Best Practices in Children's Mental Health

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Report # 16

Therapeutic Alliance with Children and Families

A Review of the National Literature
March, 2006

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Report # 16: Therapeutic Alliance with Children and Families

Review of the National Literature

Executive Summary

For many years the therapeutic alliance has been recognized as an important common factor that impacts treatment outcomes across models of therapy for adults (Drisko, 2004; Orlinsky et al., 2003; Lambert, 1992). While several meta-analytic studies of *adult* psychotherapy have underscored the predictive value of the therapeutic alliance for better outcomes (Lawson, & Brossart, 2003; Martin, Graske, & Davis, 2000; Horvath & Symonds, 1991), empirical evidence for the role of relational factors in treatment of children and adolescents is only beginning to emerge and lags behind adult research (Karver, et al., 2005; Shirk & Karver, 2003). Current evidence suggests a moderate impact of the therapeutic alliance on outcomes for children, youth and families (Hoagwood, 2005; Shirk & Karver, 2003; Weisz et al., 1998). Most consistently, studies show that better alliance ratings from parents and/or youth improve the retention of young clients in treatment. The dearth of more compelling empirical evidence is likely due to the complexity of working with children, youth, and their families, and the limits of current research tools to capture these complexities.

Existing definitions of therapeutic alliance often fail to take into account the unique and complex processes in family therapy, and to date therapeutic alliance with parents and families has received only limited attention in the literature. Most research efforts rely on the "working alliance" model, developed for adult clients, which encompasses three dimensions: emotional bond, collaboration on tasks, and agreement on goals. In the work with youth and families, alliance research is complicated since goals, tasks, and relational attention of the therapist have to extend to multiple parties. In addition, developmental factors, such as varying ages and corresponding cognitive capacities of children, pose challenges to research and practice.

Alliance in the work with children and youth is a multidimensional construct that must encompass parent-therapist alliances, requires information from various sources, and may involve differing dynamics, timelines, and discrepancies in alliance ratings. Parents tend to rate relationship as highly important, but studies show mixed results regarding the actual impact of parent alliance on outcomes (Hoagwood, 2005; Kendall et al.,1996; Motta & Tobin, 1992; Motta & Lynch, 1990). A positive relationship of parents to therapists has shown to increase engagement, retention, satisfaction and parental use of skills learned in

therapy (Hoagwood, 2005; Hawke et al., 2005; Garcia, & Weisz, 2002) while other studies (Hawley & Weisz, 2005; Shelef et al., 2005) found that youth alliance, but not parent alliance, was associated with greater decreases in symptoms.

There is evidence that alliance patterns are different for different family members, and it appears that discrepancies in alliance ratings between youth and parents may reflect important dynamics (Shelef et al., 2005; Hawley et al., 2005; Shirk & Karver, 2003; Quinn et al., 1997; Heatherington et al., 1990). Weak alliance with parents, or discrepancies in parent-therapist and youth-therapist alliance ratings, have been associated with lower retention of children and youth.

It remains unclear how the ***type or severity of clients' problems*** might be a moderator for correlations between outcomes and alliances (Shirk & Karver, 2003; DeVet et al., 2003; Garcia & Weisz, 2002; Green et al., 2001.) There is some evidence that consistently strong alliances are associated with better outcomes for youth with externalizing problems such as conduct disorders or substance abuse (Tetzlaff et al., 2005; Shelef, et al., 2005; Kaufman, et al., 2005; Shirk & Karver, 2003; Green et al, 2001). The formation of a good alliance may also be particularly important for maltreated youth who have a harder time forming initial alliances (Eltz, Shirk, & Sarlin, 1995).

Issues of diversity are rarely addressed in current research but age or developmental level, ethnicity, and gender are all very likely to be associated with differing alliance patterns, and possibly outcome (Faw et al., 2005; McLeod et al., 2005; DeVet et al., 2003; Jackson-Gilfort et al., 2001Diamond et al., 1999; Eltz, Shirk, & Sarlin, 1995).

Better alliances are associated with the following ***therapist behaviors*** (Creed & Kendall, 2005; Ackerman & Hilsenroth, 2003; Diamond et al., 1999; Dozier et al., 1998):

- With children: using collaborative behaviors, expressions such as "we", "let's," getting the child involved in setting goals, not "pushing the child" to address difficult issues, not being overly formal, and providing hope and encouragement.
- With adolescents: attending to adolescent's experience; orienting adolescent to collaborative nature of therapy; formulating meaningful goals; presenting oneself as an ally; challenging control and contingency beliefs; addressing issues of trust, honesty and confidentiality.

- With families and adults: collaborative and supportive “we” behaviors conveying trust in client’s ability to grow, hopefulness, noting progress, acceptance, open mindedness, and enthusiasm; taking a neutral and accepting position toward all family members; asking circular questions or reflexive questions that facilitate clients’ own problem-solving resources; emphasizing that the goal of treatment to improving “family relationships”; exploring parental stressors, challenges, impact on parenting (with parents alone); maintaining a focus on helping youth and family discuss important relational issues.

Therapeutic Alliance with Children and Families

Review of the National Literature

For many years the therapeutic alliance has been recognized as an important common factor that impacts treatment outcomes across models of therapy for adults (Drisko, 2004; Orlinsky et al., 2003; Lambert, 1992). While several meta-analytic studies of *adult* psychotherapy have underscored the predictive value of the therapeutic alliance for better outcomes (Lawson, & Brossart, 2003; Martin, Graske, & Davis, 2000; Horvath & Symonds, 1991), empirical evidence for the role of relational factors in treatment of children and adolescents is only beginning to emerge and lags behind adult research (Karver, et al., 2005; Shirk & Karver, 2003).

Overall, still relatively few studies involving children, adolescents, or families evaluate both the quality of alliance and outcomes (Shirk & Karver, 2003). Current evidence suggests a moderate impact of the therapeutic alliance on outcomes for children, youth and families (Hoagwood, 2005; Shirk & Karver, 2003; Weisz et al., 1998). Unlike the consistently positive findings in adult literature, however, studies on associations of outcome and therapeutic alliance with children have resulted in mixed findings (Weisz et al., 1998; Hoagwood, 2005). More consistently, studies show that alliance ratings from parents and/or youth impact the retention of young clients in treatment (Shelef et al., 2005; Hawke et al. 2005; Hoagwood, 2005; Robbins et al., 2003; Broome et al., 2001). The lack of more compelling empirical evidence to date is likely due to the complexity of relationships in the work with children, youth, and their families, and the limitations of available concepts and research tools (Hoagwood, 2005).

The complexity of therapeutic endeavors with youth complicates the construction of models and measurement tools to evaluate relationships with youth of different ages, their parents or the whole family (Shirk & Karver, 2003). Unlike adults, youth rarely enter into therapy on their own volition which underscores the importance of attending to the therapeutic relationship (Weisz et al., 1998). Subsequently, working with children and adolescents is usually not an "individual" approach. Yet, therapeutic alliances with parents and families have received only limited attention in the literature and existing definitions of alliance have been criticized as not taking into account the unique and complex processes in

family therapy (Karver et al., 2005). The three fundamental ingredients of therapeutic alliance, namely the negotiation of goals, collaboration on tasks, and the relational attention of the worker have to extend to the child's family and/or referring party. Goals of adult caretakers and young clients may differ significantly, and the quality of alliances with the therapist may be different for each family member (Shirk & Karver, 2003; Heatherington et al., 1990). In family therapy, not only alliances between individual family members and the therapist have to be considered, but also subsystem alliances between, for instance, the parents and therapist, as well as the whole family system's alliance with the therapist (Robbins et al., 2003; Heatherington et al., 1990; Pinsoff & Catherall, 1986). Research is further complicated by developmental factors, such as varying ages and corresponding cognitive capacities of children, which require flexibility and ongoing adjustments from therapists and appropriate research tools. With growing conceptual attention to the role of relationship, attempts to empirically capture the relational aspects of therapy with children and adolescents have increased but have not yet resulted in established conceptualizations or instruments (Shirk & Karver, 2003).

The following report summarizes current empirical and conceptual knowledge about the role of the therapeutic alliance in the treatment of children, adolescents and families. The summary is based on a review of more than 100 peer-reviewed articles identified in a search of national databases (PsycInfo, Social Work Abstracts, PubMed). Publications selected for in-depth review included meta-analytical studies, comprehensive reviews, quantitative and qualitative studies that either focused on, or included, measures of therapeutic relationships, and some conceptual articles on the subject. (Fifty-one of these publications are summarized in a Literature Matrix, Appendix A.).

Common Constructs

In the literature a variety of terms are used to describe relational factors in therapy. Unlike adult literature, child and adolescent treatment literature has not yet developed a clear set of constructs, definitions or measures for the relational qualities of therepeutic work (Chu et al., 2004; Shirk & Karver, 2003). Frequently used constructs include therapeutic relationship, therapeutic alliance, working alliance, helping alliance, and engagement.

The terms ***Therapeutic Relationship*** and ***Therapeutic Alliance*** tend to be used interchangeably (as they will in this report). Both terms refer to the client's (and/ or parents') level of participation in treatment as well as the affective bond with the therapist (Karver et al., 2005). The original concept of relationship in therapy has its roots in psychoanalytic traditions that view the relationship as a necessary and sufficient mechanism for change (Shirk & Saiz, 1992). Outside of psychoanalytic or psychodynamic traditions, a positive therapeutic relationship is increasingly recognized as an important, though not itself sufficient, catalyst for enhanced outcomes (Karver et al., 2005; Chu et al., 2004; Kendall & Southam-Gerow, 1996; Shirk & Saiz, 1992).

Alliance constructs used in research on work with children and youth are usually based on adult concepts such as Bordin's (1979) ***Working Alliance***. Typically, alliance encompasses three dimensions: emotional bond, collaboration on tasks, and agreement on goals.

Recently, Karver et al. (2005) suggested that it may be more useful to separate alliance into three separate constructs of emotional connection (including trust, warmth, mutual positive regard, supportiveness, etc.), cognitive connection (including hopefulness, expectations, willingness to participate etc.) and behavioral participation in treatment. Based on their review of the literature, Karver et al. (2005) propose that relational processes might begin with the pretreatment characteristics of therapists and clients that have been little researched but may influence therapists' feelings, reactions and perceptions during initial interactions. Therapists' skills and behaviors, self-disclosures and interpersonal skills during and after initial interactions influence the client's perception of how credible, and persuasive the therapist is, and how autonomous or self-directed a client can be in the relationship. These factors will in turn impact the therapeutic alliance by influencing the level of hopefulness, expectations, willingness to participate, and the level of participation in treatment along with affect toward the therapist.

