomenological research (e.g. Moustakas, 1994; Smith & Osborn, 2003; Creswell, 2007). The investigator synthesized and integrated these processes in order to develop the data analysis plan for this project.

The analysis process began with the careful reading of each interview transcript. This was followed by making notations in the margins of the transcripts summarizing

what the participant seemed to be conveying, suggestions of emerging themes, and highlighting essential quotations. Throughout the notation process, the researcher kept preliminary list of categories that was added to and modified as the margin notation process continued. Related ideas and comments were grouped together in clusters.

Next, the investigator engaged in Moustakas' (1994) procedures of horizontalizing, in which the researcher placed equal value on each statement made by participants, and creating meaningful units, in which data is categorized in a way to clarify the meaning of each statement. This occurred by printing each interview transcript on a different color paper, identifying statements that expressed separate ideas, and physically cutting them apart. These clippings were clustered together based on similar meanings or content and used to create written descriptions of the categories that were used in the next phases of analysis.

The researcher then engaged in member checking with participants. During the interview process, participants had been asked for permission for the researcher to contact them after data analysis had been completed. Following the stages of data collection detailed above, the researcher then attempted to contact all participants who granted permission, either by telephone or email. Seven participants responded and were then asked to review the themes that emerged and reflect upon whether they seemed to capture their experiences and perspectives. Participant reflections on the analysis were then incorporated into the written descriptions of the categories.

The written descriptions of the categories were then reviewed with a peer debriefer. The debriefer, Dr. Kitty Huffstutter, was selected because of her familiarity with both the topic area and qualitative research methods. More details about Dr.

Huffstutter's qualifications are provided in Chapter Four. Dr. Huffstutter provided the service gratis with the understanding that this researcher will be available to act as a peer debriefer or auditor for Dr. Huffstutter's future studies. The role of the debriefer in a phenomenological inquiry is to determine if the themes and examples provided by the investigator are clear and inclusive of the data. Dr. Huffstutter reviewed the transcripts and compared her impressions with the themes created by this researcher. The investigator then adjusted the categories to reflect the iterative process engaged in with the peer debriefer. The researcher set aside any quotes that do not seem to fit within the categories and examined the data for evidence of negative cases, that is, experiences of a participant that did not fit within the themes that emerged in the analysis process, in order to protect against the tendency to seek patterns and ignore contradictory information (Miles & Huberman, 1994).

Rigor in Qualitative Research

Reliability and validity are markers of rigor in quantitative research, but the terms are not appropriate in the evaluation of qualitative research. Instead, qualitative researchers seek to demonstrate that their study was conducted in a trustworthy manner. Trustworthiness refers to the ability of a critic to find that the inquiry was conducted in a rigorous manner and that the study's results are "worth paying attention to" (Lincoln & Guba, 1985, p. 290). Creswell (2007) indicates that there are no agreed-upon standards for trustworthiness within a particular qualitative methodology. Instead, multiple strategies for trustworthiness are suggested; I chose to use the following strategies that fit within the assumptions of the interpretive paradigm (Creswell; Padgett, 1998): (a) clarifying research bias, (b) auditing and peer debriefing, (c) negative case analysis, and

(d) member checking. These strategies are described more thoroughly in Chapter Four.

CHAPTER FOUR

Results

This chapter outlines the results of the study. It will begin by discussing the characteristics of the sample. This will be followed by a more detailed look at the strategies utilized to ensure rigor throughout the data analysis process. Finally, both major and minor domains, themes, and subthemes that emerged from the data will be delineated, along with a closer look at areas of convergence and divergence between therapist and clinician participants and negative case examples.

Sample Characteristics

The sample in this study consisted of 23 participants, 14 of whom were master- or doctoral-level clinicians, while nine others were parents of adolescents experiencing mental health and substance abuse challenges. Participants lived or worked in Virginia, Maryland, North Carolina, and Oregon. Clinicians were employed by public and private non-profit community mental health centers, residential treatment facilities, schools, hospitals, or were self-employed in private practice. Members of the parent subgroup included biological parents with sole or shared custody, step-parents, and long-term foster parents. Their children had received a variety of services, including school-based prevention services, outpatient treatment, intensive community-based treatment, acute hospitalization, wilderness treatment programs, and long-term residential placement.

Strategies Used In Analysis to Increase Trustworthiness

Several strategies consistent with the assumptions of the interpretive paradigm were utilized to increase trustworthiness during the analysis of these data. In order to clarify research bias, and to aid in bracketing, which is the process of setting aside prejudgments related to the topic at hand, the researcher kept a reflexive journal in which

she reflected on her previous experiences with the phenomenon being investigated along with her reactions while conducting the study. Journal entries were completed at the end of each day during which interviews were conducted. Periodically throughout the data collection phase, the investigator would read through the journal to reinforce the bracketing process.

Additionally, the researcher utilized a peer reviewer with whom she debriefed following the data analysis phase. Kitty Huffstutter, Ph.D, L.C.S.W. served in this capacity. Dr. Huffstutter holds an M.S.W. and Ph.D. in Social Work from Portland State University and a Master of Arts in Sociology from Humboldt State University. She has both expertise in qualitative research methods and clinical and supervisory experience with topic at hand. Dr. Huffstutter read all interview transcripts, the author's reflexive journal, and results of the study and offered feedback on the analysis process and key findings. Her feedback was integrated into the final findings as presented in this chapter.

Furthermore, the research engaged in member checking with participants. All participants were contacted and received a descriptive summary of the domains, themes, and subthemes that emerged from the interviews. Three parent participants and four clinicians responded. All respondents indicated that the findings seemed to capture their experiences. One parent added additional thoughts regarding his experience of being excluded from the decision making process regarding his daughter's treatment. Those comments were then integrated into these findings.

The final strategy utilized by this writer to strengthen the rigor of this study was to keep an analytic eye open for a negative case example. In this situation, the negative case example came in the form of a father who, when talking about possible feelings of

guilt he may have had related to his child's mental health and substance abuse challenges, expressed ways in which his spiritual orientation towards eastern philosophies helped him avoid many feelings of guilt. He stated:

I generally don't pay too much attention to guilt when it pops up in my own feelings, because I know it's an unhealthy thing, not that I don't ever want to consider what my role is, but I want to go forward rather than back. . . .In general, I mean, I've certainly done plenty of things wrong as a parent, as a person, but what good does it do to go over guilt?

To be clear, this father did not claim that he never *felt* guilt. Rather, he indicated that spiritual practices, including mindfulness, which he developed prior to having children allowed him to move through guilty feelings quickly and to believe that guilt is not a productive emotion and so it is best to notice it and let it pass. This participant stood apart from other parents who were interviewed in this study. Other caregivers indicated at some points during their interview that they did not experience guilt, yet a careful analysis of the data suggested instead that they worked hard not to feel guilty or shameful, but yet were often mired in those emotions.

Domains, Themes, and Subthemes

Overall, the results from this study are organized in four key domains:

- *Sources and Impact of Guilt and Shame*
- *Being Blamed and Blaming Others*
- *Potential Pitfalls and Strategies for Success*
- *Training and Theoretical Orientation*

The first three domains relate directly to the questions posed during the interviews, though the specific themes and subthemes within those domains emerged from the data. The final domain, however, seemed to emerge on its own. Many clinicians brought up

these issues in response to the final open ended question. While the analysis suggest that this domain is more of a minor focus than the other three, it remains worthy of discussion within this chapter.

Subthemes were categorized as either major or minor to provide an additional level of analysis. Subthemes that describe content present in many interviews and frequently reemerged multiple times within a single interview were determined to be major subthemes. Minor subthemes appeared less commonly and were often present as an aside as opposed to a focused topic of conversation. The domains, themes, and major and minor subthemes are summarized in Table 1.

Table 1.

Summary of Study Results Organized by Domain, Theme, and Subtheme

Domain	Theme	Major Subtheme	Minor Subtheme
Sources and Impact of Guilt and Shame	Parents Experience Guilt Related to Their Behaviors	Guilt and Parental History of Substance Use	Guilt and Generalized Parenting Behaviors
			Guilt Related to Parent's Previous Relationships
			Guilt About Not Acting Soon Enough
	Parents' Experiences of Guilt have Serious Impacts on Families	Parental Guilt Influences Parental Effectiveness	Parental Guilt is Perceived to Contribute to Parental Depression
Being Blamed and Blaming Others	Feeling Blame from Every Direction	Shame has a Negative Impact on the Parent-Clinician Relationship	Shame is Perceived to Decrease the Effectiveness of Family Therapy
			Guilt is Perceived as Increasing the Ability of Parents to "Dig Deeper" in Therapy or Move Forward in Family Work.
	Parents Blaming Others	Blame, and the lack there of, from therapists	Blame from the Juvenile Justice System
Blame from Insurance Companies			
Blame from Psychiatrists			
	Blame from Caseworkers	Blaming the Divorce	
	Blame from Children		
	Blaming the Other Parent		

(table continued)

Domain	Theme	Major Subtheme	Minor Subtheme
Potential Pitfalls and Strategies for Success	Anticipate issues of blame and guilt	Tune into parents' pain	Encourage Parents to build their own support network Praise Parents
	Inclusion and Exclusion in the Therapeutic Process	Exclusion of parents from the treatment process Parents crave one-on-one sessions with providers Power of including parents in decision making and treatment	
	Clarify the Process	Prepare families for what to expect	Discuss Financial Realities
Training and Theoretical Orientation	Theoretical orientation shapes practice with parents		Impact of Cognitive behavioral Theories with Families Benefits of utilizing a Motivational Interviewing Perspective Lack of Preparation
	Importance of Training that Specifically Focused on Working with Families		Importance of Mentorship Field instructors and training directors must tune into issues of guilt and blame in families

Domain 1: Sources and Impact of Guilt and Shame

Throughout the research process, this writer anticipated that guilt would be a major topic in the discussion of the results of this study. Indeed, experiences of guilt were a main focus of both the literature review and the construction of the semi-structured interview guide.

Theme: Parents experience guilt related to their behaviors. While the previous literature suggest that parents experience guilt related to a wide variety of biological, social, and intrapersonal factors (Harden, 2005; Meiser, et al., 2005; Peters & Jackson, 2008; Usher, Jackson, & O'Brien, 2007), an overarching theme of behaviorally-related guilt emerged from the data in this study. Parents in this study indicated that they felt guilt related to their actions, or sometimes, their inactions.

Major subtheme: Guilt and parental history of substance use. Throughout the interviews, both parents and therapists noted that many caregivers who had their own history of substance abuse felt guilty about the impact this may have had on their children. This subtheme emerged very strongly in the data and should be considered one of the major findings of this study. The data suggests that parents with a wide variety of experiences with substance use and abuse – from those who used casually as an adolescent to those who struggled with serious substance dependence as an adult – are feeling this sense of guilt. One parent reported:

Yeah, I felt guilty because I did drink a lot in front of my daughter. I remember one time she asked me – she probably had been about six or seven – and she asked me to stop drinking so much. And I did. I stopped, for a little bit. And then, of course, as she got older, I did continue again, so she got to see it. . . . So yeah, I blame myself in a lot of ways.

Another parent stated:

We have a lot of drug addicts in our family. I use it – well, I was taking prescription pills and drinking and my daughter did see, she witnessed that, so I don't know if that caused her to want to try an easy way out or something. She probably said, "oh, well, she's doing it, so let me. . ." I don't know if that's the case, but I don't know.

Therapists strongly indicated that parents appear to tie their substance use to their child's challenges and that this connection is a source of guilt and shame. One therapist reported:

There are parents who are guilty because they had a similar path as a teen, and they were involved in the same kinds of things and they think, "How could I expect something different for my child when I was the same way?"

Another clinician stated:

They say, "Well, I don't know what to say because then they tell me, 'you did it too when you were young,' so then I can't do anything."

A psychologist shared:

I have had parents who are in recovery or had a history of abuse themselves. I had one girl in particular, she was 15, and the mother had just gotten custody back of her, I think, when she was 11 or so. The mom had been a heroin addict and had been out in the streets and her daughter had been taken from her and mom - I mean, we can never really get through a family session without mom crying to the point of not being able to talk. She just had so much guilt around feeling that her daughter was now starting to engage in a lot of these behaviors and make some not so great choices because of what she did. Mom very much believed that it was a biological thing and she passed on this addictive trait to her daughter. So there was a lot of guilt, a lot of shame around that.

Another mental health provider stated:

[I have parents say] I know my history has caused this to happen because I was using when I was carrying them or when they were a young child and so they had to be placed into foster care.

A final clinician stated:

And all of these parents, I would say, have a plight on them, that they feel guilty and ashamed about their children's behaviors. A lot of them, they say that there

has been some things in the home environment that have kind of led their child down this road. Either the parent or the parents or someone in the house are having their own substance abuse issue.

Minor subtheme: Guilt and generalized parenting behaviors. Some parents reported that they felt guilty because they knew they must have done *something* wrong in order for their child to have so many struggles. In these cases, the parents' guilt appeared to be more generalized, rather than focused on any specific factors. Indeed, it appeared that this response may be indicative of a parent's attempt to make sense of their child's struggles. Attribution theory suggests that people have an innate need to develop causal explanations for situations and behaviors (Heider, 1958). It may be that in the face of no other explanation, parents choose to hold themselves responsible, though they may not have *specific* ideas of what they could have done to cause the problem.

One parent stated:

Now that he's an adult, I can say, "OK, it's on him". But when he was not, then it was me. It's basically my fault, my ex-husband's fault. It's our fault for him to turn up like this, whatever we did when he was growing up, during the first six years because he was the only child. So it's like I did something wrong. And then when I had another child, I vowed to myself, I'm not going to do those same mistakes.

Another reported:

Like with the oldest one, I am so, so convinced that it was my fault. . . . I've been to counselors and they say, "No, it's him doing that. He chooses to." But, to a point, I truly believe that if we could have done differently, it would have been different for him. Oh, yes, it's a major guilt.

Minor subtheme: Guilt related to parent's previous romantic relationships.

Another subtheme that emerged as a source of guilt identified by parents was the impact of their previous romantic relationships on their child. In the next domain, findings that suggest that parents blame their child's other parent will be explicated. Relatedly, this

subtheme highlights that while parents may hold another adult in their child's life responsible for the problems they face, they also blame themselves for either exposing the child to that adult, or ending a relationship with an important figure in the child's life.

One mother stated:

It's a heartbreaking thing when you get to the divorce, and I think the divorce was hardest on [my son]. So I do feel guilty. I just feel guilty that I even married him because it wasn't right, the whole marriage wasn't right.

Another parent indicated:

I had a relationship before that was mentally abusive to me and to my kids and I was with him for seven years. So [my daughter] had to deal with that, too. So that's where a lot of her anger issues come from. And, yeah, of course, I blame myself for that. That I do blame myself for, because I knew better. But I didn't know how to get out. But [my daughter] doesn't understand that, so it was just making her more angry. She was always writing letters and saying, "I don't know why my mom is still with him."

Another mother reported:

I think I shouldn't have gotten a divorce, even – I should have worked harder, maybe, my own frustration, my own anger, my own garbage from when I grew up I brought forward, my own insecurities. I just think it plays a huge factor on [my son's addiction].