Replacing the notion of therapy with the more general idea of "helping", the term ***Helping Alliance*** can be found in child welfare literature. Akin to other alliance constructs it encompasses an affective and a collaborative dimension (Morrison-Dore, 1996). Research in the child welfare field is beginning to grant attention to relational factors, but current literature tends to focus on constructs such as collaboration, compliance or client participation (Littell et al., 2001; Littell & Tajima, 2000).

Engagement typically refers to the initial stage of building an alliance (French, 2003), including the process of identification, referral, the rate of clients attending the first session,

and the retention of clients during early phases of treatment (McKay et al., 2004; Santisteban et al. 1996; Coatsworth et al., 2001). Occasionally, it is also used to denote the level of involvement between worker and client (Kroll & Green, 1997; Orrell-Valente et al, 1999). While "engagement" of children and families was not the focus of this review, a brief summary of six relevant studies can be found in Appendix B.

Finally, ***Therapeutic Involvement*** (Hawke et al., 2005) has recently been suggested, but not yet explored, as a construct that combines therapeutic engagement, rapport and working alliance measures.

Research on the Impact of Therapeutic Alliance on Outcomes

Shirk and Karver (2003) conducted the most recent and salient meta-analysis to assess the impact of the therapeutic alliance on client outcomes. The authors reviewed 23, mostly uncontrolled, studies published in the preceding 27 years to determine the predictive value of relationship measures for treatment outcomes with children, adolescents or families. The authors conclude that on average, correlations between relationship and outcomes were modest but consistent, and generally comparable to adult findings, and that the therapeutic relationship is a "reasonably robust and consistent" construct (p. 461) across divergent types of treatment (individual, family, parents; manualized and non-manualized treatments; service vs. research treatments) and developmental levels. The authors also found no significant difference for relationship-to-outcome correlations in non-behavioral versus behavioral approaches.

While these conclusions are promising, the breadth of inclusion criteria and the uncontrolled nature of most studies included in the meta-analysis call for some caution. In fact, in her systematic review of family-based services in children's mental health, Hoagwood (2005) found that there is at this time no strong support for a predictive association between relationship and outcomes because of methodological limitations of the current evidence base. Hoagwood supports the "nature and quality of the therapeutic relationship" as a core process in the involvement of families but points out that there are likely additional other factors active in child and family processes that have not been researched yet.

Methodological factors that have shown to impact the strength of measured outcome-relationship correlations in Shirk and Karver's meta-analysis (2003) include:

1. The time of relationship measurement: In contrast to adult findings, relationship measures taken later rather than earlier in the process led to stronger associations

which raises questions about the relative speed of alliance building with children (Shirk & Karver, 2003).

2. The source of relationship and outcome measure: Stronger associations of outcomes to alliance were found for therapists' alliance ratings. Perhaps in an effort to please adults, children were likely to rate their relationship with therapists invariably high leading to diminished statistical correlations (Shirk & Karver, 2003). Relationship-outcome correlations were also higher when outcomes and relationship measures came from the *same* source rather than from different sources. Only two studies in Shirk and Karver's meta-analysis involved observational ratings of the therapeutic interaction yet this should be considered the "gold standard" (Hazell, 2003). This finding supports the hypothesis that people who are satisfied with the process of therapy may also rate outcomes more highly, thus confounding the two measures (Shirk & Karver, 2003).
3. The type of measured outcome: A mixture of outcome measures was typically reported by more than one source, and tended to focus on symptoms, most often on global functioning measures. Stronger associations were found for global functioning than for specific measures (Shirk & Karver, 2003).

Alliance with Families

Emerging evidence supports the idea that alliance in the work with youth is a multidimensional construct that must encompass the alliance with families. Alliance with families includes parent-therapist alliances, requires information to be gathered from various sources, and may involve differing dynamics, timelines, and discrepancies in alliance ratings (Shelef et al., 2005; Hawley et al., 2005; Shirk & Karver, 2003; Quinn et al., 1997; Heatherington et al., 1990). While parents tend to rate relationship as highly important, studies show mixed results regarding the actual impact of relationship on other outcomes (Hoagwood, 2005; Kendall et al.,1996; Motta & Tobin, 1992; Motta & Lynch, 1990).

Positive expectations by parent and youth have shown to be strong predictors of a good relationship, and a positive relationship of parents to therapists has shown to increase engagement, retention, satisfaction and parental use of skills learned in therapy (Hoagwood, 2005; Hawke et al., 2005; Garcia, & Weisz, 2002). Tolan (2002), for instance, reported that better parent alliances were predictive of better parenting outcomes in child and family aggression prevention interventions while child alliances seemed less critical in determining outcomes. A study by Hawley et al. (2005) for youth in outpatient mental health settings concluded that parent-therapist alliance, but not youth alliance, was significantly related to

retention. At the same time, however, stronger youth alliance, but not parent alliance, was associated with greater decreases in symptoms. The authors surmised that while the parent–therapist relationship seemed important for youth attendance of sessions, a solid working alliance with youth is "critical for engendering youth motivation to work on problems, active attention and participation in session, skill acquisition, and application of skills outside of therapy" (Hawley & Weisz, 2005, p. 126).

A study of Multidimensional Family Therapy with adolescent Cannabis abusers and their families (Shelef et al., 2005) examined the role of parent and youth alliance ratings. The strength of *observer-rated* youth alliance early in the process predicted substance use up to 90 days post treatment and was a stronger and more robust predictor than youth *self-rated* alliance. Adolescent youth self-ratings were so consistently high that statistical tests did not yield correlations. Premature terminations were associated with poorer parent alliances. Again, the quality of parent alliance functioned as a moderator for the correlations of youth alliance to outcomes predicting retention in treatment, while youth alliances predicted improved outcomes.

There is some evidence that ***alliance patterns are different for different family members, and that the relationship of family members' alliance to outcomes also varies***. Johnson et al. (2002) assessed the role of therapeutic alliance in home-based therapy and found that domains of goals, bonds, and tasks together predicted changes in symptom distress for all members in the family. However, alliance made the largest impact on symptom changes in fathers (55% of the variance), followed by adolescents (39% of variance) and least on mothers (19% of the variance). Task domains of the alliance were most influential for mothers and adolescents; while goals were most predictive for fathers (Johnson et al., 2002).

In a study by Quinn et al. (1997) outcomes also tended to be better when women reported higher task alliances than their husbands. In addition, outcomes were more positive when wives thought that other family members had strong alliances. Poorer outcomes were found when husbands thought their wives had good alliances with the therapist, and wives at the same time rated their husbands' alliance as lower.

A study of gender in marital therapy versus family therapy (Werner-Wilson, 1997) suggests that the ideological underpinnings of therapy modalities may affect the therapeutic alliance of men and women differently. While women scored higher overall, specifically on the goal and task subscale, in *marital* therapy, men scored higher overall, specifically on the

goal and task subscale, in *family* therapy. There were no differences on the bond subscale, and given combinations of client gender and therapist gender did not result in differences in relationship outcomes. The authors wonder if feminist critics of family therapy may be correct in that family therapy approaches might keep women in the role of mother rather than supporting their needs as individuals, which may be better met in marital therapy. The author recommends that gender be included as a factor in therapeutic relationship research, and that practitioners' training should include reflections and awareness of gendered alliance patterns in different forms of therapy.

Some studies have begun focus on the *discrepancies* in alliance ratings between different family members or youth and therapists, respectively. Bickman et al. (2004) examined the therapeutic alliance with adolescents in day treatment and wilderness camps, respectively, and found significant and persistent discrepancies between the counselors' views of the alliance and the youth's view which did not vary by level of familiarity of therapist with youth or length of treatment. The authors suggest that therapists who frequently elicit feedback from youth may be able to improve alliances and reduce discrepancies.

Robbins et al. (2003) examined the relationship between alliance and retention for families of adolescents with behavioral problems (drug use and related problems) who either dropped out or completed functional systemic family therapy. They found that not individual ratings of adolescents or parents were predictive of completion or dropout, but discrepancies between parental and youth alliance scores. In particular, discrepancies of father-adolescent scores were statistically significant for higher dropout. Mother-adolescent discrepancies showed a similar trend but did not reach statistical significance. In contrast to other studies, parental alliances were generally higher in the dropout group. The authors conclude that individual alliances in the context of family therapy are not only insufficient indicators for retention but may in fact be misleading. Consistent with the family system view of "the sum being more than its parts," the therapist should attend to and balance the dynamics of alliances between parent-therapist and youth-therapist (Robbins et al., 2003).

In summary**,** the current literature on ***alliance with families*** indicates that alliances in the work with families require complex concepts and measures that have not yet been clearly established. While parents tend to rate relationship as highly important, studies show mixed results regarding the actual impact of parent alliance on outcomes. There is evidence that

alliance patterns are different for different family members, and it appears that discrepancies in alliance ratings between youth and parents may reflect important dynamics. Weak alliance with parents, or discrepancies in parent-therapist and youth-therapist alliance ratings, have been associated with lower retention of children and youth.

Findings for Type and Severity of Problems

It remains unclear how the type or severity of clients' problems might be a moderator for correlations between outcomes and alliances. While Shirk and Karver (2003) found that stronger alliances were measured when the intervention targeted externalizing rather than internalizing problems, studies also indicate that externalizing behaviors or family dysfunction are associated with poorer alliances (Garcia & Weisz, 2002; Green et al., 2001). Still other studies show no correlation to severity of problems (DeVet et al., 2003). For instance, inquiring into perspectives of children with SED and their mothers, DeVet et al. (2003) found that, contrary to expectations, mothers' distress and severity of children's problems did not impact the therapy bond. Rather alliance scores were higher when mothers perceived mental health services as effective, and had social supports.

For youth with ***conduct disorders*** admitted to inpatient or day treatment units, Green et al. (2001) found that main predictors of positive outcomes were family functioning and child alliance. General alliance with the child was established early in the treatment and remained stable over time. "Confiding in staff" increased during hospitalization along with child's perceptions of staff empathy and understanding. Authors identified a "hostile alliance" phenomenon, a mutually difficult perception of alliance. In a hostile alliance, staff and parents, or staff and youth, respectively, held negative views of each other. Staff ratings of the child as "hostile" correlated with high externalizing behavior ratings, and with child ratings of staff as lacking empathy and understanding. Similarly, staff ratings of parental hostility correlated with higher family dysfunction scores, and parents' ratings of staff as lacking understanding. The authors were careful to emphasize the interpersonal, dyadic dynamic of the phenomenon rather than attributing it to child or family pathology. The authors also surmised that the typically poor prognoses associated with conduct disorders may be a function of poor alliances rather than the disorder itself.