Minor subtheme: Guilt about not acting soon enough. In contrast with the previous subthemes, in which parents expressed feeling guilty about specific behaviors, this subtheme focuses on parents' guilt about the absence of behavior. Clinicians and parents alike noted that parents sometimes feel guilty because they didn't get help for their child quickly enough.

One parent stated:

Well, I mean maybe I should have done things to prevent this. I should have seen it coming, and I should have taken steps before it got this bad. When [my son] wouldn't come over to the house and [my ex-husband] wasn't doing anything, I could have gone and tried to file for custody then. I didn't have to wait until he was doing drugs. . . . I could have taken steps before it got to this point.

A clinician reported:

I have worked with parents who feel guilty about the fact that they were blind to the issues. Things like, “I should have seen this sooner” or “I should have noticed” or “Why didn’t I pick up on the cues? I missed them”. I have seen a lot of parents who expressed guilt about that.

Theme: Parents’ experiences of guilt have a serious impact on their families.

Another important theme in this domain that emerged from the data relates to the influence that parents’ feelings of guilt had on their family lives. The interviews were structured to draw out stories of the impact of these feelings on the parent-clinician relationship, but both caregivers and therapists reported that the fallout of parents’ guilt and shame carried into their day to day lives.

Major subtheme: Parental guilt influences parental effectiveness. Both clinicians and parents commented on the impact of a parent’s guilt on their ability to utilize effective parenting techniques. These emotions are described as blocking parents’ ability to effectively engage in daily activities such as limit-setting, which are necessary for children and adolescents with mental health and substance use challenges to thrive.

A stepfather of two adolescent boys noted:

[Guilt] makes me feel a little bit like there’s not much I can do, because it’s such madness. And also, it makes it a little easier for me to get angry with [my step-child] at times, just like, “OK, well, this isn’t working so whatever. I just going to let loose on him. Screw it.”

Many clinicians indicated similar responses in families they worked with:

One parent, he would almost like flog himself about how bad he was at [parenting]. And it was interesting, because it really debilitated him from really making changes because he was just “Well, I was really bad at that before. I’m not going to be able to set limits.

It becomes a vicious cycle then how they interact with their child and maybe the ability to parent as strongly or as positively as they would have.

I think the effect on the mom of her guilt really was the relationship [between her and her child] started to be a little bit strained.

I think it just kind of stifles them; they just can't parent – because they put a lot of energy into defending themselves that it because a thing about the parent and not about what the problem is or what the solution is.

Minor subtheme: Parental guilt leads to parental depression. Some parents noted that the guilt they experienced about their child's mental health and substance abuse challenges led to their own depression. Most clinicians, however, did not appear to be tuned into this particular consequence.

Parents stated:

I was mad all the time. I wouldn't speak to nobody. I went to work mad. I'm depressed.

I was just depressed more, very bad, because I didn't know where to go. I didn't know what way to get out of that situation because to me, I just thought it was no-way out because I really didn't have faith that me and my oldest daughter were going to get back.

One clinician discussed the affect of guilt on a parent's depression:

I think [guilt] contributed to some of the parents I've seen with depression, withdrawing from their social support group. I think it's impacted jobs, work performance, all that.

Theme: Guilt and shame felt by parents shaped the therapeutic process. This theme begins to highlight the differences between guilt and shame as described in the theoretical literature. As discussed in Chapter One, the researcher made a choice to combine the concepts of guilt and shame as they are often used interchangeably in the literature. However, some theorists do claim that there are key differences between the two emotions. Barrett (1995) posits that shame distances a person from others, while guilt motivates one to repair damage. Though participants spoke primarily in the language of

guilt, the differences between these two concepts become clear in these data. Indeed, participants reported that feelings of “guilt” experienced by parents could have the ability to shape the therapeutic process positively, or negatively. Those differences may be related to parents who experience guilt, as defined by Barrett, and those who experience shame.

Major subtheme: Shame has a negative impact on the parent-clinician relationship. Both parents and clinicians noted that when parents experience guilt, the relationship between the parent and clinician may suffer. In these situations, however, participants report that these feelings caused a rift in the relationship between parent and therapist. This suggests that perhaps these parents were feeling more shameful than guilty. A parent reported:

So, yes, my emotions and my guilt and everything came right out through my mouth, and I probably was attacking at times. “How can you say that! You don’t know! You haven’t been through this!” And when a counselor comes across as blaming, and you feel guilty, what that normally does is put you on the defensive. That’s our nature, even though, you know, it might have nothing to do with me.

Clinicians remembered:

I definitely saw parents who would completely lose it at times. I mean, just go to a level of emotional reactivity that you were like, “Wow!” And you could just see how much it was eating them up and how interpersonally it was getting them – I mean, one would scream at me and basically hung up on me. If they would do these things to me, you’d know it was affecting a lot of their interpersonal relationships. This one woman I worked with, the family felt naïve about the children that they had adopted. I said something and it hit too close to home, like I was saying that she hadn’t done enough research. She had never yelled at me before, but she just starts screaming at me then.

And some of the resistance [to our work together] would be, “You don’t really understand what’s going on”, or “you don’t know -- [my kid] is going to bottom out” or something. And sometimes they were right. But what I soon learned is that a lot of it was about guilt. And it was because, as a family, they thought that they had failed, that they had not been able to make their child better and they had to go to the extreme. I mean, [my agency] is the most restrictive setting of having

their child housed in a locked facility and getting treatment, and in many ways, we could become these children's families. And if I was not careful of that feeling of guilt, there would be this feeling, this barrier that would make it impossible for me to help these families and help these kids.

Minor subtheme: Shame decreased effectiveness of family therapy. Clinicians believed that parents' experiences of "guilt" decreased the effectiveness of family therapy. Again, though they use the term "guilt", they seem to be referring to the theoretical concept of "shame", which causes a person to feel compelled to hide themselves or conceal their behavior (Jones, Kugler, & Adams 1995). This subtheme highlights the ways in which the experience of shame may lead a parent to remain disengaged from the family therapy process, thereby limiting the usefulness of the intervention.

One clinician describes a mother whose sense of shame appears to limit her ability to engage in sessions or discuss important details with her son's therapist:

I think about this one young man that is really fresh in my mind that I working with now and his mom and their dynamic. She's very evasive. She doesn't really respond well to my invitation of having her join some of the sessions. When we talk about the legalities around her son's substance abuse issues, she's very to the point and they want to dismiss and I also want to know more. So you could tell that she's very uncomfortable with it, even in a little bit of time that I tried to talk with her about it, and I don't talk to her every week about it. But when I might reach out to say, "Hey, how're things going on this side so I can bring that into our session" again, it's very – this is just not happening. And that's it. So that's the way that I see her kind of manifesting that guilt.

Another therapist shared her belief that feelings of shame led to defensiveness, suspicion, and a reluctance to seek assistance:

I think that the feelings of guilt and feeling blamed caused the parents to be reluctant to ask for help. It can cause them to be suspicious. They're more defensive, and therefore once suspicious of advice that they're given because if in that advice there is any at all hint of "You should change what you're doing" they interpret that to mean "You're blaming me for the problem," which is not necessarily the case.

Minor Subtheme: Increased ability of parents to “dig deeper” in therapy or move forward in family work. While therapists tended to initially focus on the negative impact of shame on the therapeutic process, many were also eager to note that guilt could have the potential to catapult families further along in their healing process. Indeed, this mirrors the theoretical underpinnings of this study, which suggests that guilt can motivate a person to repair damage (Barrett, 1995) or atone for previous mistakes (Jones, Kugler, & Adams 1995). This subtheme, however, did not emerge during parent interviews.

Clinicians reported:

There was a benefit in the family work, because with the child there and with the child hearing their parents express their sense of guilt, that opened up the discussion.

One young person who talked about some of the issues that he’s having as it relates to his mom not being emotionally available. And when mom heard that from her child’s mouth, it was hard for her initially, but the next week when they came back, she was able to say to me that she was able to make some changes, quick easy changes, such as reduce her work schedule, things to try to be more emotionally available in person. So I think [the guilt she experienced] was a positive thing because you saw things start to get a little bit better as a result of that stuff.

I guess those feelings of guilt and self-blame kind of make you vulnerable, and a parent with those feelings goes crying to someone on the phone, or explaining to someone that I feel like I failed as a parents, feel like I didn’t do enough. So it does feel like sometimes guilt helps you build a therapeutic relationship more quickly because they turn to you as a source of support.

When there’s guilt and blame, the parents make themselves vulnerable to you. They’re making themselves emotionally vulnerable to somebody they’ve never met, who they were talking to on the phone. So usually, when you get a parent who feels that way, it’s a little bit easier for them to accept help and accept that there might actually be a problem going on.

Domain 2: Being Blamed and Blaming Others

The second main domain of these results relates to parents experiences of being blamed for their children's mental health and substance abuse challenges, as well as their experiences blaming others. During the interview, parents and clinicians were asked to reflect on parent's experiences of being blamed by professionals from whom they were seeking help. It is therefore not surprising that many stories of being blamed by professionals in child- and family-serving agencies were reported. However, additional themes and subthemes specifically related to being blamed by, and actively blaming, family members emerged unexpectedly.

Theme: Feeling blame from every direction. This theme highlights that parents are experiencing blame from multiple directions. Indeed, parents and clinicians alike discussed feeling that caregivers were blamed by many service sectors. Many of these responses were expected, as participants were specifically asked to reflect on the blaming of parents and caregivers. That said, the breadth of responses to this question was not expected by this researcher and the many sources of blame it striking.

Major subtheme: Blame, or the lack thereof, from therapists. Strikingly, although parents experienced blame from many systems, no parents reported being blamed by their mental health or substance abuse services clinician. That said, many therapists made statements during their interviews that indicated that they, consciously or unconsciously, sometimes blamed parents for their child's challenges. One group of clinicians were able to articulate ways in which they had blamed parents during over the course of their practice experience. These clinicians reported:

For a lot of my time working with her, I did blame [her father]. But then I realized at a certain point that that wasn't helping. I don't mean to give a rosy

ending to the story. There was definitely a lot of times where it still came back. But I kind of had to get on the bandwagon that she needed to get some place else that was better for her and to stop blaming him, because I could blame him forever, and there's definitely sometimes where it felt good in my head to blame him, but it was not going to help her.

I think I often will kind of blame when I see the parent having conflicts with other people. You know, just kind of naming the stigma that's out there and a lot of the lack of understanding that other people have about where mental health problems or substance abuse problems come from.

Through their reflective process, this subgroup of clinicians seemed to be able to catch themselves in the blaming process and redirect their attributions in order to better help families. Although this research did not capture data regarding the amount of postgraduate experience obtained by each clinician, anecdotal information suggests clinicians who shared openly about their experiences blaming parents may be more seasoned than some of the other clinicians who appeared to blame more unconsciously. These therapists, who appeared to be unaware of their blaming statements, described characteristics of families and family members when discussing their etiological understanding of the roots of their clients' problems, yet would deny engaging in any practice that parents might interpret as blaming. These clinicians report:

I believe it all goes back to the home and to the parents and grandparents, whoever is doing the raising. The home environment, I think, usually is what it comes down to.

I think one [cause of these problems] is the home – the instability at home, so not a lot or no supervision. And also, even the parents use, so either modeling it or their parents have used so they feel like now they can't say anything because they've used drugs themselves.

Again, it's starting with the family, that the family is usually not able to support the child in a way that they need to be supported through development and so then – because the family is chaotic then the child – depression or anxiety is just overlooked until it gets to the point that it's concerning.

I think their home life [is the cause of their problems] a lot of times. There may be some discord in their families.

[Their child's struggles] are very normative [in their community] so [the parents] don't take their responsibility. They come to me fed up and they want me to fix the child. And when I say "OK, I would love to fix your child." They say, "Can you help me" "Can we do family therapy?" They look at you like, "Why? I don't have the time. I don't want to be bothered." So they may feel that the mental health providers look in a way like it's their fault. But I don't think they have any ownership of what they may play.

Major subtheme: Blame from schools. Blame from school personnel was a major subtheme that arose from interviews with parents and therapists alike. As nearly all children are connected with the school system in some way, it is perhaps not surprising that discussions of blame from educational staff would be commonly reported. That said, as schools were often the first place parent participants turned for help, this blame seems to be initially surprising, though unfortunately, soon expected. Many therapists indicated that the parents they work with feel blamed by the school system:

I think a lot of times when you're dealing with a kid who get to a point where their alcohol or drug use has become a problem, it's obvious to many people – parents, teachers, school staff – that this is evident. The staff, at this point, knows that there's something wrong. They know it's possible drug use. A lot of time when it's out in the open like that, staff, or teachers, or counselors will question the parents: Why haven't you done anything? Why has nothing been done? . . . It become a question of how did it get to this point when you've got overt signs showing or when you get to a point where the people in the school are aware. What's going on at home?

They'll say, "all he needs is more structure." And she's a pretty competent parent who does provide structure. . . I actually worked with this parent one-on-one in her own therapy because of her struggling with being blamed for this.

Sometimes, parents do kind of feel picked on when the kid is behaviorally acting out. Otherwise, if the kid's "acting fine" at school, sometimes there's a little more sympathy. But if you're dealing with a kid that's just got behavioral issues up and down, sometimes there's a level of frustration there. "What are you doing to help your child?"

It comes up a lot where [parents] really feel blamed by the schools. And that isn't surprising because the schools blame them overtly. And they should stop that. But I definitely heard indirect expressions of this blame [from parents] where they're saying things like, you know, "I don't think so and so really understood" or I'm glad you're seeing how bad this is." You know, like the child could be going off in my office, and the parent, instead of being embarrassed by it, is really excited that somebody else is just seeing what a nightmare their child can be, and what they're going through.

Many parents reported feeling that teachers, principals, and other school officials suggest, or sometimes state outright, that if the caregivers were willing to change their parenting style and "step up to the plate", their children would not display any problematic behaviors. One parent's perspective on his interactions with the school system highlights the common experience of parents feeling chastised by officials at their child's school:

I feel like that there are certain instances where [my step-son] has acted out and the school has almost reprimanded us for it. My wife and I were called and they said, "We wish that you would take a more proactive approach." This is being recorded so I'm not going to repeat what I said back, but it was probably bolder than it should have been. So, yeah. I definitely felt they blamed us. They tried to make us feel bad about a lot of things.

Major subtheme: Blame from caseworkers. Parents and clinicians noted that caseworkers blamed both foster parents and biological parents:

A foster parent reported:

[The caseworker] had been in my house just one time and she made this assumption about my home. And it just disturbed me the assumptions that she made. Well, I have six girls in my home. Two are biologically mine. And we all sat around this table and we had a group session. We have an in-home therapist. We do a group session. And everyone sits around and say what bothered them and we talk about what we're working on that week. And [the caseworker] sat right over there. We were around our table and we were just laughing and joking and it was ok. We were having a good time. And she said "Her house is too loud. I want to move her. She has too many kids at her house. It's just too loud."

A therapist stated:

I worked with a foster family and the foster parents who've been foster parents for this one child for a couple of years. And [the foster mom] felt like the social workers and professionals were blaming her for the problems that the child was experiencing, that she wasn't doing the right things enough for the child.

Another clinician indicated frustration with caseworkers:

What I found was that it really depended on the worker that [the family] got assigned. The worker that this family got assigned did not walk them through the process the way that I wanted them to, and she very clearly judged them. I would call and be like "Listen, you're really not helping me. I've worked with this family for a while, they might have their issues, but they're trying."

Major subtheme: Blame from children. While the interview protocols were designed to invite stories from participants about how professionals and service providers blamed parents, some participants in the study indicated that over the course of services, children sometime blame their parents for their problems. Some clinicians expressed that children blamed their parents during individual therapy sessions. In these situations, the blame seemed to inform the clinician's understanding of the child's perspective on the problem. Clinicians reported:

Well, I think one – maybe one of the most important things is helping the adolescent get over those issues, because they'll bring them out and they'll be really clear. "My mom, this, this, this". I remember one kid was like, "She's the worst fucking person I know."

Some kids say "I don't like my home life. I'd rather get high or be drunk or high when I get home to deal with my parents."

In other situations, though, therapists recalled situations in which adolescents blamed their parents during family therapy sessions. These situations, when handled carefully by the therapist, and when timed when a parent had been prepared to hear the accusation, allowed the therapy process to move forward. One clinician stated:

I mean, the kid was like, “I blame you.” And the mom was able to say, “OK.” You know, I think that was probably useful.”

One parent reported that her child blamed her for several years for the child’s mental health and substance abuse challenges:

She blamed me for being with a woman because I had a relationship with a woman. And she felt like I neglected her. And I couldn’t understand why. And they, she was always nice to [my partner] but not nice to me. So I’d be kind of – it made me very, very angry.

Minor subtheme: Blame from juvenile justice. Perhaps unsurprisingly, a subtheme about parents experiencing blame from the juvenile justice system emerged from the data, though the subject was not a major focus of the interviews. Participants reported that parents were blamed by police officers responding to family crises and by juvenile probation offices. Absent from the data was the suggestion that parents were blamed by judges or lawyers. A parent of a child who had been in residential treatment for his substance abuse problems recounted her experience of being blamed by a police officer who responded to her call for help after her son became violent:

I had to call the police in my house sometimes and they’d be like, “Well, why don’t you just take his cell phone and his car away?” Well, that’s what I did, and that’s why he’s acting this way. Now what? I tried to do all these things, but it’s like” Well, you know, you just need to have control over your son.” Well, how? I mean, do you think I want to be in this situation? I mean, it was crazy, absolutely crazy. And I was like, “How can I protect myself and my child?” And they were like, “Well, you know, he’s your responsibility and if he does anything, you’re held accountable.” I mean it was awful. I mean, I felt like I was losing my mind at times because it was just – there weren’t the resources out there. . . . I mean, this is a crisis. I mean, where do I go?

A therapist with experience providing intensive community-based services for adolescents reflected on the relationship between the parents she works with and their adolescents’ probation officers:

[Parents] will tell me stuff that they don't want their probation officer to know, because they're afraid that their probation officer will just look for a way to make them fail.

Minor subtheme: Blame from insurance companies. Many of the parents interviewed for this study had little to no direct contact with insurance providers, as their children's mental health services were covered by Medicaid. Parents of children who were covered by private insurance, however, reported being blamed by insurance providers as they were trying to get preapproval for needed and recommended intensive services.

One mother who struggled to get her son into recommended residential treatment experienced the utilization review manager at her insurance company as blaming her for not "making" her child attend outpatient services regularly:

And I just heard "Why didn't you do this and why didn't you . . .? And that was my frustration. And the insurance company kept saying, "You didn't do this." And I'm like, "What—he's bigger than me. What are you saying?" How could I have done it any differently? Tell me what I could have done.

A father who sought residential treatment for his daughter also reported that he felt the his insurance provider blamed him for not seeking the approved types of treatment first, all while failing to answer his questions about what those types of treatment may be:

It's terrible, especially when you pay your insurance. All these years, I've paid the insurance. I don't use it for anything. What do you mean, it's not [covered]? Because I did not go through the hoops the right way. I didn't take the correct obstacle course. I mean, you know, it's sad. I mean it just – and it feels – it would be different if it was me. But when it's your child and they have no way of defending themselves, I just think it's a shame because if you could get to them early and they say "you went to the extreme" or "you just want to put your child away" And that what they – that's what I felt like. Like they thought I just couldn't deal with them so I wanted to put her somewhere else. That was a huge thing I felt.

Minor subtheme: Blame from psychiatrists. An additional minor subtheme that emerged from the interviews was experiences of parents feeling blamed or ignored by the psychiatrists who were evaluating or treating their children. Parents suggested that they knew their children needed medication, and therefore the services of psychiatrists, but that they dreaded psychiatric appointments because they were used to being blamed by their child's doctor. Others suggested that of all the professionals they worked with, psychiatrists seemed most likely to ignore their concerns or perspectives.

One foster mother who drove her foster daughter over an hour each way for her medication management appointments so that she could have continuity of care rather than start over with a new psychiatrist stated:

He basically bad-mouthed me, because he asked her "Were you taking your medicine?" She said, "Sometimes I take it." "Well, why isn't your mother making you take it? Blah-da-da. "Your mother should be making you take it" in front of the child. He bad-mouthed me in front of the child.

A father who believed his child needed services, but not at the intensity recommended by an evaluating psychiatrist, reported:

I think the only time I really felt like a professional wasn't respecting me was the psychiatrist at [the local hospital]. I remember going in for the meeting and them talking about how [my daughter] needed treatment, drug treatment, and I asked "Why?" And I felt like the psychiatrist just wasn't listening – the cynical side of me said, "the psychiatrist is just looking to make money and needs people for the program" or something, because he was like "We just need to take care of this." And I didn't feel like I was being listened to.

Theme: Parents blaming others. While the interview protocol was designed to solicit parents' experiences of being blamed by others, a major theme of parents placing blame on other adults emerged from the data. These stories were unsolicited and unexpected, and yet a major theme throughout the interviews. Attribution theory (Heider, 1958) emphasizes the inherent desire for people to make sense of a situation by assigning

causal factors to it. The emergence of this theme suggests that parents may blame others as they work to make sense of their child's situation.

Major subtheme: Blaming the other parent. During the interviews for this study, many parents placed blame squarely on the plate of their child's other parent. In the face of a society that so frequently blames parents for their children's problems, as was discussed in Chapter One, it may be that one parent feels compelled to blame another as a way to defend themselves against guilt, shame, and self-blame. A few clinicians described experiences that aligned with this theme.

One father started explaining his understanding of the cause of his daughter's challenges by blaming his ex-wife's genes, but quickly shifted into blaming some of her behaviors as well:

I think it's genetic depression. It runs in her mom's family. . . . In some ways I blame my ex-wife for some of the – I mean, not all of it, but because I think [my ex] went through a period where she was using drugs and drinking a lot that you know, maybe wasn't demonstrating the best behavior.

One mother reported that the root of her son's problems may have been that he did not feel loved by his father:

Maybe they felt like they weren't loved as much anymore. Basically, I feel like that's what was all the foundation [of my son's problems]. His dad was in his life for so long and then all of a sudden things changed and a new person comes in and then they have a child together. So I guess he never really felt like – that he – maybe that abandonment or rejection and maybe just to fill that void he was looking for other things.

She further held her ex-husband responsible for the escalation of her child's challenges, indicating her belief that her child's father did not properly supervise or set limits with her son:

I said "My son had drug overdoses, and he's also – the dad dropped him off at the mall the other day without supervision, and he got caught shoplifting." Now the

dad should have never dropped him off at the mall after he has had two drug overdoses and then two psychiatric wards. We know he is not doing right. And the dad leaves him at the mall with some friends. He could have gone in and supervised these kids. I would have gone in and supervised them. I wouldn't have left these kids alone in the mall. It's stupid.

Some parents were more subtle in their blame of the other parent. This father reflected that he was not a perfect parent himself, while asserting that the core of his daughter's extensive mental health and substance abuse challenges was her mother's parenting style:

It would say that finding treatment has not been an issue. The issue is reacting too much to a volatile daughter, who is much more volatile with her mother than she is with me. I'm not saying that to be better or anything. It's just a different relationship and I think it could have been handled better. . . . I remember driving behind the ambulance thinking the wrong person was going to get treatment. I was biased, but I was thinking that it's her mother that needs the help, not [my daughter].

Some stories shared by parents suggest that clinicians, perhaps in an attempt to help parents move past their own experience of guilt and shame, contributed to a shift in blame towards another parent. This mother indicated that her child's therapist had shared research findings with her that she believed indicted her child's father for his problems:

Social work has come and done studies on it. His dad just lets him run the household. The 13-year old has no restrictions and the dad doesn't know how to give the son boundaries. The dad just doesn't have it in him. He doesn't know how to parent.

One clinician reflected on the impact of parents blaming each other on an adolescent's success in treatment, suggesting that this dynamic limits a teenager's process towards wellness and recovery:

I can think of one example real easily, and it was some parent – this father and mother and their son was – he just turned 18 and was in residential treatment . . . And so talking with the parents, they have their own set of issues. The mom was going to blame the dad for the substance abuse problems and the dad blamed the mom for the mental health issues. Mom was going to the dad for the drug issues

and dad going to the mom for mental health issues. This kid was just like “I don’t care then. Why would I? If it’s one of their faults, then this has nothing to do with me.”

Another therapist’s report hints at the idea that shifting the blame onto another parent may be a way to handle a parent’s guilt:

[Parents] start to blame that guilt on someone else. His dad who maybe isn’t in the house, or his mom who may not be in the house, or they might be in the house, but it’s somebody else’s fault”

A closing statement by one mother, who earlier in the interview indicated quite strongly that she believed that her ex-husband was the sole cause of her child’s current problems, similarly suggests that the issues of guilt and blame may be closely intertwined:

I feel kind of bad because I blame it all on [my ex-husband]. When I talk to people, I’m like – I’m always blaming it all on [my ex-husband], and they’re probably going “Yeah, but it’s a lot your fault too.” Maybe I am overlooking my role in the situation because maybe I’m blaming it all on my husband without looking at what I could be doing better.

Minor subtheme: Blaming the divorce. Some parents appeared to be able to sidestep the issue of blaming their child’s other parent or blaming themselves and instead focused blame on their divorce. For some participants, this seemed to be a path towards externalizing the problem – exonerating both themselves and their ex-spouses from blame and guilt, while still having something to point to as the cause of the problem. One father indicated that his child’s therapist helped him understand how children could develop problems years after their parents’ separation, but which still could be directly related to their divorce:

I think she never – her mom and I are divorced and I think she never really processed that. [My daughter’s therapist] called it the “sleeper effect”. You know, we’ve been separated now for like seven years or six years, and fully divorced for two years.

Other parents reflected on their personal process of moving from blaming themselves to blaming their divorce. This parent suggested that she needed years of support from therapists to help get to the point where she didn't convict herself for her child's struggles:

I'd say [her problems started] because of the divorce. Guilt and blame for me is out of the question. It's like what happened is being blamed. It's like the divorce, what happened with that marriage is the one that went wrong. Whatever happened to me and my ex and how that divorce came up. And that's basically it – it wasn't – I guess [the therapists] were trying to tell me. I went to four different once telling me that it's not my fault. It's not my fault. I have to move on.

Domain 3: Potential Pitfalls and Strategies for Success

Perhaps some of the most important results of this study are contained in this section on pitfalls and strategies for success. This domain covers areas identified by therapists and parents as creating barriers to their ability to work together successfully and suggestions for others to consider when aiming to build a positive, collaborative parent-therapist alliance, especially with respect to issues of blame and responsibility. During the interview, both parents and clinicians were asked to reflect on suggests for therapists who were concerned with strengthening their partnerships with parents. Therefore, it was expected that this domain would be a component of the results, though each of the themes and subthemes emerged from the data. Many of the themes and subthemes in this domain focus less on feelings of guilt, or perceptions of blame, but rather on the responsibility for addressing problems and obtaining needed services.

Theme: Anticipate issues of blame and guilt. Parents and clinicians alike indicated that in order to build a successful working relationship with parents, therapists need to anticipate that issues of guilt and blame may arise throughout the course of

treatment and to take steps from the earliest days of engaging with the family to address some of those issues.

Major subtheme: Tune into parents' pain. This subtheme, expressed in the interviews from both therapists and caregivers, reemphasizes that it is essential to not only attend to the pain a child may be feeling, but to tune into the pain of parents as well. Therapists, in particular, noted that providers develop an ability to be perceptive about parents' feelings of guilt and blame. Without this sensitivity, it seems that it is quite easy to overlook these issues with parents, which, if unaddressed, can negatively impact the therapeutic process. A psychologist with experience working in a residential treatment facility stated:

I mean, I think it's really important to really try to become very savvy to recognize the guilt and the blame and to realize that it's probably going to be in every—especially when you're working with parents, because here you are, this person stepping in and basically your job as a family therapist is to get to know their intimate family history and they know that you're going to teach them something and so how can it not be present? And so you really have to figure out where it is and figure out what's the best way to get around it -- not to sweep it under the rug, I'm not saying that – but actually to use it, to facilitate it and make it less painful either to bring out in the open or acknowledge until you're able to bring it out in the open.

Another clinician who was providing services to adolescents and their families at a community mental health center indicated:

[Guilt] wasn't right out there, but it was definitely always a part of it and I felt like I have to become more savvy to help them get there, because it was such a part of the family, and just maybe, you wouldn't see it on your first pass.

Other therapists focused on parents' sense of despair as it related to guilt and shame. These clinicians highlighted that many parents expect to be blamed by their child's therapist, so providers must actively and explicitly work to lessen that expectation.

One community-based clinician stated:

They're wanting to know kind of your ideology, you know, waiting for you to come out and say "This is your fault." And sometimes, when I can tell that's what they're asking, I will almost – I mean, I'll exclusively – say "I don't think this is your fault. It's not something you've done as a parent, you know."

A seasoned therapist who provided outpatient services primarily to adolescents indicated:

So in order to counteract that despair, you have to reinforce, every single time that you talk with them, "This is not your doing. This is not your doing. This is not your doing." You've got to do that, even if a part of you thinks a part of the problem might be their doing.

Similarly, parents suggested that therapists try to understand the pain of parents more readily. One mother, whose son had been in a residential substance abuse treatment program offered this advice:

I guess maybe the therapists could be more – have more – empathy. I know that's – we're taught that all the time, but honestly to put yourself, like, close your eyes and visualize yourself in another person's shoes. How they might be feelings, because here again, on the outside you can see so much more and you don't have the emotion there. But sometimes the parent is floundering in their emotion and being able to, I guess, suck it up and take some of the stuff the parent is saying and being able to give it back to them in a positive way, versus letting it be your defense because you know it's not about you, even though it feels like that they're attacking you. They're attacking you as a professional, but it's not where it's coming from. It's stemming from something else, and that's hard. That's so hard to do.

Minor subtheme: Encourage parents to build their own support network. Some therapists encouraged fellow clinicians to dedicate time to helping parents develop a personal support network. These clinicians seemed to have an understanding of many of the challenges that their parents struggled with and found that developing these supports was beneficial for the entire family. In particular, therapists connected the presence of a strong support network with a parent's ability to tolerate and work through feelings of

guilt and blame that may arise throughout the course of treatment. One clinician reported:

I think seeking their own support, whether that's building it through like AA or getting their own therapist and working through – realizing that they themselves have to be able to process what's been happening. I'm trying to think of – trying to link more with schools and people who are in the child's life, building outside resources whether that's seeking additional treatment or getting support from other parents.