A study examining the working alliance and outcomes for male juvenile offenders in community-based residential programs (Florsheim et al., 2000) indicated that youth with a positive alliance with program staff after three months were more likely to make gains on behavioral functioning and less likely to show recidivism. However, contrary to expectations, a single high alliance score early in the process was not predictive of good outcomes. More important was the overall trend of alliance scores. While alliance scores after 90 days in treatment showed significant though modest correlations to outcomes, single early high scores with this population were correlated with negative outcomes. Authors suggest that delinquent, and often anti-social, youth may develop a false early alliance (honeymoon) which can actually inhibit treatment and requires tracking of alliance trends over time. Another factor was the level of involvement with peers who struggle with similar problems. Higher deviant peer scores were correlated with lower alliance scores suggesting that delinquent boys more deeply embedded with deviant peer were less likely to develop therapeutic alliances. There was no notable difference between types of programs which included proctor homes, group homes, and a restitution-oriented work program.

An experimental study by Kaufman et al. (2005) examined factors influencing outcomes for adolescents with both conduct disorder and major depression who were assigned either to a manualized cognitive-behavioral group treatment or a control group providing life skills training. Results indicated that working alliance scores were higher for the experimental group by the third session but these scores did not predict reduction in depressive symptoms.

A study about patterns of alliance for ***children and youth who were maltreated*** (Eltz, Shirk, & Sarlin, 1995) showed that especially youth who were abused more than once had a significantly harder time forming *initial* alliances with therapists even if severity of symptoms were controlled for. Maltreatment did, however, not show any significant impact on changes in the alliance over time. Rather, low expectations and more interpersonal problems predicted problems in alliance. Maltreatment alone was also not correlated with poorer outcomes. Yet, the group of children that fared the poorest and had difficulties forming good alliances throughout the process consisted of those who had interpersonal problems and had been maltreated. The authors conclude that alliance may be a mediator of outcomes, and that the formation of a good alliance is particularly important for maltreated youth.

A survey of psychotherapists (Steinberg et al., 1997) about effects of mandated child abuse reports on the therapeutic relationship also points to the protective effects of good alliances when child abuse reports are required. Although 25% of clients dropped out of treatment following a report, the majority of families remained in treatment. The stronger the alliance was before the mandated report, and the more explicit the therapist was about consent and confidentiality rules, the better was the response by clients after the mandated report.

For youth with ***substance abuse*** problems, Tetzlaff et al. (2005) found that adolescents with stronger alliances early in treatment were slightly less likely to relapse within the first six months after intake, and that treatment satisfaction was unrelated to relapse. In this study of a family-focused substance abuse treatment, the initial severity of substance use and working alliance were the only predictors of posttreatment use at three and six months follow up. However, at nine, twelve, and 30 months follow up intervals, alliance scores were no longer predictive and only initial severity predicted outcomes. Similarly, a study of adolescent and parental alliance in Multidimensional Family Therapy for Cannabis use (Shelef et al., 2005) found that the strength of observer-rated youth alliance early in the process predicted substance use up to 90 days post treatment, but did not predict outcomes at six or nine months post treatment.

Issues of Diversity

Ethnicity. Overall, existing studies rarely attend to issues of ethnic diversity. Study samples typically consist of male, adolescent, Caucasian participants (Shirk & Karver, 2003). Although some studies used samples of clients who belonged to minority groups (Faw et al., 2005; McLeod et al., 2005; DeVet et al., 2003; Diamond et al., 1999), no study specifically addressed differential effects on ethnicity.

A study involving Multidimensional Family Therapy for adolescents with substance abuse problems and conduct disorder (Jackson-Gilfort et al., 2001) is ***the only identified study*** focusing on ethnic diversity, and presenting an alliance or treatment model clearly designed to target diverse populations. Although limited by a small sample size, and unclear measures of relationship, the study examines factors and practices facilitating the therapeutic involvement and relationship of African-American boys with African-American therapists. Findings indicate that better involvement was predicted by Afro-centric discussions of

anger/rage, alienation, and the journey from boyhood to manhood. Discussions or trust/mistrust negatively impacted the relationship when they focused on parent-child trust issues. Relationship was positively predicted by discussions of alienation and respect/disrespect.

Age/ Developmental level. While no study specifically inquired into differences in alliances for children of different ages or developmental levels, children and youth appear to display different patterns of alliance ratings depending on these factors. A study by Kronmüller et al. (2002), for instance, found that young children tended to regard the *emotional bond* as positive while adolescents rated collaborative *tasks and goals* but less often the bond as positive. Similarly, DeVet et al. (2003) found that older children with serious emotional difficulties (SED) showed lesser therapeutic bonding.

Gender. The only differential finding for gender was noted in the study by Eltz, Shirk, and Sarlin (1995). Maltreated girls with interpersonal problems showed greater improvements in alliance than their male counterparts, leading authors to conclude that boys with interpersonal difficulties have a particularly hard time forming alliances with female therapists which dominated the study.

In summary, studies show mixed findings in regards to how ***type or severity of youth's problems*** functions as a moderator for correlations between outcomes and alliances. Some evidence suggests that consistently strong alliances are associated with better outcomes for youth with externalizing problems such as conduct disorders or substance abuse. The formation of a good alliance may also be particularly important for maltreated youth who have a harder time forming initial alliances.

Issues of ***diversity*** are rarely addressed in current research but age or developmental level, ethnicity, and gender are all very likely to be associated with differing alliance patterns, and possibly outcome.

Therapist Activities Associated with Better Alliance

Collaborative and supportive behaviors have been identified as key ingredients for alliance building with children, youth, and families (Ackerman & Hilsenroth, 2003; Ribner et al., 2002; Brent & Kolko, 1998). Insofar as working with children and youth requires

attention to alliance with adult caregivers, findings from adult alliance literature may provide some guidance.

For adults, successful alliance building has been associated with specific tasks such as enhancing client involvement, and good interpersonal relational skills that reverse clients' hopelessness and increase positive expectations (Dew & Bickman, 2005; Brent & Kolko, 1998). Because the relevance clients attribute to treatment is correlated with changes in outcome (Kazdin et al., 1999), accommodating clients' perceptions of what is important in treatment may be a key to alliance building (Duncan et al., 1994). A review of mostly adult-focused studies (Ackerman & Hilsenroth, 2003) shows that clients' perception of therapists as competent and respectful are characteristic of good early alliance. Techniques that conveyed support correlated with higher alliance scores. Collaborative and supportive behaviors included "we" behaviors that conveyed trust in client's ability to grow, hopefulness, noting progress, acceptance, open mindedness, enthusiasm, and early discussion and emphasis on the need for hard work from therapist and client. Positive early alliance is influenced by therapists' ability to convey trustworthiness, affirmation, warmth, flexibility, acceptance, and be alert, interested, relaxed and confident. Later in the process, therapist behaviors of "helping and protecting" positively influenced alliance ratings. While the amount of supportive techniques correlated to higher alliance ratings, adherence to specific treatment models did not (Ackerman & Hilsenroth, 2003).

For youth treatment, there is some evidence suggesting that supportive approaches are necessary but most effective when amended by active treatment approaches (Brent & Kolko, 1998). Three studies specifically attempted to identify which therapists' behaviors furthered or hindered alliances with children and adolescents, respectively.

In the first study, Creed and Kendall (2005) developed a scale to identify alliance-building behaviors in cognitive-behavioral treatment for anxiety in children ages 7 to 13 years. The scale identified seven positive and four negative behaviors. Positive behaviors included customizing the session to child (such as asking likes/dislikes, incorporating information of child), being playful (such as being on the floor, getting involved in fun activities), providing hope and encouragement, collaboration (using words such as "we", "let's" etc. child involved in setting goals), validating (such as accepting child's hesitance/ ambivalence about treatment), general conversations (such as interchange with child about treatment in general, or topic of child's interest), and finding common ground (such as providing "me, too" behaviors and responses). Negative items included: pushing child to talk,

being too formal, not following through with promises (forgetting to provide expected rewards, activities etc.), and talking on inappropriate level (too high or too low for child's development, having family discussions in front of, but excluding, the child). Ratings of the relationship were provided by observers reviewing videotaped sessions.

Results showed that collaborative behaviors were most strongly associated with positive ratings of alliance. Children's ratings indicated an association of alliance and collaboration already after session three, while therapists' ratings were predictive after the seventh session. "Pushing the child" to speak to anxiety (especially early in the process), being overly formal, or "emphasizing common ground" had a negative impact on alliance. Authors surmised that the latter, somewhat surprising, finding may be related to therapists' overeager efforts to seek common ground early in the process which the child may interpret as naïve or disingenuous. No other behaviors showed significant associations with alliance ratings in this study.

The second study is based on a small process evaluation, in which Diamond et al. (1999) identified therapist behaviors associated with improving poor alliances with adolescents in a modified version of Multidimensional Family Therapy. The study distinguished six alliance building behaviors: (1) attending to adolescent's experience; (2) orienting adolescent to collaborative nature of therapy; (3) formulating meaningful goals; (4) present self as an ally; (5) challenge control and contingency beliefs; (6) address issues of trust, honesty and confidentiality in the therapeutic relationship. In cases of successfully improved alliances, the therapist increased and maintained his or her efforts to attend more to the adolescent's experience, to present him/herself as ally more often and extensively help formulate a goal meaningful to the adolescent. The presentation of self as an ally and advocate for the teenager was most characteristic for improved alliances and resulted in teens participating more fully. In cases of unimproved alliances, therapists decreased their alliance building behaviors between second and third sessions giving the impression of having given up. While all therapists spent significant time early in the process to explain therapy, in improved alliance cases therapists moved more quickly to action-oriented interventions such as goal formulation. The authors suggest that alliance building with teens is a two step process from transforming negative expectations into a believable promise of a collaborative task and, second, moving quickly to agency-oriented ideas in which the teen can recognize benefits.

In a later conceptual article, the same authors (Diamond et al., 2000) also propose five sequential steps of alliance building with parents and adolescents in family therapy:

1) re-frame the goal of treatment to improving "family relationships" rather than "fixing" the youth.
2) bond with adolescent in individual sessions by exploring damaged parent-child trust, contracting with youth to support discussion of issues with family
3) build alliance with parents alone by exploring parental stressors, challenges, impact on parenting; emphasize that the focus of treatment is on relationship building, and that re-attachment between family members as an amelioration effort.
4) maintain a focus on helping youth and family discuss important feeling, thoughts, memories previously identified and impeding positive relations
5) as family tensions diminish, shift the focus to competence building for youth in relation to peers, and other social groups.