Minor subtheme: Praise parents. Both parents and clinicians highlight the need for therapists to offer praise to parents. Participants indicated that praising parents early in the treatment process can serve as a partial antidote against simmering feelings of shame. A therapist who had experience with in both community mental health and private practice stated:

One of the first things I do is praise parents, "God! Look at you, what a great parent. You're here! This is just a testimony to how much you care about your kids/ What a great parent you are! How terrific that you're here getting some help because you see something you don't like, that's awesome!" And you'd see this like "Ahh." They're shoulders relax and then they say, "Oh thank God. You're not going to judge me for being this monster."

A provider who worked extensively in a residential treatment facility reported that she actively worked to find ways to praise a parent's ability to parent their child, even while they were living apart:

Something I got better at seeing is when I can give them compliments about "Well, you really know your daughter. I really appreciate when you said that because I was thinking this." And so that's how I would try to collaborate with them – and I would be genuine, like, I really didn't see that. They taught me something about their daughter.

One stepfather noted how important it was for his child's therapist to be positive about his parenting ability:

The main thing he's done is that he's encouraging. He is, for me personally. "Hey, you're the stepfather. You got to get this right, but the fact that you've

stepped into this role shows that you have some desire to do it. You're trying to be man enough to do it." So yeah, he's definitely been positive with me.

Theme: Inclusion and exclusion from the therapeutic process. Throughout the interviews, stories emerged from parents and clinicians of the importance of including parents in the treatment process, experiences of parents feeling isolated or left out of their child's services, and suggestions for ways that clinicians can better involve parents.

Major subtheme: Exclusion of parents from the treatment process. Both parents and clinicians noted that parents, particularly those who share custody of their biological children, step-parents, or foster parents, are often excluded from the treatment process.

One stepmother reported:

I asked for a wraparound team. I mean, I asked for us to form our own wraparound and [my partner] said that basically [my step-daughter's biological mother] wouldn't have anything to do with it. Oh, yeah. We talked about a lot of ideas about having like a neighborhood intervention, because [my step-daughter] lives on a neighborhood street . . . We brought it up [with her service providers] and they said, "Oh, yeah, that's a great idea. That's a great idea, but do it on your own." But I think the frustration for me was not having the power at that point to say, "No, this is what I'd like to try."

A biological father who shared custody of his daughter with his ex-wife, shared his dismay at being cut out of services for his child while she was in a residential treatment program:

So that part was very frustrating – and the fact that it led from there to, I don't know – four or six weeks at [the treatment facility], in a residential setting where [my daughter] was basically – I was unable to reach her. I mean, we had an hour of visitation once a week, or something like that and she's too angry to talk, really talk. So I couldn't be a parent in that situation.

Similarly, an experienced foster parent expressed frustration that she had been excluded from the Family Assessment and Planning Team (FAPT) meeting for a foster child who had been in her home for several years:

Even when they go to their FAPT meetings every month, I'm never invited. I'm never invited to the FAPT meetings. And this is for this one particular child. I'm never invited. I never went to a FAPT meeting. And [the caseworkers] make these decisions without the parent there. How can you make a decision and not get –they don't invite the in-home therapist. They invite no one for this FAPT meeting. So you have this group of people that are sitting around the table making decisions about this child and you're not – you don't even have the key players around the table.

This same foster mother went on to describe the challenges she faced when trying to be actively involved with her foster child's care by regularly attending appointments with her psychiatrist. The treating psychiatrist's office was over an hour away from the family's home and work, and only had appointments in the middle of the foster mother's work day.

I went to that last appointment. We sat there waiting for a little while – actually a long time. We sat there for almost two hours and I kept calling him. I said, "OK, our appointment was two hours ago. Why are we still sitting here?"

One mother contrasted her experiences with two different residential treatment facilities that her son attended. In the first, she was not allowed to contact her child, who was physically assaulted by other residents of the center:

His dad was at work, picked him up, and then took him to a treatment center in South Carolina. He was assaulted there by another student. So he was there a month, and they don't let you have contact with him. I mean, you can't write him. So that wasn't – something in my gut just – and the only reason I took him there was because I had talked to the people in Utah, at the Utah treatment center and I really, really liked that, but I could not bring myself to sending him that far away. So, when he was assaulted, it was so weird [the providers from the Utah center], they called to check on him. I had not talked to the people in Utah, because they knew he went somewhere else – and I was in tears and they said, "Bring him here. Bring him here."

A stepmother reflected on how therapists would not allow her to be an active part of family sessions with her step-daughter, regardless of the fact that she had been actively parenting her stepdaughter for several years:

When I read that there are parents who are willing to be engaged in a kid's life and then their treatment, then how would you not go for that, right? Some of the parents in this parent group said, "Oh, the stepparent, they can't do this, they can't do that". Well, we had all three parents willing to be there. So, we did that again, the child and the parents had individual session with an individual therapist. Nope. I couldn't go. And I thought, "Wow! What a shame." Really. What a shame. What a wasted opportunity for the kid.

Clinicians also reflected on how they sometimes contributed to the exclusion of parents from the therapeutic process. It appears that the underlying assumptions of many agency policies and therapist practices include the idea that families are not an essential component of the healing process of adolescents, and may in fact, hinder therapeutic progress. One social worker who had experience working in a residential facility revealed ways in which agency policy limited the involvement of parents:

Early on [in my career], I would maybe limit contact – I mean not intentionally. It really was up to us a lot, but I would, I would, I don't know. Maybe I would stick to the stringent regulations like "OK, you guys can have ten minutes of visiting time." And by the time I'd been there for a while, I was like, "You haven't seen each other in two weeks, take an hour." What does it – it doesn't make any difference to me. I can hang out here and do paperwork. Even if it wasn't right with the regulations of the agency, it just seemed ethical. But definitely, earlier on, I don't know.

A therapist reflected on his experiences in a treatment system that emphasized work with adolescents over family-based treatment:

The focus of my treatment is typically the teenager and the parent is in some ways an afterthought – it's really frustrating that the structure of the program is that way, because we're sending kids right back home to be with the parent, but we haven't really done a good job of including them.

Major subtheme: Parents crave one-on-one sessions with providers. One suggestion that many parents had for therapists was to include them in services through one-on-one sessions. In other words, these parents were not asking for family therapy alone, but for an opportunity to talk with their child's therapist by themselves. Some

parents seem to have been rebuffed by therapists when they tried to communicate with them on a one-to-one basis. One father shared his attempts to communicate with his daughter's therapist:

I guess I long for, but I know this isn't possible, or maybe isn't professional, I longed for one-on-ones with [my daughter's therapists] so I could tell them what was going on. I ended up writing a letter to her therapist, trying to explain the situation with [my ex-wife].

Another parent wished for, but had not been able to have, one-on-one sessions with her child's therapist:

Yeah, I wish we could have one-on-one's with therapists. I know they can't take sides, or shouldn't take sides, but it's helpful to know what one parent thinks of the other parent and their contribution to whatever the problem is.

The parent of an adolescent in a residential treatment facility shared her desire to have a one-on-one session with her child's therapist, but that she never felt empowered to make such a request:

Yeah, well, I'm not sure if they couldn't make [a one-on-one] happen and maybe I could have requested it, but I don't remember actually doing that. I don't think I thought it was possible. But I felt the need through the whole thing that it was that we needed family counseling and family counseling to me is not all three of us are going all the time to every session, but a therapist really getting to know all three of us, having us together and sometimes having mom and dad there by themselves sometimes.

Other parents report successful progress in treatment occurred when they were able to talk directly with their child's therapist, without the adolescent present. One parent indicated that her child's therapist asked her to meet with her individually, providing them with the opportunity to build a working relationship:

[The clinician] called me at her office and had a one-on-one with me. So that was surprising. I didn't expect her to give me her full attention for an hour. That was nice. We had a nice discussion. I got to know her, and she got to know me. So I feel like we have a good relationship now.

Another parent indicated that she requested monthly meetings with her child's therapist to review treatment progress, share observations about the child and prepare for a family session. This parent indicated that these one-on-one sessions were the foundation of a successful partnership with her daughter's therapist:

And I said, "Why don't we do this? Why don't I have a session with you with just us?" And then when you have our session, we'll go over your notes that you did for the whole month and then I would bring her in so we can all, three of us, can sit around." That worked real well.

Major subtheme: Power of including parents in decision making and treatment. In contrast with the voices of parents who expressed distress about being excluded from their children's treatment process, some parents articulated their belief that treatment was more successful because therapists went out of their way to include them in services in services. One parent explained that, at first, her daughter's therapist seemed resistant to including her in treatment as the therapist felt that the adolescent would benefit more from individual work rather than family sessions. They were able, however, to come up with a plan for services that allowed space for individual treatment while still including the parent in the process:

Once we [the therapist and I] started to communicate and we started talking after sessions. What I'd been doing was asking if I could be a part of all the sessions, but she didn't want me to do that. But once I talked with [the therapist] regularly, you know what? I don't have to be in your session. Like after your session, or if there's something going on, I want to talk to you beforehand so I can tell you what's going on so that you can address it in your session, or if there's nothing going on, I'll sit out there and wait until the session's over. You wrap it up ten minutes before your 45 minute mark. Bring me in and then we can discuss what you guys worked on.

Another parent, who had felt disconnected from her daughter before they began family work, talked about the benefits of family-based treatment for her daughter:

What our counselor did, she was interacting with both of us and she did help both of us. When she met me, I was saying “I don’t know so much of my daughter”, but I think by being there, interacting with both of us, it helped my daughter think about another way to deal with the issues.

Other parents expressed the support they felt when therapists and providers reached out to them following a crisis with their child. Family members expressed a sense of isolation that parents sometimes felt and the benefit of having someone check in with them to see how they, and not just their child, are faring:

So who has our back? We got the kid’s back. The social worker supposedly has the kid’s back. The at-home counselor, the therapist, the agency, the case manager’s agency, everybody has this kid’s back, but who has the parent’s back? We get drained, we get overwhelmed, and just to say, even though I didn’t need anything, but just to know that you’re there and I have your back and I’m on the same page as you. That means more to me than anything. Say you need anything, don’t hesitate, it doesn’t matter what time it is to call.

Just being there for support [is important]. Just being there, just not saying they will be there, then don’t. If they’d been there no matter what so that I can call when I have issues going on to get their support.

I guess after a crisis, and I call them while I’m in the middle of the crisis, that once the crisis is over, they follow up with a phone call. And they say, you know, “Hey, we just want to know how’s everything going? Is there anything that we can do for you, not the child, for you? Because they don’t understand when we go through these crisis, we’re going through it with the child too.”

Theme: Clarify the process. Both parents and clinicians alike think it is beneficial if time is set aside to help parents understand the treatment process. It appears that many therapists jump in to services, leaving parents unsure of what to expect. This may be a result of clinicians forgetting that what is everyday knowledge to them, is a new, confusing world for parents. Parents report:

I mean, I wish they would just be frank. I mean, not like in your face type stuff, but just kind of saying “You know, here is what we’re dealing with.” Kind of being that liaison. . . .And it’s really I guess two different ways of treating, one, the depression, and then two, the substance abuse.

The Intensive Outpatient Program was a big help to here. And I think it's not for everybody, but I think it's, I mean, it's both for parents and for the kids. I think even in some programs like the DBT therapy, that if there was a parent involvement in that . . . It doesn't have to be every week, but a family session at some point to, you know, for us to understand the whole process.

Major subtheme: Prepare families for what to expect. Parents and clinicians alike reported the importance of being oriented to the treatment process for their child and having the therapist help them understand the situation they were dealing with, options for treatment, and what any one therapist could, or could not, provide. Parents asked for therapists to be more upfront with them from the beginning of the treatment process. One father, whose child had been served by many different providers and required different intensity of services over the course of her adolescence reported his desire that therapists give a manual to parents that explained not only the services that one specific provider could offer, but also what other services were available in the community:

I wish they had gone through the whole thing and I guess everybody's going to be different, but if there were more of a, you know, here are your choices on this, here are your choices on that.

Other parents focused less on being prepared for the course of treatment, and more on being prepared for severity of their child's challenges and the difficulties they may face as a family. One mother emphasized the importance of her child's therapist sharing with her some of the more difficult truths about addiction:

I mean, I think the biggest thing is just being honest. You know, some of the fact are difficult to hear, but I think it makes for a safer environment. I mean, just to kind of know what we're up against. I mean, I know even hearing that is not going to totally take away the risk, but just maybe knowing what to prevent or knowing what to look for as warning signs.

Therapists also shared their around the importance of helping families understand treatment services from the beginning of the process. They highlighted that many parents

may not have previous experience in therapy and rely on misinformation about what mental health and substance abuse services look like. One therapist stressed the importance of sharing this information in the first session:

I think we should be preparing families appropriately for what actually happens in therapy and what to expect. Kind of what their role is, what the clinician's role is, how long things take, what can – what therapy can and can't do. So just orient them really strictly to the situation from the beginning.

Another therapist stressed that taking time to do a thorough informed consent session with parents, over and above what may be legally required, can better prepare families to be active participants in the treatment process:

I think everything really rests in a relationship—the therapeutic alliance. I think that without it there's pretty minimal change. And with it, I think when I have that relationship with the parent where they know that there is mutual respect and – well, and I think also just having a really solid informed consent session first thing of “This is who I am. This is what I have to offer. I don't have all the right answers. I'm going to ask you to try some things that may bomb, some things that might be really hard for you, some things that might make you feel worse. I'm really just here to shed some light on ideas that may or may not work.” And I think the honesty upfront is a big part, going through the parameters of what you can provide.

Minor subtheme: Discuss financial realities. A minor theme emerged from parents with private insurance. These parents experienced a great deal of frustration and blame when attempting to obtain insurance approval for their children's recommended treatment. These parents suggested, without fail, that therapists help them understand the realities of working with an insurance provider, including the limitations that may be set on their child's treatment and the financial reality that payment for services may sometimes be denied. One father reported:

I guess, I wish they had helped me prepare about the financial part, the insurance. I wish there were some kind of guideline. I wish that they would help these parents, because it's a crisis because this is your child. It's not the same as if it was you going to rehab or your spouse or an adult.

Domain 4: Training and Theoretical Orientation

A domain encompassing issues of training, supervision and the influences of theoretical orientation emerged unexpectedly from the data. The researcher did not include questions regarding these topics as part of the interview protocol, but the topic of conversation was brought up by numerous clinicians. Although at first glance, issues related to training and theoretical orientation may seem discrete, clinicians themselves linked the two, drawing connections between their training process and the development of their orientation towards therapeutic work.

Theme: Theoretical orientation shapes practice with parents. Therapists spontaneously shared their experiences of how practicing from a particular theoretical orientation contributed to the ways they interacted with parents. Some clinicians reflected on theoretical perspectives they used to hold, but found wanting, when working with families. Others focused on ways in which their theoretical orientation positively shaped their interaction with parents.

Minor subtheme: Impact of cognitive and behavioral theories with families.