The third study (Dozier et al., 1998), used concepts put forth by Karl Tomm and examined families' ratings of alliance for four styles of questioning (lineal, reflective, circular, and strategic) in family therapy. Lineal questions attempt to reach an explanation or definition of a problem. They are familiar but tend not to produce new information. Strategic questions have corrective intent and tend to place the therapist in an oppositional or confronting position to the family. Circular questions are exploratory and attempt to bring forth patterns that connect. The therapist's position is neutral and accepting as the family listens to each other and discovers connections. If used excessively the style can be boring or confusing due to lack of direction. Reflexive questions are more creative, and aim to facilitate clients' own problem-solving resources. Viewing intake sessions performed by actors and scripted to meet one of the four questioning styles, families who watched circular and reflexive questioning styles indicated significantly higher alliance with the therapist than those viewing lineal or strategic scenarios. Thus, while each type of question may have its place in the course of therapy, circular and reflexive questions are more likely to support the development of an early alliance.

In a conceptual article, Barnard and Kuehl (1995) promote ongoing evaluation during sessions as a procedure to enhance the working alliance in family therapy. The authors suggest that evaluation questions should be asked of each present family member, typically at the end of a session. Feedback questions should be prefaced with a reassurance to family members that they will not hurt therapists' feelings but that honest feedback will be useful. Candid positive and negative feedback is invited. The authors view ongoing evaluations as

beneficial because they set a tone of open exchange with clients expressing otherwise suppressed ideas, because the client's world view can be more easily accommodated, a more symmetrical relationship can be established advancing client empowerment, and because therapists' skills can be improved through the feedback.

In summary, current literature suggests that better alliances are associated with the following ***therapist behaviors***:

- With children: using collaborative behaviors, expressions such as "we", "let's," getting the child involved in setting goals, not "pushing the child" to address difficult issues, not being overly formal, and providing hope and encouragement.
- With adolescents: attending to adolescent's experience; orienting adolescent to collaborative nature of therapy; formulating meaningful goals; presenting oneself as an ally; challenging control and contingency beliefs; addressing issues of trust, honesty and confidentiality.
- With families and adults: collaborative and supportive "we" behaviors conveying trust in client's ability to grow, hopefulness, noting progress, acceptance, open mindedness, and enthusiasm; taking a neutral and accepting position toward all family members; asking circular questions or reflexive questions that facilitate clients' own problem-solving resources; emphasizing that the goal of treatment to improving "family relationships"; exploring parental stressors, challenges, impact on parenting (with parents alone); maintaining a focus on helping youth and family discuss important relational issues.

Limitations of Current Research

Current studies of therapeutic alliance are hampered by a variety of limitations. For instance, studies fail to establish a timeline relation with outcomes (Kazdin, 2005). Alliance measures are typically assessed early while outcomes are assessed later. Improved outcomes can thus be the result of improved alliance, or alliance may have improved due to early outcome improvements (Kazdin, 2005).

Moreover, most studies are uncontrolled and there is a lack of consistency in the choice of informants about the alliance across studies (Hazell, 2003). Few studies elicit information from more than one source to arrive at a more complete picture of alliance patterns (Hazell, 2003; Weisz et al., 1998). Most often ratings of the alliance come from therapists or youth while parents' or other family members' views are rarely elicited (Hazell, 2003). Ideally, therapist, parents or other family members, and young clients provide ratings for alliance,

along with blind ratings of the outcome. To these ends, the field still needs a well-validated set of measures that can be adapted to the varying developmental levels of child clients, and can assess the family-therapist relationship along with the therapist-child dyad (Shirk & Karver, 2003; Weisz et al., 1998).

Instruments

A wide variety of instruments is used to measure therapeutic relationship. No one instrument or construct of alliance has emerged as dominant so far (Shirk & Karver, 2003) and only few published studies have focused on instruments for measuring therapeutic alliance with youth (Faw et al., 2005). While studied instruments have shown adequate psychometric properties, samples are often small. Thus is remains to date difficult to discern which instrument may be the most promising or comprehensive. Scales that have been lent some validation in multiple studies and include: The Working Alliance Inventory (WAI) (adapted from adults), the Vanderbilt Therapeutic Alliance Scale (VTAS) (adapted from adults); and Therapeutic Alliance Scales (TAS) by Shirk and Saiz (1992), the only scale specifically developed for younger children.

The Working Alliance Inventory (WAI). Several authors chose one or more of the WAI scales for to assess alliance with adolescents or different adult family members (Hawke et al., 2005; Kaufman et al., 2005; Shelef et al., 2005; Tetzlaff et al., 2005; Florsheim et al., 2000; Werner-Wilson et al., 1997). The WAI (Horvath & Greenberg, 1989) is the one of the dominant instruments used in research on alliance with adults. The WAI contains several 12-item questionnaires for therapist, client, and observers. Each questionnaire is designed to yield goal, task, and bond alliance ratings (Andrusyna et al., 2001). DiGiuseppe, Linscott, and Jilton (1996) adapted the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) lowering the reading level for adolescents (ages 11 to 18 years) and demonstrated adequate internal consistency($\alpha > .90$) in the sample (Faw et al., 2005).

Several studies employed scales developed by the Center for Mental Health Policy at the Vanderbilt Institute for Public Policy Studies (Shelef et al., 2005; Bickman, et al., 2004; Robbins, et al. 2003; DeVet et al., 2003; Diamond, et al. 1999). A study by Diamond, Liddle, Hogue, and Dakof (1999) used a revised version of the observer-rated ***Vanderbilt Therapeutic Alliance Scale (VTAS)***, which was originally designed for adults, to rate therapeutic alliance for adolescents in family therapy. Internal consistency and intraclass correlations (ICC) were found to be high ($\alpha = .95$; $ICC_{2,11} = .83$). The Vanderbilt Therapeutic

Alliance Scale elicits responses from youth, worker (and caregiver), focused on two dimensions: mutuality/empathy and collaborative working rapport. The ***Vanderbilt Psychotherapy Process Scale*** (VPPS) is an observer-rated instrument typically used to assess adult clients' therapeutic relationships (Jackson-Gilfort, et al. 2001). No psychometric information was available.

The ***Therapeutic Alliance Scales*** by Shirk and Saiz (1992) (also used by Hawley et al., 2005, Creed, et al., 2005; and Kronmüller et al., 2002) is the only instrument piloted specifically with younger children (ages 7-12). The sample consisted of in an inpatient setting and scales elicit child and therapist views. The measure included bond and negativity subscales. Child scale items were elicited from the child by staff member other than the therapist. Results showed acceptable internal consistencies of scales (Cronbach's $\alpha > .72$ and .74, respectively, for the bond and negativity scales on the child version, and .88 and .72, respectively, for the therapist version). The two perspectives, though at time convergent, were not interchangeable. Affective items showed stronger conversion between child and therapist than task/collaboration items (Shirk & Saiz, 1992).

The ***Adolescent Therapeutic Alliance Scale (ATAS)*** (Faw et al., 2005) is an 14-item observer-rated scale piloted with 51 (n) African-American adolescents in a family based substance abuse prevention program. The ATAS draws upon items from the revised Vanderbilt Therapeutic Alliance Scale and Bordin's (1979) theory of the alliance. It assesses therapist and client contributions to development of bond (liking, respect, trust), tasks (specific activities), and goals (areas target for change). Initial results of psychometric properties indicated that alliance for adolescents was one unidimensional construct (with three perhaps interrelated but not clearly distinct tracks of bond, tasks, goals). Reliability of measures was largely good at beginning and end of ratings (with a drop in middle phases similar to adult findings). The scale showed convergent validity of observer-rated and therapist rated alliance. Neither initial nor early improvement in alliance was predictive of retention rates, nor were alliance ratings related to outcomes. There was a trend toward correlations of alliance and school bond. Researchers conclude there is a need for multi-informant scales. Factor analysis suggested the ATAS measures one construct (Eigenvalue = 8.6, accounting for 61.3% of total scale variance). Item loadings ranged from .40 to .90. Convergent validity with both therapist- and observer-rated engagement was also high. Internal consistency reliability ($\alpha > .90$) and intraclass correlation ($ICC1,2 = .74$) were acceptable.

The ***Integrative Psychotherapy Alliance Scale (IPAS)*** was used in efforts to assess the multiple alliance perspectives in family therapy (Dozier et al., 1998; Quinn, et al., 1997). Combining individual, family and couple scales each of which assessed bond, tasks and goals dimensions, ratings of interpersonal dimensions of self-to-therapist, other-to-therapist, and group-to-therapist were also collected immediately after the third session (Quinn, et al., 1997). As expected all scales and dimensions showed statistically significant correlations although lower than in previous studies using IPAS. High levels of correlations between subdimensions of the scale suggest that they may indeed not be separate constructs (Quinn, et al., 1997).

McLeod and Weisz (2005) developed the ***Therapy Process Observational Coding System—Alliance Scale*** which assesses bond and task in alliance with children and parents. Results of a pilot study with 22 (n) youth in an outpatient community mental health clinic with anxiety and depressive disorders showed that bond and task items overlapped substantially (suggesting these two dimensions may not be distinct constructs). Parent-therapist and child-therapist rating forms appeared to be independent, not showing significant correlations. Interrater reliability was deemed acceptable (at least .40). The child form showed internal consistency (α =.95), early alliance (i.e., average of first two sessions; α =.93), and late alliance (i.e., average of last two sessions; α =.91). and moderate stability of scores over time. The correlation between early and late alliance was .54 ($p. < .01$) . The parent form showed internal consistency (α = .89), early alliance (α = .87), and late alliance (α =.79), as well as high stability over time. The correlation between early and late alliance was .88 ($p. < .01$).

Conclusion

The importance of therapeutic alliance in the work with children and youth is receiving growing attention and empirical support. While the empirical evidence linking therapeutic alliance with outcomes for children, youth and families is lagging behind research on adult therapy, emerging data suggests that a therapist's relationship with the young person is a critical element in treatment success. At the same time alliance in the work with young people must be viewed as part of a more complex web of factors that includes therapist's alliance with adult caregivers which has shown to impact retention of young clients in treatment. Other factors that have yet to be researched in more detail include the interaction of age, gender, ethnic diversity, or the type and severity of symptoms with therapeutic alliance.