Therapists talked relatively negatively about how cognitive- or behavior-based therapists can either contribute to the problem of parents feeling blamed, or miss it all together. Some of these therapists, like this psychologist, used interventions based in cognitive-behavioral therapy for years before shifting her approach after seeing a negative impact on families:

I think a lot of times, when parents are given a kind of behavior plan – you know, we relied for a long time on behavior plans or things like that – when parents try all these kinds of reinforcement things, and then when they don't work, people kind of keep on going. Clinicians kind of keep going back to things that don't work. The parents feel like there's an implication that if they, you know, if they

were doing these things correctly, it would, it should, get better. They [the therapist] promised you'd get better.

Other therapists, like this clinician who identified as psychodynamically oriented, suggested that therapists focusing on the here-and-now that is called for in CBT, risk missing the larger picture of the ways that guilt and blame filter into a family's dynamic:

I think the people who conceptualize more on a cognitive level, or more on the behavioral level, I don't think they are going to get to the guilt and the blame in their own issues.

Minor subtheme: Benefits of utilizing a motivational interviewing perspective.

Some therapists explicitly credited their training in, and orientation towards, motivational interviewing as the key to their success in helping parents address issues of guilt and blame, by using strategies designed to work with resistance:

Y'know, I base most of my work off of motivational interviewing. Maybe that's the benefit of being trained that way – now I use it with families, not just with kids that are using. Showing the parent that I am on the family's side and that I'm not against the family and that as far as mandatory reporting, these are my obligations. But besides that, I'm not trying to break up your family, I'm not trying to destroy your family, what I'm trying to do is figure out the best way that I can help your family, and that you as the family need to let me know how I can help you, and I can offer suggestions. And so I think it's really just that, coming alongside.

Well, I use a lot of motivational interviewing. I think that helps a lot. I ask them about their struggles with it, more than what you need to do. I don't go back there [in session] and ask "What can you do?"—more we talk about how difficult it is.

Theme: Importance of training that is particularly focused on working with families. Clinicians emphasized their belief that graduate schools, training programs, and agencies that hire new professionals need to work to help prepare clinicians for working effectively with parents, particularly around issues of blame and guilt.

Minor subtheme: Lack of preparation. Many clinicians reported that they felt ill-prepared to provide appropriate and effective services to families. Therapists stressed

that their graduate programs helped them develop skills for working with individuals, but once they began practicing they were overwhelmed by family work, which may have contributed to their tendencies to exclude parents from treatment. One therapist noted how she felt only partially prepared by her training and education to work well with families, while simultaneously acknowledging how essential family work is to a child's success:

I think my graduate program did prepare me for [working with families] and I think the experiences that I had did prepare me for it, to a degree. I think I could have been better prepared and it's definitely something that I'll continue to do, with continuing education and consultation, being licensed now. So it's interesting, because I feel like I could have been better prepared, but it is hard for me not to be judgmental with other clinicians, because there's been clinicians that I've worked with who give up so easily on the family piece, especially in the residential facility I worked in. "Oh, there's a transportation concern." "Oh, I'll just cancel the session – I won't be able to help because of transportation." "Or, you know, the scheduling was hard, and I really can't reschedule them, so I'll just cancel." Or they wouldn't push their families, or they would just focus on behavior, rather than on family issues, and I almost feel like you could do a study, and like if you were to measure the outcomes, you can be like "Those kids are not doing as well." Short-term and long-term, you could like identify the families because I had other families who were working their asses off to get their families in and working on really big family therapy issues.

Minor subtheme: Importance of mentorship. Other therapists noted the importance of having a mentor early in their career as they learned to better handle issues of blame and guilt. For some therapists, an influential clinical supervisor seemed to play this role, while for others the relationship was less formal, yet still hugely beneficial in their development as a clinician. A seasoned social worker shared a story of how his mentor helped him develop a different perspective regarding parents than was held by most staff at the agency in which he was first employed:

When I was first starting out, I went through a phase where I was like "OK, that's just kind of the way we see parents – as constantly interfering in treatment. And then, along the way, I had a mentor who kind of helped me look at it a bit

differently, and OK, how do we incorporate the strengths of the parents like you should?

Minor subtheme: Field instructors and training directors must tune into issues of guilt and blame in families. Therapists voiced the importance of having agency-based educators focus on issues of guilt and blame. It seems that these professionals, whether they be social work field instructors or training directors in psychology predoctoral programs, have the potential to bridge the gap in graduate education mentioned by some therapist, perhaps by serving as a mentor as described by others. One clinician who spends a portion of her time at work supervising students and new clinicians reflected on her role in helping train about blame and guilt with parents:

On blame and guilt – you know, as a supervisor, it’s something I deal with a lot with my trainees. And I think it’s not something that we—I mean, I think – a parallel process really comes out here. And that when I find myself – when a therapist wants to throw themselves in front of the child, you know, and protect the child. And so they’re kind of aligning against the parent and then I find myself aligning with the parent, because I feel like the parent is being blamed. It’s more like I find myself frustrated with the clinician who’s frustrated with the parent who’s frustrated with the child. So I think as a supervisor, I could really also fall into this really easily. And so kind of being aware of it at that level, but then also helping newer clinicians who, you know, haven’t learned that.

Chapter Five

Discussion

Study Synopsis

The purpose of this study was to understand and describe the experiences of parents of, and clinicians who provide services to, adolescents with co-occurring mental health and substance use challenges, particularly as they relate to issues of guilt, blame, and responsibility. The study was based in a theoretical framework derived from Symbolic Interactionism (Blumer, 1969), Attribution Theory (Heider, 1958), and Barrett's (1995) Theory of Guilt and Shame. The guiding question the study was *What are the experiences of parents of adolescents with co-occurring mental health and substance abuse challenges and clinicians who provide treatment services around issues of blame, guilt, and responsibility, and how do those experiences shape their collaboration?*

Twenty three participants engaged in in-depth interviews with the researcher. Women and men were included as participants in both subgroups, as were individuals who identified as Caucasian, African-American, and Latino/a. Clinicians held master's degrees in a Social Work, Counseling Psychology, Rehabilitation Counseling, or Marriage and Family Therapy, or a doctoral degree in Clinical Psychology. These participants worked in outpatient mental health clinics, schools, juvenile detention centers, psychiatric hospitals and residential facilities. Parent participants included those whose children had received services in outpatient, community-based, residential, or hospital settings. These services were funded through Medicaid, private insurance, or out-of-pocket costs. Following data collection, the researcher transcribed the interviews

and analyzed the resulting data using a phenomenological approach to qualitative research.

The results of the study were organized within four domains, the first three of which loosely correspond to topics broached in the interview guide developed by the researcher. The first domain, Sources of and Impact of Guilt and Shame was comprised of three themes: (a) Parents experience of guilt related to their behaviors, (b) Parents' experiences of guilt has a serious impact on families, and (c). Guilt and shame felt by parents shaped the therapeutic process. The second domain, Being Blamed and Blaming Others, was comprised of two themes: (a) Feeling blame from every direction and (b) Parents blaming others. The third domain, Potential Pitfalls and Strategies for Success included three themes: (a) Anticipate issues of blame and guilt, (b) Inclusion and exclusion of parents the therapeutic process, and (c) clarify the process. The fourth, and final domain, which emerged from the data without a direct connection to the interview guide was Training and Theoretical Orientation Issues. It consisted of two key themes: (a) Theoretical orientation shapes practice with parents and (b) Importance of training specifically focused on working with families. All themes delineated here included major and/or minor subthemes to increase the depth of the analysis.

Most of the findings of this study seemed to transcend context, in that the themes and subthemes did not appear to be bound to the participant characteristics described above. However, the subthemes Blame from Insurance Companies and Discuss Financial Realities arose from parents and clinicians who relied on private insurance providers for funding of services. Parents who paid for services out of pocket, or whose children were covered by Medicaid, did not report these same concerns. Likewise, the entire domain

of Training and Theoretical Orientation arose from clinician interviews. Parents, perhaps unsurprisingly, did not discuss these issues as they related to their experiences in seeking or receiving services for their child. That said, within the clinician subgroup, the themes within this domain were not limited by practice settings or clinician background.

Surprising Findings

Many of the themes and subthemes that emerged from that data collected in this study are aligned with the findings from previous research that has been conducted that explores parental experiences of guilt and blame. However, a few themes that emerged were a surprise.

Blame from Every Direction

The results of this study strongly indicate that family members were often blamed by professionals tasked with helping their children get better. While some of the systems that blamed parents had been mentioned in previous literature, specifically representatives of the school system (Litt, 2004) and doctors (Harden, 2005; Usher, Jackson, & O'Brien, 2007; Williams, 2006), the parents in this study reported blaming statements coming from nearly every direction imaginable. While these parents did highlight schools as being particularly blaming, they also discussed being blamed by caseworkers from the Department of Social Services, probation officers, psychiatrists, and, interestingly, insurance companies. Blame seems to be wide spread and potentially lurking around every corner.

While it seems contradictory with the aforementioned experiences of blame, parents in this study did not report that their primary mental health or substance abuse treatment provider (as opposed to other collateral professionals they encountered) acted

toward them in a blaming way. This is in contrast to previous literature that described parent's experiences of humiliation after being blamed for their child's problems by a mental health provider (Harden, 2005). That said, many therapists admitted that they had implicitly, or sometimes explicitly, blamed parents for their child's struggles. It may be that parents were aware that the interviewer was a clinician herself, making them less comfortable discussing ways in which clinicians acted in a negative fashion.

Additionally, as many parents in this study were recruited by their clinicians, the sample may have been more representative of parents who had more positive relationships with their therapists than a sample that was recruited in a different manner. However, another possibility may be that through ongoing supervision, clinicians may be more able than other helping professionals to monitor the ways in which they blame parents and sensor some of their statements in a way that parents perceive as less blaming. If this latter theory is correct, it highlights the importance of supervision and consultation when providing family-based services.

Blaming Other Parents

The interview guide for this study was constructed with the experiences of parents being blamed by others in mind. However, while those themes did emerge, a theme of parents blaming others was also present. In particular, many parents in this study explicitly held their ex-spouse accountable for their child's problems. Therapists also noted this trend, one mentioning that when parents blamed each other, the child felt "off the hook" and did not have any motivation to work for changes in their own life. Both the intensity and the frequency of this blame was surprising to the researcher, and has implications for clinical practice and training, both of which will be discussed below.

Training and Theoretical Orientation

Interview questions for this project did not explicitly ask clinicians to discuss issues related to their training or their theoretical orientation as it related to the topic at hand. Yet several therapists mentioned these issues in their responses. A handful of participants mentioned that their training left them inadequately prepared to work effectively with parents, particularly around issues of guilt and blame. It is clear that educators, field instructors, and clinical supervisors need to attend to these issues in their work with students, trainees, and staff members. Some therapists mentioned that when their work, or the work of others, was more grounded in cognitive and behavioral theories and therapies, parents seemed more likely to perceive blame than when they worked from other perspectives. Specifically, clinicians mentioned motivational interviewing and psychodynamic perspectives as being more helpful when addressing issues of guilt and blame. Indeed, clinicians suggested using strategies initially designed to help therapists engage with individuals experiencing addiction (Miller & Rollnick, 2013) for building relationships with the parents of the adolescents they serve.

Lack of Complex Understanding of the Causes of Mental Health and Substance Use Challenges

As reviewed previously, the existing literature suggests that the root causes of co-occurring mental health and substance use disorders are varied and complex. However, an understanding of that complexity was not present in the responses of participants in this study. Indeed, many participants, parents and clinicians alike, focused primarily on the role of environmental factors in the development of these problems, though some participants did emphasize the genetic nature of addiction. The overly-simplified

understanding of etiology is particularly surprising amongst clinician participants. Though these participants should have been immersed in the idea of the multifaceted causes of human problems during their graduate program, they do not appear to have internalized these concepts in a way that informed their practice on a day-to-day basis.

Strengths and Limitations of the Study

Strengths of this study included the gathering of rich, descriptive data allowed for by qualitative research conducted within the interpretive paradigm, specifically the phenomenological methodology. This research design lent voice to the participants, many of whom, particularly in the parent subgroup, may not be otherwise heard. An additional strength of the methodology of this study was the numerous strategies utilized to increase the rigor of the analysis. The researcher's use of reflexive journaling, a peer reviewer, member checking, and searching for a negative case example all contributed to the trustworthiness of this study.

The researcher's professional experience working in the domain of adolescent mental health and substance abuse could be considered both a strength and a limitation of the research. This specialized background provided a knowledge base from which to draw to help ensure that the study was relevant to social work practitioners in the field while also being a meaningful contribution to the literature. That said, despite attempts to bracket and set aside her preexisting conceptions about the topic at hand, her professional experience unquestionably shaped her understanding and interpretation of the participants' experiences. Likewise, it is possible that the researcher's background as a therapist shaped participants' responses. It remains surprising to this writer that while parents voiced many experiences of being blamed by a wide variety of child-serving

professionals, and many clinicians acknowledged that they had implicitly or explicitly blamed the parents of their adolescent client, not one parent indicated that they were blamed by their child's therapist. One possible explanation for this finding is that parent participants self-censored their responses to avoid the chance of offending the researcher, given their knowledge of her professional background.

Possible criticisms of this study include the limited diversity of the sample. While two parents of color and two clinicians of color were interviewed for the study, the vast majority of the participants were Caucasian. It is possible that from a more ethnically and racially diverse sample themes related to the ways that such diversity impacts guilt, blame, and shame would have emerged.

Implications for Clinical Practice

Many implications for clinical social work practice arose from this study. Practitioners who serve adolescents and are aiming to improve their work with families may benefit from some of the explicit suggestions made by the participants, along with other information that can be gleaned from their responses. Other implications arose from the process of doing this research, as opposed the findings themselves. Both types of implications will be discussed in this section.

Implications Arising from Study Findings

Need to involve all important adults in an adolescent's life. Many parents in this study, particularly those who did not have primary custody of their children, expressed that they often felt excluded from their child's treatment. There is nothing groundbreaking in suggesting that including parents is a key component of successful treatment for their adolescent children. Indeed, proponents of the wraparound model of

treatment have been advocating inviting all supportive adults to the service planning table for many years (Burns & Goldman, 1999). However, experience suggests that while many therapists engage effectively with the parent who initially seeks services for their child, fewer clinicians reach out to work with other parents in a child's life, even in an ideal situation where all parents are equally involved and invested in the success of the child. Findings from this study suggest that engaging all parents and step-parents may be more difficult than it first seems. Indeed, one of the key findings from this research was the common occurrence of one parent blaming another for their child's problems. When this blame rises to the level of vitriol, it is easy to understand why therapists may choose not to engage more than one family member in the treatment process. However, the difficulty of successful engagement does not make it any less important. Rather, it suggests that therapists need to act creatively and flexibly in order to work with all parents who are willing to participate in services. One step-parent interviewed for this study suggested that therapists first aim to have all adults in a child's life sitting around a table, working collaboratively to find solutions. If that is not a possibility, however, she insisted upon the importance of finding other ways to involve all parents. One option may be to hold multiple planning meetings with parents, making sure to create spaces where all parents feel that their voice and perspective can be heard.