#	Author(s) & Date	Type of Article	Key Variables/Components	Main Conclusions	Notes
1	Ackerman, S.J., & Hilsenroth, M.J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23* (1), 1-33.	Review of 25 (n) studies investigating a quantifiable influence of therapists' contributions (personal characteristics and/or activities) to therapeutic alliance.	Inclusion criteria for studies were: 1. Quantifiable relationship between therapist qualities and alliance 2. Study explicitly focused on role of therapist attributes or activities related to development, or maintenance of alliance 3. Published between 1988-2000	***Personal attributes*** were significantly related to alliance. It appears, therapists can influence alliance early and late in the process. Early positive alliance is influenced by therapists' ability to convey trustworthiness, affirmation, warmth, flexibility, acceptance, being alert, interested, relaxed and confident. In addition, clients' perception of therapist competence and respect are characteristic of good early alliance. Therapist behaviors of helping and protecting positively influence alliance ratings later in the process. ***Application of techniques*** that conveyed support and correlated with higher alliance scores included: "we" behaviors that convey trust in client's ability to grow; hopefulness, noting progress; acceptance open mindedness; enthusiasm; attitude of collaboration; early discussion and emphasis on need for hard work from therapist and client; exploratory behaviors (if clients and therapists share view of usefulness of exploration as part of the joint effort); higher level of therapist was interpreted as interest, collaborative effort. Amount of supportive techniques correlate to higher patient alliance ratings. Amount of adherence to specific treatment model was not correlated with alliance ratings. There was little variation across theoretical orientation.	Adult-focused, includes only one study involving family therapy Limited by variability of quality and focus of studies, and instruments used.
2	Barnard, C.P. & Kuehl, B. P. (1995). Ongoing evaluation: In-session procedures for enhancing the working alliance and therapeutic effectiveness. *American Journal of Family*	Conceptual article outlining a procedure of ongoing evaluation to enhance working alliance in family therapy	Argues that "theoretical diversity results from the unique interplay of therapist and client variables" (p.162) in which the working alliance becomes a central factor. Ongoing evaluation (OE) is viewed as an important mean to improve outcomes as well as the	*Six assumptions:* 1) Clients' experience is what matters most 2) Clients are assessing therapists at the same time as therapists assess clients 3) Clients have information and expertise that, if elicited and incorporated, can	Ongoing evaluation

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	Therapy, 23 (2), 161-172.		working alliance. Authors define working alliance as being predicated upon the development of collaboration and trust, agreed upon goals, and faith in the therapist and procedures of therapy. OE is "designed to enhance the family therapist's attention to the working alliance regardless of theoretical orientation. Benefits of OE include establishing with clients that it is OK to talk about things, that otherwise suppressed ideas can be expressed, and that the client's world view can be more easily accommodated toward a mutual sense of understanding, a more symmetrical relationship, advancing client empowerment, and improving therapists' skills.	advance the development of the WA 4) Clients' experiences have been underutilized as a way to improve outcomes and therapists' skills 5) Therapists usually spend more time with clients than with other MH professionals 6) Ideas generated in training settings should be tentative until substantiated in therapeutic settings. *Procedures of ongoing evaluation:* Ask <u>each</u> family member present, typically at the end of a session (but there is no reason not to ask during another point in time), preface feedback question with introduction that reassures family that they won't hurt your feelings, ask for positive and negative feedback, invite people to be candid, and that honest as possible feedback has proven very useful. Authors list concrete wording for questions for early, middle and ending phases of therapy.	
3	Bickman, L., Vides de Andrade, A. R., Lambert, E. W., Doucette, A., Sapyta, J., Boyd, A. S., Rumberger, D. T., Moore-Kurnot, J., McDonough, L. C., & Rauktis, M. B. (2004). Youth therapeutic alliance in intensive treatment settings. *Journal of Behavioral Health Services & Research*, 31 (2), 134-149.	Study examining the TA that develops between teacher/ counselors (n=45) and youth (n= 178) in a partial hospital/day school and a wilderness camp	***Sample***: in both settings majority male, most African-American or Hispanic, mean age 14, most diagnosed with conduct disorder. ***Measures over 8 months***: Symptom severity rating (CAMS); Therapeutic Alliance Scale by Doucette & Bickman, eliciting responses from youth, worker (and caregiver), focused on two dimensions: mutuality/empathy and collaborative working rapport.	***Results*** indicate a lack of relationship between the counselor's view of TA and the youth's view that remained unchanged over time. Therapists and youth had significantly different views of the TA which did not vary by level of familiarity of therapist with youth or length of treatment. Authors suggest that therapists eliciting feedback on TA from youth could improve TA; if both level of alliance and discrepancy are considered, it is expected that those who are low in discrepancy and high in TA level would be the most effective counselors, while those low in TA level and high in discrepancy should be the least effective. Some counselors appeared to be better than others at fostering alliance with youth (modest correlations of youth ratings seeing the	Day treatment / wilderness camp

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				same therapist).	
4	Brent, D.A., & Kolko, D.J. (1998). Psychotherapy: definitions, mechanisms of action and relationship to etiological models. *Journal of Abnormal Child Psychology, 26* (1), 17-25.	Conceptual article reviewing role of TA in treatment of children, suggesting dimensions and mechanisms of action and relationship.	Suggests seven domains of psychotherapy mechanisms: Relationship Attitudes Thoughts/beliefs Affect Behaviors/skills Development Context Biological substrate	Authors summarize findings that relationship, although often called a nonspecific factor, requires specific tasks such as enhancing patient involvement, good interpersonal relational skills, consistent therapeutic orientation (Note: not sure what the latter means), in order to reverse hopelessness of clients. Client appreciate support, understanding, advice, reciprocity in relationship, while therapists tend to attribute success to technique, clients tend to attribute it to relationship. For youth treatment there is some evidence that suggests that supportive approaches are necessary but most effective when amended by active treatment approaches.	
5	Broome, K.M., Joe, G.W., & Simpson, D.D (2001). Engagement models for adolescents in DATOS-A. *Journal of Adolescent Research*, *16* (6), 608-623.	Research article introducing conceptual model of factors impacting therapeutic engagement of youth, and presenting results of a study that examined treatment readiness and engagement for 1106 (n) youth in three different substance abuse treatment settings.	No measure of outcome. Therapeutic readiness conceptualized as being influenced by multiple factors, measured by Treatment Readiness Scale. Engagement measured at one month post intake via combination of ratings.	Treatment readiness (motivation) and social support (for residential treatment group only) associated with engagement (therapeutic involvement).	Substance abuse
6	Chu, B.C., Choudhury., M.S., Shortt, A.L., Pincus, D.B., Creed, T.A., & Kendall, P.C., (2004). Alliance, technology and outcome in the treatment of anxious youth, *Cognitive and Behavioral Practice, 11* (1), 44-55	Conceptual article reviewing TA with anxious youth and the role and impact of technology-based treatment modalities on outcomes	1) Definition of TA across theoretical orientations: CBT emphasizes therapist role as educator, consultant, diagnostician, focused on collaborative skill building 2) Outcome-Alliance research sparse, especially for internalizing/ anxious symptomatology. 1) alliance and advanced technology 2) Virtual reality Treatments 3) computer-based treatment 4) audio aided treatment	Argues that TA, flexibility and responsiveness of therapist, are of particular importance in CB treatment with anxious youth who are to confront fears. Limited variability of alliance ratings hampers clear results. No clear correlation between TA and outcomes could be established. But positive TA may influence level of child participation (a critical element of CBT). Higher participation is linked to better outcomes in behavioral and CB	technology

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				treatments. As technology advances into treatment (virtual means of desensitization, etc.), TA requires closer attention to see to what extend use of technology hampers, advances, or otherwise changes the role of TA, or the type of population with whom face-to-face vs. other forms of treatment are most beneficial.	
7	Creed, T.A, & Kendall, P.C. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of Consulting and Clinical Psychology, 73* (3), 498–505.	Study analyzing the specific alliance building behaviors of therapists in manualized C-B treatment of anxious youth (n=56)	***Measures***: (1) Anxiety Disorder score (ADIS) rated by independent diagnostician (2) Adapted version of Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992) with separate ratings from child and therapist from sessions 1,3, and 7; (3) Therapist Alliance-Building Behavior Scale (TABBS) containing seven positive valence items, and four negative valence. Positive valence items included: customizing the session to child (such as asking likes/dislikes, incorporating information of child), being playful (such as being on the floor, getting involved in fun activities), providing hope and encouragement, collaboration (using words such as "we", "let's" etc. child involved in setting goals), validating (such as accepting child's hesitance/ ambivalence about treatment), general conversations (such as interchange with child about treatment in general, or topic of child's interest, finding common ground (such as providing "me, too" behaviors and responses). Negative valence items included: pushing child to talk, being too formal, not following through with promises (forgetting to provide expected rewards, activities etc.), talking on inappropriate	***Results*** show that collaborative behaviors were most strongly associated with positive ratings of alliance after the third and seventh session within this manualized treatment approach. Children's ratings indicated an association of alliance and collaboration already after session three, while therapists' ratings were predictive after session 7. "Pushing the child" to speak to anxiety (especially early in the process), being overly formal, or "emphasizing common ground had a negative impact on alliance. Authors surmised that the latter, somewhat surprising, finding may be related to therapists' overly eager efforts to seek common ground early in the process which the child may interpret as naïve or disingenuous. No other behaviors showed significant associations with alliance ratings. Ratings by observers, children, and therapists were significantly correlated at session 3 (but not at session 7.) ***Limitations***: It is possible that children rating collaboration and alliance as high were already prone to collaborate well	