Need to “tune into” issues of guilt and blame for parents. As treatment progresses, it is important for therapists to “tune into” issues of guilt and blame that may be arising for the parents they work with. First and foremost, clinicians should be aware of ways in which their own practice may be perceived as blaming parents. One social worker who participated in this study noted that he became more aware of ways that the

questions that he regularly asked as a part of his assessment process may easily be perceived as blaming by parents when he was serving as a translator for another therapist. Having been an outsider allowed him to hear the conversation from the perspective of a parent, rather than a therapist. Creating opportunities, such as this one, to step outside of a dyadic conversation with parents is one way to increase our awareness of the ways in which our practice may, inadvertently, blame parents. Participating in live supervision, peer supervision groups, or facilitating family meetings for clients in which the social worker may not be the primary clinician could be other means to create enough separate to effectively evaluate one's practice.

Clinicians should also stay alert to ways that parents may hint at ways that they are feeling blamed, either by the therapist herself, or by providers in other systems.

Across the board, parents indicated that they had experienced being blamed by professionals to whom they turned for help. Therapists and parents alike indicated that when parents were feeling guilty, or had been blamed for their child's problems, they were more likely to speak angrily toward providers or withdraw from services.

Clinicians highlighted the importance of being aware of this way of communicating. It seems important for therapists to use these hints from parents as a cue to alter the course of treatment, by exploring parents' experiences, reassuring parents that their child's challenges are not their fault, or taking ownership for blaming statements they may have made.

Need to educate parents about the treatment process. Social workers may also want to consider the benefits of dedicating time to educate parents about the process of treatment. Nearly all parents interviewed in this study discussed being blamed by one

service provider or another (though again, not their mental health therapists) while they were trying to get help for their child. A few mentioned how helpful it would be for therapists to orient them to both the expected process and different routes they could pursue if the initial course of treatment is not helpful. In this discussion, clinicians may want to include information about different levels of care that are available and the potential barriers, including problems with insurers or other financial or bureaucratic impediments, that may cause difficulty as parents try to help their children get better. Along the way, clinicians can support parents by helping them navigate the complicated, and often blaming, systems.

Implications Arising from the Research Process

Need for ongoing substance abuse assessment. One implication for practice arose out of clinicians who self-selected out of the study. Many mental health therapists contacted the researcher expressing their interest in being interviewed, but stated during the screening process that though many or most of their clients were adolescents, they had not worked with anyone in the past year who was using or abusing substances of any kind. As research suggests that a large proportion of adolescents with mental health challenges also struggle with substance use (Center for Mental Health Services, 2001), this was a surprising phenomenon. Although data was not collected on this issue as a part of the study, this experience suggests that therapists working in agencies that are primarily focused on helping families with mental health challenges may not be adequately or appropriately screening for substance use among their client population. In this writer's experience in child and family focused mental health settings, it has sometimes been an agency policy to complete a brief substance abuse screening

instrument during an initial assessment of an adolescent client. While these brief screening tools can be beneficial in some cases, in other situations, it seems that adolescents do not disclose substance use until they have developed some level of trust with their therapist. Therefore, it is essential that clinicians working with adolescents assess for substance use on an ongoing basis throughout treatment.

Need for parents to stay apprised of their adolescent's challenges. Similarly, several parents indicated their desire to participate in this research, but reported that they were not eligible as their child had not used drugs or alcohol. Interestingly, in most of these cases, their child's therapist had referred them to the project with the understanding that only parents' whose children had both mental health and substance abuse challenges were eligible to participate. While it is certainly possible that the clinicians brought this study to the attention of parents who were not eligible, we should also consider that therapists were under the impression that the parents were aware of their child's substance use, when in fact, they were not. Indeed, one of the findings of this study is that parents are craving one-on-one communication with the therapist providing services to their adolescent, both to share their own perspective and to stay in the loop with regards to their child's challenges, prognosis, and treatment options. Experience suggests that clinicians sometimes choose not to disclose an adolescent client's substance use to their parents, and that those decisions can be appropriate ones. Therapists must balance a parent's right to know about potentially dangerous behaviors in which their child is engaging with an adolescent's right to some level of privacy within a therapeutic relationship. However, the possible disconnect between clinicians referring parents to this project, and the parents themselves suggests that clinicians may need to more

purposeful in their decision-making and communication processes in order to ensure that parents are informed about the range of challenges their children are facing.

In the early stages of treatment, it is important for clinicians to set the stage for ongoing open and honest communication between parents and therapists. The significance of keeping the lines of communication open was mentioned in interview after interview, by parents and therapists alike. As mentioned above, clinicians and parents specifically discussed the power of having one-on-one sessions, where parents had the opportunity to talk with therapists without other family members present. Therapists providing services to adolescents may want to make this a regular part of their initial assessment process with all families and keep in mind the possibility of having these parent-only sessions throughout the treatment process.

Implications for Education and Training: A Suggested Case-Based Training Model

This study offers many implications for the education and training of social workers and allied professionals. It is clear that therapists, particularly those new to the profession, need assistance in learning how to navigate the difficult topics of guilt and blame as they present in the families they work with. Likewise, ongoing support related to case conceptualization and increasing clinicians' understanding of the multidimensional nature of the causes of mental health and substance abuse challenges is needed. Clinical supervisors need to be prepared to discuss these issues directly. However, even those in supervisory roles may not have had either the formal or informal training that would help them work effectively with their supervisees around these issues. Ideally, more education and training around these issues would be available for all clinicians.

A case-based training model could be one way to infuse social work classrooms and agency team meetings with key concepts to foster creative thinking around these issues. Case-based learning is a small group pedagogy technique which utilizes client or patient case situations as a foundation for learners to engage in critical inquiry while applying new concepts to real life situations (Thistlethwaite , et al., 2012). Literature supports case-based learning as a pathway to enhancing learners' critical thinking and problem solving skills (Barrows, 1986). It has been used widely across disciplines in higher education and as a part of effective continuing education practices in multiple professions (Kiessling, Lewitt, & Henriksson, 2011; Smits, Verbeek, & de Buissonje, 2002).

A case example, written as a composite of the stories told by participants in this study, can be found in Appendix C. Seven training module concepts are described below. Each module, designed to be brief enough to be included as a part of an existing class or during a team meeting, could use this case example, or examples provided by trainees, as launching point for the areas of discussion listed below. In the context of social work education, these modules would be appropriate for use in either a Human Behavior in the Social Environment course or in a generalist or clinical practice class. Each module includes a listing of themes and subthemes from this study that pertain to the specific topic. The discussion topics are planned to allow trainees to delve into some of the key issues brought to light by this study.

Module 1. The first module of this training program is designed to set the stage for the educational tasks that follow in the next six modules. During this session, supervisors, educators, or trainers should provide core content to students that will

provide them with a framework for the case-based critical thinking and problem-solving work yet to come. It is expected that unlike the future sessions, this module will be primarily lecture-based in nature. Educators should focus the content of their lecture on helping students understand the differences between shame, blame and responsibility, along with the biopsychosocial model of causality.

Module 2. Module 2 focuses on issues of guilt and blame during the assessment process. In an agency setting, clinicians should be asked to analyze their own assessment procedures for ways in which the process may be sending a message of blame towards parents. Therapists should consider different ways of asking questions that may alleviate parents' feelings of guilt or blame. Participants should struggle with different ways of establishing the beginnings of an open line of communication between themselves and parents, while still attending to an adolescent's right to, and desire for, a level of privacy in the therapeutic relationship. This module is designed to encourage learners to incorporate content from the following subthemes reported in this study: shame has a negative impact on the parent-clinician relationship; feeling blame from every direction; and anticipate issues of blame and guilt.

Module 3. Module 3 emphasizes parents' experiences of being blamed prior to seeking services from their current provider. Trainees should identify the different sources of blame that are highlighted in the case example. This should serve as a springboard to discussing their experiences of parents coming into services having been blamed by others or expecting to be blamed by therapists. Supervisors should support a discussion of ways to use parents' previous experiences of being blamed in a productive manner through the therapeutic process. This module is designed to encourage learners to

incorporate content from the subtheme feeling blame from every direction into their case-based group processing.

Module 4. Module 4 focuses of the benefits and challenges present when working with divorced parents or other alternative family structures. Discussion should highlight strategies for engaging with parents who did not initially seek services, working with effectively with parents who are blaming each other, and ways to ensure that all parties have a voice in the treatment process and that children are able to benefit from the support from as many adults as possible. Supervisors should be sure to include information about state laws and agency policies that inform practice with non-custodial parents. This module is designed to encourage learners to incorporate content from the following subthemes reported in this study: blaming other parents, blaming the divorce, exclusion of parents from the treatment process, and power of including parents in decision making and treatment.

Module 5. Module 5 focuses on the relationship between blame and guilt. This discussion should investigate the ways that guilt and blame seem to be intertwined and the possibility that some parents may blame others as a way to protect themselves against their own sense of guilt. The conversation may piggyback off of the previous module's discussion of parents blaming each other and will include content from the following subthemes: guilt and shame felt by parents shaped the therapeutic process, feeling blame from every direction, blaming others, and anticipate issues of blame and guilt.

Module 6. Module 6 focuses on the ways in which clinicians can foster a shared learning environment in which they can effectively educate parents about the treatment process and likewise, parents can teach therapists and share their own experiences. As it

seems that many newer therapists are at times not aware of levels of care available outside of their own agency, supervisors may need to spend time educating therapists about other treatment options and discussing the ways in which insurance companies and other funders can shape the services that are delivered. Supervisors are encouraged to highlight the education process for parents as an intervention aimed to empower families and to combat blaming systems. Family-centered care models of treatment (Johnson, 2000) may help frame the conversation. Conversations should be informed by content related to the subthemes clarifying the process, preparing families for what to expect, and discussing financial realities.

Module 7. This module is designed to focus on ways in which mental health practitioners subtly blame parents. It is intentionally placed at the end of the series as it is recognized that this may be a difficult topic for some clinicians to tackle and that the previous conversations may serve as a “warm up” for this discussion. Clinicians are asked to consider the ways that they blame parents for their children’s problems. Discussions should focus on therapists’ understandings of why adolescents develop mental health and substance abuse issues and how those perspectives play out in the treatment process. There should be an assumption that most therapists blame parents at times and facilitators should attempt to push the conversation past a point where clinicians claim that they have not, at times, caused parents to feel guilty or blamed. Therapists should discuss ways in which they can shape their interventions so that they are able to work effectively with families, even in situations in which they assign responsibility to parents for their child’s problems. Content from the subthemes feeling

blame from every direction, blame, or lack thereof, from therapists, and blame from psychiatrists, should be included in case-based discussions.

Implications for Future Research

There are several implications for future research that emerge from this study. First, as this study investigated the experience of parents and clinicians, it is clear that additional research is needed to highlight the voice of adolescents and their perceptions of guilt and blame as it relates to their own services. In particular, this study reflected a finding present in a previous study that suggests that children with mental health or substance abuse challenges may blame their parents for their problems (Usher, Jackson, & O'Brien, 2007). Therefore, a qualitative inquiry seeking to answer the question *how do adolescents with mental health or substance abuse problems describe the causes of their challenges?* is suggested.

Secondly, the responses of parents and clinicians in this study around guilt, specifically, were very scattershot. As mentioned in Chapter One, the scholarly literature often uses the concepts of shame and guilt interchangeably, though some argue that they are indeed distinct emotions (Barrett, 1995). In this study, the investigator noted that participants used the word guilt when referring to a wide variety of emotional and cognitive dynamics. Therefore, it may be beneficial to conduct a factor analysis further investigating the construct of guilt. A possible research question for this suggested study is *what are the overlapping and discrete factors that are present in the related emotions of guilt, shame, and blame?*

Thirdly, in analyzing the transcripts of the participant interviews, Dr. Huffstutter, the peer reviewer for this study, suggested while interviews with parents were relatively

easy to follow, the verbatim transcripts of interviews with clinicians were more difficult to understand. Following further discussion between Dr. Huffstutter and this investigator, it was agreed that there was a fair amount of nonverbal communication occurring between the interviewer and clinician participants. Therefore, research to further investigate patterns of communication styles amongst clinicians may be indicated. It is suggested that a study be conducted that aims to measure the variability of participants' understanding of a conversation between two therapists based on their assignment to one of three conditions: reading a transcript of a conversation, hearing an audio recording of the same encounter, or watching a video of that discussion.

Finally, given the surprising theme that emerged regarding parents blaming each other for their child's struggles, along with reports from parents that they felt excluded from their child's treatment process while simultaneously believing that their child's other parent was able to be more involved, research regarding family services for divorced parents is warranted. A survey designed to capture the extent to which clinicians currently work to involve both parents in the treatment of children and adolescents, along with therapist perceptions of barriers to such engagement, is suggested.

References

- Alexander, L. B. & Morrisson-Dore, M. (1999). Making the *parents as partners* principle a reality: The role of the alliance. *Journal of Child and Family Studies*, 8, 255–270.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Anastasi, A. (1958). Heredity, environment, and the question ‘how?’. *Psychological Review*, 65, 197-208.
- Andersen, S. L. & Teicher, M. H. (2008). Stress, sensitive periods and maturational events in adolescent depression. *Trends in Neurosciences*, 31(4), 183-191. doi: 10.1016/j.tins.2008.01.004
- Asarnow, J. R., Tompson, M., Hamilton, E. B., Goldstein, M. J. & Guthrie, D. (1994). Family-expressed emotion, childhood-onset depression, and childhood-onset schizophrenia spectrum disorders: Is expressed emotion a nonspecific correlate of child psychopathology or a specific risk factor for depression? *Journal of Abnormal Child Psychology*, 22, 129-146.
- Awad, A. G. & Voruganti, L. N. (2008). The burden of schizophrenia on caregivers: A review. *Pharmacoeconomics*, 26, 149-162.
- Barrett, K. C. (1995). A functionalist approach to shame and guilt. In J. P. Tangney & K. W. Fischer (Eds.). *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 25-63). New York: The Guilford Press.
- Barrows, H. S. (1986). A taxonomy of problem-based learning methods. *Medical Education*, 20, 481-486.

- Beebe, L. A., Vesely, S. K., Oman, R. F., Tolma, E., Aspy, C. & Rodine, S. (2008). Protective assets for non-use of alcohol, tobacco and other drugs among urban American Indian youth in Oklahoma. *Maternal and Child Health Journal, 12*, S82-S90. doi: 10.1007/s10995-008-0325-5
- Ben Amor, L., Grizenko, N., Schwartz, G., Lageix, P., Baron, C., Ter-Stephanian, M., Zappitelli, M., Mbekou, V. & Joobor, R. (2005). Perinatal complications in children with attention-deficit hyperactivity disorder and their unaffected siblings. *Journal of Psychiatry and Neuroscience, 30*, 120-126.
- Bettelheim, B. (1967). *The empty fortress: Infantile autism and the birth of the self*. Oxford, England: Free Press of Glencoe.
- Beyers, J. M., Toumbourou, J. W., Catalano, R., Arthur, M. W. & Hawkins, J. D. (2004). A cross-national comparison of risk and protective factors for adolescent substance use: The United States and Australia. *Journal of Adolescent Health, 35*, 3-16.
- Birmaher, B., Ryan, N. D., Williamson, D.E., Brent, D.A., Kaufman, J., Dahl, R.E., Perel, J.M. & Nelson, B. (1996). Childhood and adolescent depression: A review of the past 10 years. Part I. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1427–1439.
- Birzniece, V., Backstrom, T., Johansson, I. M., Linblad, C., Lundgren, P., Lofgren, M., Olsson, T., Ragagnin, G., Taube, M., Turkmen, S., Wahlstrom, G., Wang, M. D., Wihlback, A. C., Zhu, D. (2006). Neuroactive steroid effects on cognitive functions with a focus on the serotonin and GABA systems. *Brain Research Reviews, 51*, 212-239.

- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, CA: Prentice Hall.
- Boyle, M. H., Offord, D. R., Racine, Y. A., Szatmari P., Fleming, J. E. & Links, P. S. (1992). Predicting substance use in late adolescence: Results from the Ontario child health study follow-up. *American Journal of Psychiatry*, 149, 761-767.
- Brewin, C. & Antaki, C. (1987). An analysis of ordinary explanations in clinical attribution research. *Journal of Social and Clinical Psychology*, 5, 78-98.
- Brook, J.S., Brook, D.W., Arencibia-Mireles, O., Richter, L. & Whiteman, M. (2001). Risk factors for adolescent marijuana use across cultures and across time. *Journal of Genetic Psychology*, 162(3), 357-374.
- Brown, G. W., Birley, J. L. & Wing, J. K. (1972). Influence of family life on the course of schizophrenic disorders: A replication. *British Journal of Psychiatry*, 121, 241-258.
- Brown, R. A., Lewinsohn, P. M., Seeley, J. R. & Wagner, E. F. (1996). Cigarette smoking, major depression, and other psychiatric disorders among adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1602–1610.
- Burns, B. J., & Goldman, S. K. (Eds.). (1999). *Systems of care: Promising practices in children's mental health, 1998 series: Volume IV. Promising practices in wraparound for children with severe emotional disorders and their families*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
- Burrell, G. & Morgan, G. (1978). *Sociological paradigms and organisational analysis*.

- Burlington, VT: Ashgate.
- Buss, A. (1980). *Self-consciousness and social anxiety*. San Francisco: W. H. Freeman.
- Caspi, A., Sugden, K., Moffitt, T., Taylor, A., Harrington, H., McClay, J., Mill, J., Martin, J., Braithwaite, A., & Poulton, R. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, *301*, 386–389.
- Center for Mental Health Services (2001). *Mental health care for youth: A national assessment, annual/final progress report*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Cohen, P., Chen, H., Crawford, T. N., Brook, J. S. & Gordon, K. (2007). Personality disorders in early adolescence and the development of later substance use disorders in the general population. *Drug and Alcohol Dependence*, *88*, S71–S84.
- Cornelius, J. R., Kirisci, L., Reynolds, M., Clark, D. B., Hayes, J., & Tarter, R. (2010). PTSD contributes to teen and young adult cannabis use disorders. *Addictive Behaviors*, *35*(2), 91-94. doi: 10.1016/j.addbeh.2009.09.007
- Costello E. J., Sung M., Worthman C. & Angold, A. (2007). Pubertal maturation and the development of alcohol use and abuse. *Drug and Alcohol Dependence*, *88*, S50–S59.
- Creswell, J. D. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. (2nd ed.). Thousand Oaks, CA: Sage.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications.
- Dick, D. M., (2007). Identification of genes influencing a spectrum of externalizing

- psychopathology. *Current Directions in Psychological Science*, 16, 331-335.
- Dierker, L. C., Vesel, F., Sledjeski, E. M., Costello, D. & Perrine, N. (2007). Testing the dual pathway hypothesis to substance use in adolescence and young adulthood. *Drug and Alcohol Dependence*, 87, 83–93.
- Drabick, D. A. G., Gadow, K. D. & Sprafkin. (2006). Co-occurrence of conduct disorder and depression in a clinic-based sample of boys with ADHD. *Journal of Child Psychology and Psychiatry*, 47, 766-774.
- Edenberg, H. J. (2007). The genetics of alcohol metabolism: Role of alcohol dehydrogenase and aldehyde dehydrogenase variants. *Alcohol Research and Health*, 30, 5-13.
- Edenberg, H. J., Dick, D. M., Xuei, X., Tian, H., Almsy, L., Bauer, L. O., Crowe, R. R., Goate, A., Hesselbrock, V., Jones, K., Kwon, J., Li, T. K., Nurnberger, J. I., O'Connor, S. J., Reich, T. Rice, J., Schuckit, M. A., Porjesz, B. Foroud, T. & Begleiter, H. (2004). Variations in GABRA2, encoding the alpha 2 subunit of the GABA(A) receptor, are associated with alcohol dependence and with brain oscillations. *American Journal of Human Genetics*, 74, 705-714.
- Edwards, A. C., Svikis, D. S., Pickens, R. W. & Dick, D. M. (2009). Genetic influences on addiction. *Primary Psychiatry*, 16(8), 40-46.
- Enoch, M. A., Hodgkinson, C. A., Yuan, Q, Albaugh, B., Virkkunen, M. & Goldman, D. (2009). GABRG1 and GABRA2 as independent predictors for alcoholism in two populations.
- Erhmin, J. (2001). Unresolved feelings of guilt and shame in the maternal role with substance-dependent African American women. *IMAGE: Journal of Nursing*

- Scholarship*, 33, 47-52.
- Faraone, S. V., Biederman, J., Weber, W., & Russell, R. L. (1998). Psychiatric, neuropsychological, and psychosocial features of *DSM-IV* subtypes of attention-deficit/hyperactivity disorder: Results from a clinically referred sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 185-193.
- Feinstein, N. R., Fielding, K., Udvari-Solner, A., & Joshi, S. V. (2009). The supporting alliance in child and adolescent treatment: Enhancing collaboration among therapists, parents, and teachers. *American Journal of Psychotherapy*, 63(4), 319-344.
- Fergusson, D. M., Horwood, L. J. & Ridder, E. M. (2007). Conduct and attentional problems in childhood and adolescence and later substance use, abuse and dependence: Results of a 25-year longitudinal study. *Drug and Alcohol Dependence*, 88, S14–
- Fernandez, M. C. & Arcia, E. (2004). Disruptive behaviors and maternal responsibility: A complex portrait of stigma, self-blame and other reactions. *Hispanic Journal of Behavioral Sciences*, 26, 356-372. doi: 10.1177/0739986304267208
- Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L. & Ozechowski, T. J. (2008). Ethnic background, therapeutic alliance and treatment orientation in functional family therapy with adolescents who abuse substances. *Journal of Family Psychology*, 22, 167-170. doi: 10.1037/0893-3200.22.1.167
- Furlong, M. & Young, J. (1996). Talking about blame. *Australian and New Zealand Journal of Family Therapy*, 17, 191-200.
- Garland, A. F., Haine-Schlagel, R., Accurso, E. C., Baker-Ericzen, M. J. & Brookman-

- Frazel, L. (2012). Exploring the effect of therapists' treatment practice on client attendance in community-based care for children. *Psychological Services, 9*, 74-88. doi: 10.1037/a0027098
- Gilvary, E. (2000). Substance abuse in young people. *Journal of Child Psychology and Psychiatry, 41*(1), 55-80.
- Glowinski, A. L., Madden, P. A., Bucholz, K. K., Lynskey, M.T, Heath, A.C. (2003). Genetic epidemiology of self-reported lifetime DSM-IV major depressive disorder in a population-based twin sample of female adolescents. *Journal of Child Psychology, Psychiatry, and Allied Disciplines, 44*, 988–996.
- Griesler, P. C., Hu M. C., Schaffran C. & Kandel D. B. (2008). Comorbidity of psychiatric disorders and nicotine dependence among adolescents: Findings from a prospective, longitudinal study. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1340–1350.
- Guxens, M., Nebot M. & Ariza C. (2007). Age and sex differences in factors associated with the onset of cannabis use: A cohort study. *Drug and Alcohol Dependence, 88*, 234-243.
- Hansen, D. L., & Hansen, E. H. (2006). Caught in a balancing act: Parents' dilemmas regarding their ADHD child's treatment with stimulant medication. *Qualitative Health Research, 16*, 1267–1285.
- Harden, J. (2005). “Uncharted waters”: The experience of parents of young people with mental health problems. *Qualitative Health Research, 15*, 207-223. doi: 10.1177/1049732304697
- Hawley. K. M. & Weisz, J. R. (2005). Youth versus parent working alliance in usual

- clinical care: distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology*, 34(1), 117-128.
- Heider, F. (1958). *The psychology of interpersonal relations*. New York: John Wiley & Sons.
- Herbert, J. D., Sharp, I. R. & Gaudiano, B. A. (2002). Separating fact from fiction in the etiology and treatment of autism: A scientific review of the evidence. *The Scientific Review of Mental Health Practice: Objective Investigations of Controversial and Unorthodox Claims in Clinical Psychology, Psychiatry and Social Work*, 6(1), 23-43.
- Hornstein, G. A. (2000). *To redeem one person is to redeem the world: The life of Frieda Fromm-Reichmann*. New York: Free Press.
- Horvath, A., & Greenberg, L. (1994). Introduction. In A. Horvath & L. Greenberg (Eds.), *The working alliance: theory, research, and practice* (pp. 3-12). New York: John Wiley and Sons.
- Horvath, A., & Symonds, B. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counseling Psychology*, 38, 139-149.
- Huffine, C. & Anderson, D. (2003). Family advocacy development in systems of care. In A. J. Pumariega & N. C. Winters (Eds.) *The handbook of child and adolescent systems of care* (pp. 35-65). San Francisco: Jossey-Bass.
- Hunter, R. W. & Friesen, B. J. (1996). Family-centered services for children with emotional, behavioral, and mental disorders. In C. A. Heflinger & C. T. Nixon (Eds.). *Families and the mental health system for children and adolescents* (pp. 18-40). Thousand Oaks, CA: Sage.

- Jackson, D. & Mannix, J. (2003). Then suddenly he went right off the rails: Mothers' stories of adolescent cannabis use. *Contemporary Nurse, 14*, 169-179.
- Johnson, A. M. & Szurek, S. A. (1952). The genesis of anti-social acting out in children and adults. *The Psychoanalytic Quarterly, 21*, 323-343.
- Johnson, B. J. (2000). Family-centered care: Four decades of progress. *Families, Systems and Health, 18*, 137-156.
- Jones, W. H., Kugler, K. & Adams, P. (1995). You always hurt the one you love: Guilt and transgressions against relationship partners. In J. P. Tangney & K. W. Fischer (Eds.). *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 301-321). New York: The Guilford Press.
- Kalat, J. W. (2010). *Introduction to psychology* (9th ed.). Belmont, CA: Cengage Learning.
- Kanner, L. (1946). Irrelevant and metaphorical language in early infantile autism. *The American Journal of Psychiatry, 103*, 242-246.
- Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*(3), 453-463.
- Kazdin, A. E., Whitley, M. & Marciano, P. L. (2006). Child-therapist and parent-therapist alliance and therapeutic change in the treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Child Psychology and Psychiatry, 47*, 436-445. doi: 10.1111/j.1469-7610.2005.01475.x
- Keeley, M. L., Geffken, G. R., Ricketts, E., McNamara, J. P. & Storch, E. A. (2011). The therapeutic alliance in the cognitive behavioral treatment of pediatric

- obsessive-compulsive disorder. *Journal of Anxiety Disorders*, 25, 855-863. doi: 10.1016/j.janxdis.2011.03.017
- Kendler, K. S., Prescott, C. A., Myers, J. & Neale, M. C. (2003). The structure of genetic and environmental risk factors for common psychiatric and substance use disorders in men and women. *Archives of General Psychiatry*, 60, 929-937.
- Kiessling, A., Lewitt, M., & Henriksson, P. (2011). Case-based training of evidence-based clinical practice in primary care and decreased mortality in patients with coronary heart disease. *Annals of Family Medicine*, 9, 211-218. doi: 10.1370/afm.1248
- King, S. M., Iacono, W. G. & McGue, M. (2004). Childhood externalizing and internalizing psychopathology in the prediction of early substance use. *Addiction*, 99, 1548–1559.
- Klasen, H. (2000). A name, what's in a name? The medicalization of hyperactivity, revisited. *Harvard Review of Psychiatry*, 7, 334–344.
- Kuehl, B. P., Newfield, N. A., & Joanning, H. (1990). A client-based description of family therapy. *Journal of Family Psychology*, 92, 310-321.
- Lerner, M. D., Mikami, A. Y., & McLeod, B.D. (2011). The alliance in a friendship coaching intervention for parents of children with ADHD. *Behavior Therapy*, 42, 449-461. doi: 10.1016/j.beth.2010.11.006
- Liddle, H. A. (2004). Family-based therapies for adolescent alcohol and drug use: Research contributions and future research needs. *Society for the Study of Addiction*, 99(2), 76-92.
- Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. New York: Sage.

- Litt, J. (2004). Women's carework in low-income households: The special case of children with attention deficit hyperactivity disorder. *Gender & Society, 18*, 625–644.
- Lonczak, H. S., Fernandez, A., Austin, L. (2007). Family structure and substance use among American Indian youth: A preliminary study. *Families, Systems & Health, 25* 10-22.
- Lopez, K. A. & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14*, 726-735.
- Lord, R. G. & Smith, J. E. (1983). Theoretical, information processing, and situational factors affecting attribution theory models of organizational behavior. *Academy of Management Review, 8*, 50-60.
- Lubman, D. I., Allen, N. B., Rogers, N., Cementon, E. & Bonomo, Y. (2007). The impact of co-occurring mood and anxiety disorders among substance-abusing youth. *Journal of Affective Disorders, 103*, 105-112. doi: 10.1016/j.jad.2007.01.011
- Mak, W. W. S. & Kwok, Y. T. Y. (2010). Internalization of stigma for parents of children with autism spectrum disorder in Hong Kong. *Social Science & Medicine, 70*, 2045-2051. doi: 10.1016/j.socscimed.2010.02.023
- Mason, R. A., Watts, E. L. & Hewison, J. (1995). Parental expectations of a child and adolescent psychiatric out-patient service. *Association of Child Psychology and Psychiatry Review and Newsletter, 17*, 313-332.
- McNeil, S. (2013). Understanding family-centered care in the mental health system:

- Perspectives from family members caring for relatives with mental health issues. *Social Work in Mental Health*, 11, 55-74. doi: 10.1080/15332985.2012.720662
- Meiser, B., Mitchell, P. B., McGirr, H., Van Herten, M., & Schofield, P. R. (2005). Implications of genetic risk information in families with a high density of bipolar disorder: An exploratory study. *Social Science & Medicine*, 60(1), 109–118.
- Miller, W. R. & Rollnick, S. (2013). *Motivational interviewing: Helping People Change*, 3rd ed. New York: The Guilford Press.
- Mordricin, M. J. & Robinson, J. (1991). Parents of children with emotional disorders: Issues for consideration and practice. *Community Mental Health Journal*, 27, 281-292.
- Morrison, J. R. & Stewart, M. A. (1971). A family study of the hyperactive child syndrome. *Biological Psychiatry*, 3(3), 189-195.
- Morse, J. (1995). The significance of saturation. *Qualitative Health Research*, 5, 147-149.
- Moses, T. (2010). Exploring parent's self-blame in relation to adolescents' mental disorders. *Family Relations*, 59, 103-120. doi: 10.1111/j.1741-3729.2010.00589.x
- Moses, T. (2011). Parents' conceptualization of adolescents' mental health problems: Who adopts a psychiatric perspective and does it make a difference? *Community Mental Health Journal*, 47, 67-81. doi: 10.1007/s10597-009-9256-x
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.
- Myers, D. G. (1995). *Psychology* (4th ed.). New York: Worth Publishers.
- Myles, J. & Willner, P. (1999). Substance misuse and psychiatric comorbidity in children