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			level (too high or too low for child's development, having family discussions in front of but excluding the child). Rating of the relationship was provided by observers reviewing videotaped sessions.		
8	DeVet, K. A., Kim, Y. J., Charlot-Swilley, D., & Ireys, H.T. (2003).The Therapeutic Relationship in Child Therapy: Perspectives of Children and Mothers. *Journal of Clinical Child and Adolescent Psychology, 32* (2), 277–283.	Study of low income children (ages 9-14) with SED and their mothers (n= 229 mother-child pairs) analyzing their perceptions of therapeutic relationship.	***Sample***: urban low income families, children: mean age 11, 75% male, 71% African-American. Mothers: mean age 40, 39% H.S. 38% less than H.S. education; 50% single mothers. ***Measures***: Therapeutic Bond Scale (TBS, Shirk & Saiz, 1992) for child's perspective, modified TBS version for mothers' perspective. Child's Report of Parental Acceptance/Rejection was used to measure child perception of maternal warmth. Mothers' CBCL reports and Youth Self Report were used to measure externalizing and internalizing behaviors. Vanderbilt Questionnaire assessed mothers' perceived efficacy of MH services Psychiatric Symptom Index measures mothers' psychological distress	***Results***: Children's relationships with their mothers correlated with their perceptions of therapeutic bonds, but older children showed lesser therapeutic bonding and children whose mothers were on welfare had higher therapeutic bond scores. If mothers perceived MH as efficacious, and had social supports, their relationship scores with the child's therapists were higher but contrary to expectation mothers' distress and severity of children's problems did not impact the therapy bond. These findings appear to support other evidence that not problem severity but relational problems predict therapeutic alliance factors in children	Client perspective, child welfare
9	Dew, S.E. & Bickman, L. (2005). Client expectancies about therapy. *Mental Health Services Research, 7* (1)*,* 21-33.	Review of 39 child and adult studies about relation of client expectancy to improvement, alliance and attrition with emphasis on examining client characteristics and expectancy	What are expectancies? Two main types: role expectancies (for therapist, client, caregiver) and outcome expectancies (including prognoses, expectations of helpfulness, duration etc.). In both types, caregiver expectancies are an important part in child treatment. Differentiating expectancy, placebo, and hope: There is no placebo in therapy because therapeutic ingredients are always embedded in relationships and cannot be "inactive." Hope requires expectancies but expectancies do not require hope (one can expect therapy	Proposed preliminary pathways of expectancies: Pretreatment characteristics of clients (symptom intensity, duration, comorbidity etc.) are the strongest moderators of expectancies. As a process to "remoralize" demoralized clients, the attention effect of therapy seems less effective with clients who bring a long history of severe problems. Attention may no longer be hope-inducing. Outcome expectancies are in turn related to clients' actual outcomes of reducing symptoms, and improving functioning. Studies linking outcome expectancies and	Review, not child specific

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			not to be helpful). Measurement: There are no gold standards of measurement. Both instrumentation and timing of measuring expectations need improvements. Relationship studies of outcome expectancies to improvements are mixed, and studies are often methodologically flawed. Evidence for a link between premature termination and role expectancies is weak. There is some evidence that incongruence between client and therapist expectancies are linked to higher attrition.	TA indicated a connection in that TA appears to mediate between expectations and outcomes. Some studies also indicate relationship of role expectancies to TA. The authors hypothesize that discordance of role expectations will impact TA early unless clients can be "socialized" into understanding roles of the therapist, including am active collaborative approach.	
10	Diamond G. M., Diamond, G.S., & Liddle, H.A. (2000).The therapist–parent alliance in family-based therapy for adolescents. *Psychotherapy in Practice*, *56* (8), 1037–1050.	Conceptual article outlining procedures for developing TA with parents in family therapy, includes case examples.	Focused on family therapy with depressed adolescents. Stipulated sequential tasks emphasize relationship building between youth and family (reattachment) and competence building for youth. Modified version of Multidimensional Family Therapy	1) re-frame goal of tx to improving family relationships (not "fixing" youth) 2) bonding with adolescent (indiv. sessions): exploring damaged parent-child trust, contracting with youth to support discussion of issues with family 3) alliance building with parents (with parents alone): explore parental stressors, challenges, impact on parenting; emphasizing attachment as amelioration effort, and focus of treatment on relationship building 4) reattachment focus on helping youth and family discuss important feeling, thoughts, memories previously identified and impeding positive relations 5) as family tensions diminish, focus shifts to competence building for youth in relation to peers, other social groups	
11	Diamond, G., Liddle, H.A., Hogue, A., & Dakof, G. A. (1999). Alliance building interventions with adolescents in family therapy: a process study. *Psychotherapy, 36* (4), 355-368.	Exploratory process study identifying therapist behaviors associated with improving alliance with 10 (n) adolescents in multi-dimensional family therapy (MDFT).	***Sample***: 10 adolescents (mean age 15) from a substance abuse program at an inner city university based clinic; 70% male, 80% African-American, 70% from single parent, low income families. ***Measures***: Vanderbilt Therapeutic Alliance Subscale, the Alliance Building Behavior Scale (developed for this	This study explored initially poor therapist-adolescent alliances that improved by the third session, or had failed to improve. Therapist behaviors in nominated cases were observed and rated as to alliance, and therapists' alliance-building behaviors. The study distinguished six alliance building behaviors:	

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			study); the social acceptance subscale of the Self-Perception Profile for Adolescents as a self-reported measure of pre-therapy interpersonal relations. All therapists were trained in manualized MDFT approach.	1. attending to adolescent's experience 2. orienting adolescent to collaborative nature of therapy 3. formulating meaningful goals 4. present self as ally 5. challenge control and contingency beliefs 6. address issues of trust, honesty and confidentiality in the therapeutic relationship In cases of successfully improved alliance, the therapist increased and maintained efforts between sessions 2 and 3 to attend more to the adolescent's experience, to present self as ally more often and extensively help formulate a goal meaningful to the adolescent. The presentation of self as an ally and advocate for the teenager was most characteristic for improved alliances and resulted in teens participating more fully. In cases of unimproved alliances therapists decreased their alliance building behaviors giving the impression of having given up. While both groups spent significant time early in the process to explain (socialize) therapy, in improved alliance cases therapists moved more quickly to action-oriented interventions such as goal formulation. The authors suggest that alliance building with teens is a two step process from transforming negative expectations into a believable promise of a collaborative task and, second, moving quickly to agency-oriented ideas in which the teen can recognize benefits.	
12	Dozier, R.M., Hicks, M.W., Cornille, T.A., & Peterson, G.W. (1998). The effects of Tomm's therapeutic questioning styles on	Experimental study examining TA ratings of family members (n=120) who evaluated one of four styles of questioning	***Sample***: 120 family participants from 40 families, whose sons (ages 15-18) attended a developmental research school. 75% of all participants were white, 20.8% black.	***Conceptual Underpinnings:*** Tomm's dimensions that differentiate therapeutic questions: 1) the continuum of locus of change that lies behind the question: at one end is	

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	therapeutic alliance: a clinical analog study. *Family Process, 37* (2), 189-200.	(lineal, reflective, circular, strategic) in family therapy	***Procedure*** family triads were randomly assigned to view a family intake session (performed by actors) that was scripted to meet one of the four questioning styles, and identify themselves with one of the clients. ***Measures***: Interpersonal subscales of the Integrative Psychotherapy Alliance Scale was used to elicit viewers' perceptions of alliance. ***Limitations***. The study is limited by its analog design of a scripted performance involving non-clinical subjects. Viewers may or may not have put themselves into the shoes of one of the client actors. Thus it is not certain if viewers had had the same impressions if they had been themselves involved as clients.	orienting intent (change therapist's understanding or perception), at the other end is influencing intent (to change others' perception and understanding). 2) The continuum of assumptions about the cause of mental phenomena and therapy: at one end lineal, cause and effect construct, at the other end circular, cybernetic constructs. Based on this matrix, questions are grouped into four main categories along the two axes: a) Lineal questions, b) strategic questions, c) circular questions, d) reflexive questions. Lineal questions attempt to reach an explanation or definition of a problem. They are familiar but tend to be conservative of family's beliefs and perceptions in that they do not tend to produce new information. Strategic Questions have corrective intent and tend to place the therapist in an oppositional position. Circular questions are exploratory in an attempt to bring forth patterns that connect. Therapists' position is neutral and accepting as the family listens and discovers connections. If uses excessively these style can be boring or confusing due to lack of direction. Reflexive questions are more creative, and aim to facilitate clients' own problem-solving resources. Each type of question has its place in the course of therapy but Tomm contends that circular and reflexive questions are more likely to support the development of a TA. ***Results*** indicate that viewers of circular and reflexive questioning styles felt themselves significantly more allied with the therapist than those viewing lineal or strategic scenarios. Early alliance may be best supported through reflexive and	

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				circular types of questions.	
13	Drisko, J.W. (2004). Common factors in psychotherapy outcome: Meta-analytic findings and their implications for practice and research. *Families in Society, 85* (1), 81-90.	Meta-analysis on common factors in adult psychotherapy	Cautions not to predict outcomes based on client characteristics alone. Critiques and expands upon Lambert's (1992) frequently cited four common factors of change to include client and agency context. Elements of therapeutic relationship.	Researchers caution making predictions about outcomes based on client characteristics alone. Motivation and readiness, number and severity of problems, and capacity to relate and tolerate change have been identified as having an impact on outcomes, but generalizations are difficult due to the wide range of client variables. Lambert's understanding of extratherapeutic factors fails to include context set by policies and agencies, including availability, affordability, and accessibility of services along with their cultural sensitivity and user-friendliness Client context includes familial and peer supports, neighborhood resources and the relative appraisal and meaning of "getting therapy" to a client and his/her culture. Therapeutic relationship has been related to concepts and indicators such as empathy, mutual affirmation (possibly including affective attunement), and therapist's encouragement, support, and acknowledgement of changes and risks taken by clients. The ability to recover from mistakes and misattunements has been noted as impacting the relationship along with activities that prepare clients such as clarifying expectations, establishing shared goals, activity level of the client, therapist's adherence to model and correct assessment of suitability of the client.	Meta-analysis ADULT FOCUSED
14	Eltz, M.J., Shirk, S.R., & Sarlin, N. (1995). Alliance formation and treatment outcome among maltreated adolescents. *Child Abuse and Neglect, 19,* 419-431.	Study examining the alliance formation and outcomes of 38 (n) hospitalized adolescents (ages 12-18) separated into maltreated and not maltreated group	***Sample***: 25 female, 13 male, 83 % Caucasian Predominant diagnoses: dysthymia, major depression, conduct disorder Mean length of tx: 57 days. ***Measures*:** therapist and youth alliance questionnaires, interpersonal	Results show that maltreated youth, especially those who were abused more than once, had a significantly harder time forming initial alliances with therapists even if severity of symptoms were controlled for. No other variable (expectations, social competence or	inpatient