- and adolescents. *Curent Opinion in Psychiatry*, 12, 287-290.
- Naidu, T. & Behari, S. (2010). The parent-child-therapist alliance: A case study using a strategic approach. *Journal of Child and Adolescent Mental Health*, 22 41-50.
doi: 10.2989/17280583.2010.493674
- Nathenson, D. (1987). A timetable for shame. In D. L. Nathenson (Ed.), *The many faces of shame* (pp. 1-63). New York: The Guilford Press.
- Nevas, D., & Farber, B. (2001). Parents' attitudes towards their child's therapist and therapy. *Professional Psychology: Research and Practice*, 32, 165-170.
- Padgett, D. K. (1998). *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, CA: Sage.
- Pardini, D., White, H. R. & Stouthamer-Loeber, M. (2007). Early adolescent psychopathology as a predictor of alcohol use disorders by young adulthood. *Drug and Alcohol Dependence*, 88, S38-49.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Patton, G. C., McMorris, B. J., Toumbourou, J.W., Hemphill, S. A., Donath, S., Catalano, R. F. (2004). Puberty and the onset of substance use and abuse. *Pediatrics*, 114, 300-306.
- Peters, K. & Jackson, D. (2008). Mothers' experiences of parenting a child with attention deficit hyperactivity disorder. *Journal of Advanced Nursing*, 65(1), 62-71. doi: 10.1111/j.1365-2648.2008.04853x
- Piers, G. & Singer, M. B. (1971). *Shame and guilt*. New York: Norton.
- President's New Freedom Commission on Mental Health (2003). *Achieving the promise:*

- Transforming mental health care in America*. Rockville, MD.
- Radwan, G. N., El-Setouhy, M., Mohamed, M. K., Hamid, M. A., Azem, S. A., Kamel, O., Israel, E. & Loffredo, C. A. (2007). DRD2/ANKK1 TaqI polymorphism and smoking behavior of Egyptian male cigarette smokers. *Nicotine and Tobacco Research, 9*, 1325-1329.
- Reimers, S. & Street, E. (1993). Using family therapy in child and adolescent services. In J. Carpenter & A. Treacher (Eds.), *Using family therapy in the 90s* (pp. 32-56). Oxford, UK: Blackwell.
- Riebschleger, J. (2002). Community mental health professionals' theoretical assumptions about families: Responses to a practice simulation vignette. *Psychiatric Rehabilitation Journal, 26*, 91-96.
- Robbins, M., Turner, C., Alexander, J., & Perez, G. (2003). Alliance and dropout in family therapy for adolescents with behavior problems: Individual and systemic effects. *Journal of Family Psychology, 17*, 534-544.
- Roser, K. (1996). A review of psychoanalytic theory and treatment of childhood autism. *Psychoanalytic Review, 83*(3), 325-341.
- Schore, A. N. (1991). Early superego development: The emergence of shame and narcissistic affect regulation in the practicing period. *Psychoanalysis and Contemporary Thought, 14*, 187-250.
- Seeman, M .V. (2009). The changing role of mother of the mentally ill: From schizophrenogenic mother to multigenerational caregiver. *Psychiatry: Interpersonal & Biological Processes, 72*, 284-294.
- Seipp, C. M., & Johnston, C. (2005). Mother–son interactions in families of boys with

- attention-deficit/hyperactivity disorder with and without oppositional behavior. *Journal of Abnormal Child Psychology*, 33(1), 87–98.
- Sheridan, M., Peterson, B. D., & Rosen, K. H. (2010). The experiences of parents of adolescents in family therapy: A qualitative investigation. *Journal of Marital and Family Therapy*, 36(2), 144-157. doi: 10.1111/j.1752-0606.2010.00193.x
- Silberg J., Rutter M., D'Onofrio B., & Eaves L. (2003). Genetic and environmental risk factors in adolescent substance use. *Journal of Child Psychology and Psychiatry*, 44, 664–76.
- Singh, I. (2004). Doing their jobs: Mothering with Ritalin in a culture of mother-blame. *Social Science & Medicine*, 59, 1193–1205.
- Smits, P. B. A., Verbeek, J. H. A. M., & de Buissonje, C. D. (2002). Problem based learning in continuing medical education: A review of controlled evaluation studies. *BMJ*, 324, 153-156.
- Spooner, C. & Hall, W. (2002). Preventing drug misuse by young people: We need to do more than ‘just say no’. *Addiction*, 97(5), 478-483.
- Thistlethwaite, J. E., Davies, D., Ekeocha, S., Kidd, J. M., MacDougall, C., Matthews, P., Purkis, J. & Clay, D. (2012). The effectiveness of case-based learning in health professional education: A BEME systematic review. *Medical Teacher*, 34, E421-E444.
- Thapar, A., O'Donovan, M. & Owen, M. J. (2005). The genetics of attention deficit hyperactivity disorder. *Human Molecular Genetics*, 14, R275-R282.
- U.S. Department of Labor, Bureau of Labor Statistics. (2010). *Occupational outlook handbook: 2010-11*. Retrieved from <http://www.bls.gov/oco/ocos060.htm>

- Usher, K., Jackson, J., & O'Brien, L. (2007). Shattered dreams: Parental experiences of adolescent substance abuse. *International Journal of Mental Health Nursing, 16*, 422-430. doi: 10.1111/j.1447-0349.2007.00497.x
- Vaughn, C. E. & Leff, J. P. (1976). The measurement of expressed emotion in the families of psychiatric patients. *British Journal of Social and Clinical Psychology, 15*, 157-165.
- Wadley, V. G. & Haley, W. E. (2001). Diagnostic attributions versus labeling: Impact of Alzheimer's Disease and major depression diagnoses on emotions, beliefs, and helping intentions of family members. *The Journals of Gerontology, 56B(4)*, 244-248.
- Walls, M. L., Whitbeck, L. B., Hoyt, D. R. & Johnson, K. D. (2007). Early-onset alcohol use among Native American youth: Examining female caretaker influence. *Journal of Marriage and Family, 69*, 451-464. doi: 10.1111/j.1741-3737.2007.00376.x
- Weiner, B. (1986). *An attribution theory of motivation and emotion*. New York: Springer-Verlag.
- Weiner, B. (1995). *Judgments of responsibility*. New York: The Guilford Press.
- Weiner, B., Frieze, I., Kukla, A., Reed, L., Rest, S., & Rosenbaum, R. M. (1971). *Perceiving the causes of success and failure*. Morristown, N. J.: General Learning Press.
- White, H. R., Xie, M., Thompson, W., Loeber, R. & Stouthamer-Loeber, M. (2001). Psychopathology as a predictor of adolescent drug use trajectories. *Psychology of Addictive Behaviors, 15*, 210-218. doi: 10.1037/0893-164X.15.3.210

- Williams, J. (2006). How social myths about childhood, motherhood and medicine affect the detection of subtle developmental problems in young children. *Contemporary Nurse*, 23(2), 274–287.
- Wittchen, H. U., Fröhlich, C., Behrendt, S., Günther, A., Rehm, J., Zimmermann, P., Lieb, R. & Perkonig, A. (2007). Cannabis use and cannabis use disorders and their relationship to mental disorders: A 10-year prospective-longitudinal community study in adolescents. *Drug and Alcohol Dependence*, 88, S60–S70.
- Wolpert, M. (2000). Is anyone to blame? Whom families and their therapists blame for the presenting problem. *Clinical Child Psychology and Psychiatry*, 5(1), 115-131.
doi: 10.1177/1359104500005001012
- Xu, K., Lichtermann, D., Lipsky, R. H., Franke, P., Liu, X., Hu, Y, Cao, L., Schwab, S. G., Widenauer, D. B., Bau, C. H. Ferro, E., Astor, W., Finch, T., Terry, J., Taubman, J., Maier, W., Goldman, D. (2004). Association of specific haplotypes of D2 dopamine receptor gene with vulnerability to heroin dependence in 2 distinct populations. *Archives of General Psychiatry*, 6, 597-606.
- Yanagawa, M. (1973). On the etiology of stuttering and personality tendencies of mothers and children. *Japanese Journal of Child Psychiatry*, 15, 22-28.
- Yang, B. Z., Kranzler, H. R., Zhao, H., Gruen, J. R., Luo, Z, Gelernter, J. (2008). Haplotypic variants in DRD2, ANKK1, TTC12, and NCAM1 are associated with comorbid alcohol and drug dependence. *Alcoholism, Clinical and Experimental Research*, 32, 2117-2127.
- Zalsman, G., Brent, D. A. & Weersing, V. R. (2006). Depressive disorders in childhood and adolescence: An overview of epidemiology, clinical manifestation and risk

factors. *Child and Adolescent Psychiatric Clinics of North America*, 15, 827–841.

APPENDIX A

Interview Protocol – Parents

1. As we get started today, could you tell me the story of your experiences related to mental health or substance abuse services for your child?

[Prompts: knowing there was a problem, seeking services, experiences once in the system]

2. Could you talk a little about what you think are the main reasons that your child has experienced mental health and substance abuse challenges?

[Prompts: genetic factors, family experiences, parenting behaviors, internal (to child, self, family), external (to child, self, family)]

3. It seems that over time, some parents experience a sense of guilt for the problems their children face, regardless of their understanding of the causes of those problems.

a. Has this been true for you?

b. Could you say more about this?

[Prompts: genetic factors, family structure, parenting behaviors, “bad parent” – i.e. shame]

4. Some parents report feeling blamed for their child’s problems by the professionals they work with.

a. Has this ever been true for you?

b. Could you say more about this?

c. Are there any ways in which your child’s therapist has exonerated you or “let you off the hook” for something you’d been feeling guilty about?

[Prompts: normalizing, focusing on parenting strengths, discussing biological factors]

5. [Ask if relevant] What effect, if any, do you think these feelings of guilt, blame, or

responsibility have had on you?

[Prompts: relationship with your child's clinician, negative impact, positive impact]

6. I'm interested in ways in which parents and clinicians can work together to move past issues of blame and guilt in order to have a good working relationship. I would like you to consider a specific time when an issue of guilt or blame came up, or could have come up, while you were working with a professional.

[Prompts: blame and guilt can be something you felt, something that was discussed, or an experience you heard about from someone else]

- a. As a parent, what are the things you have done, or could do, to address the issue of blame and guilt?
 - b. What is the most important thing that professionals have done, or could do, that you believe really can help you have a positive working relationship?
 - c. What is one thing you wish your clinicians had done differently?
 - d. Tell me about any changes that have occurred over time in your relationship with your child's clinician. What do you think accounted for those changes?
7. What advice would you give for ways that parents and clinicians can form successful working relationships?
8. Do you have any last thoughts or comments before we wrap up?

APPENDIX B

Interview Protocol – Clinicians

1. To get started, could you talk about the main causes for mental health and substance abuse problems in the adolescents with whom you work? How do adolescents come to have these issues?

[Prompts: genetic factors, family experiences, parenting behaviors, internal (to child, parent, family), External (to child, parent, family)]

2. It appears that some parents experience feelings of guilt around their child's struggles with mental health and substance abuse issues. Could you give some examples of parents who have shared their feelings of guilt regarding their children. Did they let you know the source of that guilt?

[Prompts: genetic factors, family structure, parenting behaviors, "Bad parent" - i.e. shame]

3. Some parents report feeling blamed by the professionals – teachers, doctors, therapists – that they work with when seeking help for their child with either mental health or substance abuse problems. Could you tell me about an experience where the parent of one of your clients may have felt blamed by you, or another professional?

4. Think of a parent you have worked with who may have experienced feelings of guilt, blame, or responsibility with regards to their child's challenges with mental health or substance abuse. What effect, if any, do you think those feelings may have had on the parent?

[Prompts: parent clinician relationship, positive impact, negative impact]

5. I'm interested in ways that parents and clinicians can work together to move past issues of blame and guilt in order to have a productive working relationship. What do you think is the most important thing you have done in your work with parents that has

helped you overcome some of these barriers?

- a. How have the parents you've worked with contributed to moving past these issues?
- b. Are there ways that you think you might have stymied progress towards a successful alliance with parents?
- c. Think of a memorable case you've had where your relationship with a parent changed over the course of the time you worked with them. What do you think accounted for those changes?

[Prompts: relationship improved, relationship deteriorated]

6. What advice do you have about ways that parents and clinicians can work together to form successful working relationships?
7. Do you have any last thoughts or comments before we wrap up?

APPENDIX C

Case Example for Training Modules

Christopher is a 15-year-old boy referred for outpatient mental health services with you by his mother, Melissa. Melissa called the intake line at your agency and reported, “Christopher’s principal said he needs a therapist before he is allowed to come back to school”. She further indicated that Christopher had been suspended after an incident in which he flipped over a desk in his classroom before storming out of the building.

During your initial session, you met with Christopher and Melissa separately. Christopher stated that he did not think he needed to see you and that he had seen lots of counselors at school in the past, but nothing seemed to change. He said he gets angry five or six days a week and has gotten in trouble for punching a hole in the wall at home and getting in fights at school. One time, his mom called the police after he broke the screen on their computer. Christopher reported that he smokes pot most days of the week to help him calm down. He states that his mom has a medical marijuana card, so he is able to get most of his supply from her stash if he doesn’t want to smoke with his friends. Christopher reports that he drinks a couple of times a month, but only at parties with his friends.

When it was time for you to meet with Melissa, she was not in the waiting room. You found her on the phone in the parking lot and asked her to join you in your office. Ten minutes later, Melissa came in and said that she had been on the phone with her boss, who was frustrated that she had to miss work today. Melissa recounted the story of getting the most recent call from the school telling her that Christopher had been suspended. She said that the principal asked her what was going on at home, as Christopher had been acting up more frequently. She indicated that when she called the

police after Christopher broke the computer, the officer who responded just told her that she needed to get him under control. You tried to gather more information about this incident in order to assess safety risks due to Christopher's angry outbursts, but Melissa said she did not have time to go into it all today, picked up her things, and left your office.

After Christopher and Melissa went home, you had a chance to review the paperwork that Melissa filled out in the waiting room. On it, you notice that Melissa indicated that Christopher's father, Charles, lives in a neighboring town and that they have joint legal custody, but neither Christopher nor Melissa mentioned him during your session, even after you asked about other family members who may want to be involved in treatment. When you call Melissa to gather more information, Melissa tells you that she does not want Christopher's father involved as she thinks most of Christopher's problems are a result of his Charles' behavior when they divorced.

Vita

Katherine Cohen-Filipic was born on October 10, 1978 in Columbus, Ohio. She earned a Bachelor of Arts in Psychology from Earlham College in 2001 and her Master of Social Work from Virginia Commonwealth University (VCU) in 2004. Prior to returning to VCU to begin her Ph.D., Ms. Cohen-Filipic worked as a community-based mental health therapist for children and families and provided substance abuse treatment for court-involved adolescents. While enrolled in the doctoral program, Ms. Cohen-Filipic taught Generalist and Clinical Practice Courses to Master of Social Work students at VCU, worked as a child and family therapist in Richmond, VA, and managed community mental health programs in Portland, OR. She currently resides in Ithaca, NY.