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			expectation scale, interpersonal problem scale, CBCL, outcome ratings (by therapists and adolescents)	interpersonal problems) was predictive of initial alliance formation. Maltreatment did, however, not show any significant impact on changes in the alliance over time. Over time, low expectations and more interpersonal problems predicted problems in the alliance. Girls with interpersonal problems showed greater improvements in alliance than their male counterparts, leading authors to conclude that boys with interpersonal difficulties have a particularly hard time forming alliances with female therapists which dominated the study. Maltreatment alone was not correlated with poorer outcomes. Yet, the group that fared the poorest were youth who had interpersonal problems and had been maltreated; a group that showed an difficulties forming good alliances at any point in the process. Authors conclude that TA may be a mediator of outcomes, and that the formation of a good alliance is particularly important for maltreated youth. Although the Interpersonal Problem Scale and the social competence subscale of the CBCL showed high correlations the IPS was a much better predictor of alliance problems.	
15	Faw, L., Hogue, A., Johnson, S., Diamond, G.M. & Liddle, H.A. (2005). The Adolescent Therapeutic Alliance Scale (ATAS): Initial psychometrics and prediction of outcome in family-based substance abuse prevention counseling. *Psychotherapy Research, 15* (1-2), 141-154.	Pilot study of 14 item observer-rated scale to measure TA with 51 (n) African-American adolescents in a family based substance abuse prevention program	***Aims and hypotheses:*** Design and test developmentally sensitive measure for adolescent therapy in context of family-based work; examine relation of alliance to outcomes (self-worth, family cohesion, bonding to school, peer antisocial behaviors). ***ATAS Scale characteristics***: Observer-rated, 14 items assessing therapist- client contributions to	Results of psychometric properties indicate that TA for adolescents is one unidimensional construct (with three perhaps interrelated tracks of bond, tasks, goals). Alliance could be measured reliably for adolescents in individual sessions and in family sessions. Reliability of measures was largely good at beginning and end of ratings (with a drop in middle phases similar to adult findings).	Instrument More than 50% attrition: 24 completers, 19 partial completers

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			development of bond (liking, respect, trust), tasks (specific activities), and goals (areas target for change), as well as client contributions to same areas. ***Test Sample:*** recruited from community-based academic enrichment and multidimensional family prevention program, Pre-post test (four months after baseline); 51% girls, mean age 12.5 years; 45% single parent; 65% less than $15,000 income. ***Measures*** *Alliance* rating via coding of videotaped sessions *Engagement* rating by therapist and observer *Symptoms* CBCL, Youth self report, self-perception, family relation scale (cohesion only), bonding to school scale (self report), peer anti social behavior questionnaire (from Oregon SL Center).	The scale showed convergent validity of observer-rated and therapist rated alliance. Neither initial nor early improvement in alliance was predictive of retention rates, nor were alliance ratings related to outcomes. There was a trend toward correlation of TA and school bond. Researchers conclude there is a need for multi-informant scales, need for ATAS scaling (1-4) to have anchors	
16	Florsheim, P. Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs, *Journal of Clinical Child Psychology, 29* (1), 94-107.	Study examining role of working alliance and factors impacting alliance and outcomes for 78 (n) male juvenile offenders in four community-based residential programs	***Sample:*** 78 boys (mean age 15.6) in youth corrections custody, 63% white, 64% from single-mother low income families. Intervention Programs included: Proctor (therapeutic foster care-like) homes, group homes, and a restitution-oriented work program ***Measures***: delinquent history, deviant peer influence (self-report), drug use questionnaire, working alliance inventory (WAI), CBCL for youth and staff rating, and recidivism one year following placement. Data were collected 1-2 weeks after placement (functioning, history), three weeks after placement (quality of working alliance with staff), and 90-100 days into treatment (functioning and alliance).	Results indicate that youth with a positive WA with program staff after 3 months were more likely to make gains on behavioral functioning and less likely to show recidivism. However, contrary to expectations, a single high alliance score early in the process was <u>not</u> predictive of good outcomes. More important was the overall trend of alliance scores, and the scores after 90 days in treatment showed significant though modest correlations. In fact, single early high scores with this population were correlated with negative outcomes leading authors to conclude that delinquent, and often anti-social youth may develop a false alliance (honeymoon) that can actually inhibit treatment and underscores the need to track alliance trends over time. Higher deviant peer scores were further correlated with lower	Juvenile offenders, residential program

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				WA scores suggesting that boys more deeply embedded with deviant peer were less likely to develop therapeutic alliances. There was no notable difference between programs. ***Limitations***: short-term outcomes measured only.	
17	Foreman, S. A., Gibbins, J., Grienenberger, J. & Berry, J.W. (2000). Developing methods to study child psychotherapy using new scales of therapeutic alliance and progressiveness, *Psychotherapy Research, 10* (4), 450-461.	Single case study of TA and progressiveness (defined as combination of child relaxation and boldness) in child psychotherapy using video-based ratings	Case of a 10 year of girl seen in weekly play therapy for a total of 50 hours over the course of 2 years, complaining of having no friends, poor grades. Measures: Progressiveness scale (by first author) Plan-compatibility scale (adapted by authors) Child Therapeutic alliance Scale (CTAS, by authors)	Results indicate acceptable reliability for instruments. Construct validity was somewhat tentative. Strongly limited by n=1 sample and limited hours of material reviewed.	Research/ instruments
18	Garcia, J.A., & Weisz, J.R. (2002). When youth mental health care stops: therapeutic relationship problems and other reasons for ending youth outpatient treatment, *Journal of Consulting and Clinical Psychology, 70* (2), 439–443.	Study of factors leading to premature termination of outpatient therapy with 344(n) youth (ages 7-18) using the Reasons for Ending Treatment Questionnaire (RETQ)	10 community clinics in California. 135 were dropouts, 85 completers. 41 item RETQ, factor analysis yielded 4 factors. CBCL subscales and demographics collected.	1. Higher CBCL (externalizing) associated with higher scores on Therapeutic Relationship Problems and Staff and Appointment Problems factors. 2. Higher SES associated with higher scores on Time and Effort Concerns. 3. Dropouts (both early and late) had higher Therapeutic Relationship Problems (lack of involvement, investment, competency, effectiveness) and Money Issues. Did NOT report child not needing treatment.	C More evidence about importance of TA with kids and families.
19	Green, J., Kroll, L, Imrie, D., Marino Frances, F., Begum, K., Harrison, L., & Anson, R. (2001). Health gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry, *Journal of the American Academy of Child and Adolescent Psychiatry, 40* (3), 325-332.	Quasi-experimental Study of improvements in 55 (N) children and youth (ages 6-17) admitted to inpatient or day treatment units in England, including TA as one factor; wait list with treatment as usual as comparison group.	***Sample***: 60% males, mean age 11.4, 15% with previous hospitalizations, 3.6% in nonfamily care, 72% family history of mental illness in first or second degree relatives. ***Measures***: Symptoms and adjustment (health scales, CBCL, teacher report forms) Family functioning Therapeutic alliance scales (developed by authors) one to assess clinician's view of family engagement, and another	Results indicate statistically significant health gains (reduction of symptoms) from admission to discharge and sustained to follow up. Ratings by teachers in children's regular schools indicate significant improvements from pre-admission to follow up. Main predictors of positive outcomes were family functioning and child alliance. General alliance with the child was established early in the treatment and remained stable over time; "confiding in	Inpatient/ day treatment See also article Kroll & Green (1997) about instrument development and validation

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			for child and parents' view of alliance. Instruments were pilot tested and initially validated Measures were taken at referral, intake, discharge and 6 months follow up.	staff" alliance increased during hospitalization along with child's perceptions of staff empathy and understanding. Staff ratings of the child as hostile correlated with high externalizing ratings , and with child ratings of staff as lacking empathy and understanding indicating the mutuality of difficulties. Similarly, staff ratings of parental hostility correlated with higher family dysfunction scores, and parent ratings of staff as lacking understanding. Authors refer to this phenomenon as a hostile alliance and are careful to emphasize the interpersonal, dyadic dynamic (rather than attributing the phenomenon as a result of child or family pathology). Outcomes for youth with conduct disorder indicated that positive general alliances by the first month predicted better outcomes within this group. The authors conclude that poorer prognoses associated with conduct disorders may be a function of poor alliances rather than the disorder itself.	
20	Hawke, J. M., Hennen, J., & Gallione, P. (2005) Correlates of therapeutic involvement among adolescents in residential drug treatment, *American Journal of Drug and Alcohol Abuse*, 31 (1), 163-178.	Study of therapeutic involvement (TI) (combining therapeutic engagement, rapport and working alliance measures) of 185 (n) adolescents (ages 13-18) in 5 residential substance abuse programs	Cognitive-behavioral models Measured symptoms, self esteem, self efficacy, spirituality, TI (3 adult measures, including Horvath's WAI)	TI associated with outcome through impact on retention. Analysis only reported for intercorrelations of 3 TI scales, not for relationship to symptoms. Goal was to identify sound measures of TI among adolescents.	C Useful only in identifying properties of TI for adolescents.
21	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*	Study of associations of alliance between youth and therapist, and parents and therapist with retention, satisfaction and outcomes for 65 (n) youth (ages 7-16) in outpatient mental health settings	*Sample* 65 youth (mean age 11.9), 58.5% boys; caregivers 89% female, majority biological family member; attended a mean 23 sessions in community-based mental health care. *Measures*: Behavioral symptoms: CBCL, youth	Results: tentatively suggest that alliance may be a factor in youth therapy and support the need to pay attention to both youth-therapist and parent-therapist alliance. Parent-therapist alliance, but not youth alliance, was significantly related to retention. Stronger youth alliance, but not parent alliance, was associated with	

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	Psychology, *34* (1)*, 117–128.*	using Therapeutic Alliance Scale for Children (Shirk & Saiz, 1992)	self-report; satisfaction with services for youth and parents Therapeutic alliance scale for children (Shirk & Saiz) , and parallel scale developed for parents. Collection points at intake, 6 moths, 1 year, and 2 years post intake conducted by graduate research assistants. Retention (percentage of sessions attended by other family member; percentage of sessions missed or canceled; therapist concurrence with termination) based on reviews of records	greater decreases in symptoms.	
22	Hazell, P. (2003). Review: therapeutic relationship is modestly correlated with treatment outcome in child and adolescent psychotherapy, *Evidence-Based Mental Health*, *6* (4), 122.	Brief commentary on meta-analysis of Shirk & Karver (2003) [see below]		Most of the primary studies were uncontrolled, and it is unlikely that the outcome ratings were blind. Only two studies involved observational ratings of the therapeutic interaction yet this should probably be considered the "gold standard". There was a lack of consistency across studies in choice of informant. Ideally one would like to see both therapist and patient ratings of the alliance, and blind ratings of the outcome. A good therapeutic alliance is often hard to win with a conduct disordered child and his or her family, so one might anticipate a greater variability in scores on measures of therapeutic alliance. This variability in scores leads, in turn, to a greater chance that an association will be found.	Commentary
23	Heatherington, L. & Friedlander, M.L. (1990). Couple and Family Therapy Alliance Scales: empirical considerations, *Journal of Marital and Family Therapy, 16* (3), 299-306.	Study of psychometric properties of Couple and Family Therapy Alliance Scales with 16 couples and 12 families, and 16 therapists, participating in short term systemic family/marital therapy.	Measures administered 3rd through 6th session: Couple and Family Therapy Alliance Scales (CTAS, and FTAS) by Pinsof and Catherall (1986), two self-report Likert scales measuring client's perception of own relationship with therapist, others' therapeutic relationship, and overall group	As in previous study, scales and subscales showed good reliability and significant intercorrelations. Strongest associations were found for tasks and bond ratings while "goals" was the least stable item. Correlations of TA with the SEQ were mixed not yielding a clear picture. Split alliances (significantly different	

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			relationship with therapist, as well as tasks, bond, and goal content. Session evaluation questionnaire (SEQ) evaluating ease/ smoothness of session from clients' perspective	relationships for individuals vs. couple or family ratings) were found for 14% of couples and 42% of families.	
24	Hoagwood, K.E. (2005). Family-based services in children's mental health: a research review and synthesis, *Journal of Child Psychology and Psychiatry, 46* (7), 690–713.	Systematic review of family-based services in children's mental health, using 41 (n) studies grouped into three categories: families as recipients, families as co-therapists and studies of processes (including TA)	Studies included focus on intervention for or with families (not therapy to families), were published since 1980, experimental design; or non-experimental study targeting key processes of involvement; targeting mental health or general health. Excluded: studies of family therapy or parent management training (reviewed elsewhere) Studies were categorized as ***(1) families as recipients*** (n=14) (including education/ psycho-education; family support; adjunctive services; engagement; empowerment) Family based *education* in children's MH is most often incorporated into other intervention models making it impossible to assess the effects of education alone, but allowing for greater flexibility through multi-modal intervention approaches. Family *support* models aiming to create family-to-family support and sharing of information are the least frequently studied mode in children's MH. While models exist, there is currently no clear evidence as to effectiveness. A small group of studies shows that *adjunctive services* (such as a problem-solving intervention aimed to reduce family stress, or family skills training) can increase positive outcomes when added to regular therapy. A manualized *engagement* intervention (see McKay et al.) has shown to increase initial attendance and return rates of low income families.	***Studies of core processes of involvement*** fall into five main categories: (1) the nature and quality of therapeutic relationships: unlike adult meta-analyses, a recent child and family meta-analysis (see Shirk et al.) shows only a modest relationship between alliance and outcomes. At this time there is no strong support for predictive association between relationship and outcomes likely because there are additional other factors active in child and family processes that have not been researched yet. There is a lack of robust literature on process variables other than alliance. Several factors moderate the strength of measured alliance: stronger alliance is measured when therapy targeted externalizing rather than internalizing problems, when alliance was measured later rather than early in the process, when therapists rather than parents or youth reported, and when global functioning rather than specific symptoms were used as outcome correlates. Parents rate relationship as highly important, but studies show mixed results re. impact of relationship on outcomes. Positive relationship of parents to therapists has shown to impact engagement and retention, satisfaction (though not necessarily other outcomes), and parental use of skills learned in therapy. Strong predictors of relationship are positive parent and youth expectations. (2) family engagement factors: studies found that traditional demographic	Family-focused review

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			Engagement activities include open communication about parental beliefs and attitudes re. treatment, and problem-solving re. barriers to access and continue treatment during pre-session telephone call and during first session. Only one study so far has evaluated *empowerment* interventions which resulted in higher self-efficacy and higher knowledge. ***(2) families as co-therapists*** (n=6)***;*** Only a few studies, mostly focused on children with autism, have evaluated families as co-therapists and found better outcomes for children. A series of studies focused on obesity points to developmental dimensions: younger children benefited when families participated as clients, and adolescents benefited when parents served as supportive co-therapists. ***(3) studies of involvement processes*** (n=20) (alliance, engagement, empowerment, expectancies, and choice) see next column for summary	characteristics (age, gender of child, history of abuse neglect etc.) were NOT associated with service access and continued involvement but rather caregiver attitudes and beliefs about seeking and receiving mental health services (3) empowerment and self efficacy: studies support empowerment and self-efficacy interventions as predictive of family perception of engagement, satisfaction, and outcomes for youth with externalizing behaviors. Reduction of strain/stress has shown to increase self-efficacy and social/educational variables predict empowerment. (4) expectations and attributions about services. A few studies present families' perspective on what makes treatment acceptable. Socioeconomic status, parental mental illness or stress, and severity of child problems impact parent expectancies which in turn predicted subsequent barriers to participation, adherence to recommendations (which tends to be lower for psychological than for school-based or non-professional services), and drop out rates. Perceived barriers are reduced slightly over time of participation and when outcomes improve. Changing perceptions of barriers through increased self-efficacy and empowerment may ultimately lead to better outcomes. Family expectancies about helpfulness of services, and meeting expectations of continuity, and sustained contact with one provider may increase likelihood for return visits. (5) impact of family preference or choice on outcomes: Only one study was located that showed strong similarities between mother's choices and therapists' blind	

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				recommendations, there are currently no studies rigorously examining impact of family choice on treatment.	
25	Jackson-Gilfort, A., Liddle, H.A., Tejeda, M.J., & Dakof, G.A. (2001). Facilitating engagement of African-American male adolescents in family therapy: a cultural theme process study, *Journal of Black Psychology, 27* (3), 321-340.	Study of factors and practices facilitating therapeutic engagement with 18 (n) male African-American adolescents (ages 12-17), diagnosed with conduct disorder and substance abuse, participating in Multidimensional Family Therapy (MDFT) with African American therapists.	Sample was from larger clinical study. Analysis of 82 videotaped family sessions. Ratings (8 point scale) of how extensively 6 ***cultural themes*** from Cultural Theme Rating Scale (CTRS) were discussed. ***Engagement*** and ***relationship*** measured by observer ratings using Vanderbilt Psychotherapy Processing Scale (VPPS)	Regression Analysis used. ***Relationship*** negatively predicted by by trust/mistrust discussions (focused on parent-child trust issues); positively predicted by alienation and respect/disrespect discussions. ***Engagement*** predicted by discussions of anger/rage, alienation, and journey from boyhood to manhood.	Diversity focus, substance abuse
26	Johnson, L.E., Wright, D.W., Ketering, S.A. (2002).The therapeutic alliance in home-based therapy: is it predictive of outcome?, *Journal of Marital and Family Therapy, 28* (1), 93-102.	Pre-Post study of associations of TA and symptom distress(SD), interpersonal relations (IR) and family coping (FC) in 43 families (participants: n= 81) at risk for removal of youth and receiving home-based family therapy	Mean 14.3 weeks tx., 2xwk Ecosystemic approach Co-therapy-Doc student and CM 1.Family Tx. Alliance Scale (interpersonal dimension only) 2. Outcome Q. (SD, IR) 3. F-COPES—how cope Rated by mothers, fathers, adolescents.	1. Domains of goals, bonds, and tasks (together) predict changes in symptom distress for all in family. 2. Tasks most influential for mothers and adolescents; goals for fathers. 3. Variance acct. for: 19% of SD for mothers, 55% for fathers, 39% for Ad. 4. No sign. results for IR or FC.	Home-based treatment, small N for fathers and ad., (15 & 26) 26 individuals. (13 families) dropped out
27	Karver, M.S., Handelsman, J.B., Fields, S., & Bickman, L. (2005). A Theoretical Model of Common Process Factors in Youth and Family Therapy, *Mental Health Services Research, 7* (1), 35-51.	Conceptual article outlining model to include common factors such as TA in current discussion and development of empirically supported treatments with youth and families.	Theoretical model of relationship variables and outcomes containing the following factors: (1) Client pretreatment characteristics (2) Therapist pretreatment characteristics (3) Therapist reactions, perceptions, and feelings (4) Counselor interpersonal skills (5) Therapist self-disclosure (6) Therapist direct influence skills (7) Therapist credibility/ persuasiveness (8) Autonomy (9) Affect toward therapist (10) Willingness to participate in tx	Argues that attention to common factors, albeit not yet thoroughly researched or conceptualized, constitute an empirically supported treatment (EST) for children and youth. The hypothesized model of a treatment process incorporates a host of relationship and outcome variables. Relational processes begin with the pretreatment characteristics of therapists and clients that are little researched but hypothesized to influence therapists' feelings, reactions and perceptions during initial interactions. Therapists' subsequent skills and behaviors, self-disclosures and interpersonal skills influence the client's perception of how credible, and	

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			(11) Parental willingness to participate in tx (12) Client participation in tx (13) Parental participation in tx (14) Therapeutic relationship with youth client (15) Therapeutic alliance with youth client (16) Therapeutic relationship with parents (17) Therapeutic alliance with families	persuasive the therapist is, and how autonomous/ self-directed a client can be in the relationship. These factors will in turn impact the therapeutic alliance or relationship which is here defined as consisting of client's (and/or parents') level of hopefulness, willingness to participate and level of participation in treatment along with affect toward the therapist. Authors find that constructs of therapeutic alliance and therapeutic relationship are essentially the same and distinctions seemed not meaningful. Alliance is seen as influencing outcomes wither as a necessary change mechanism, or as a catalyst for other treatment processes that lead to outcomes. Bordin's (1979) alliance/relationship definition encompasses three dimensions: emotional bond, collaboration on tasks and agreement on goals (definition by 1979). Other definitions of alliance include client behaviors toward therapist such as hostility, negativity, distortions etc. The authors contend that it may be more useful to separate alliance into three constructs: emotional connection (including trust, warmth, mutual positive regard, supportiveness, etc.), cognitive connection (including hopefulness, willingness to participate etc.) and behavioral participation in treatment. Parents and families are critical in the treatment of children and youth. Therapeutic alliance with parents and families has received only limited attention in the literature and existing definitions of alliance have been criticized as not taking into account the unique and complex processes in family therapy.	

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28	Kaufman, M. (2000). Effects of therapist self-monitoring on therapeutic alliance and subsequent therapeutic outcome. *The Clinical Supervisor, 19* (1), 41-60.	Experimental study exploring: Can self reflectiveness enhance development of TA and/or therapeutic outcome?	16 therapists randomly assigned to experimental (44 clients) and control (32 clients) groups. Tracked for 6 sessions. Measures of TA (HAq & study form), functioning (GAF and Personal Status Inventory), self monitoring for Exp. Group.	Self monitoring NOT predictive of alliance, outcome, or patient perception of facilitating behaviors. Alliance and patient functioning at Week 1 predictive of outcome.	No review of training methods to enhance TA. Incomplete data. Adds to previous questions about whether TA can be taught.
29	Kaufman, N., Rohde, P., Seeley, J.R., Clarke, G.N., & Stice, E. (2005).Potential mediators of cognitive–behavioral therapy for adolescents with comorbid major depression and conduct disorder, *Journal of Consulting and Clinical Psychology, 73* (1), 38–46.	Secondary analysis of experimental study focusing on mediating factors for outcomes in 93 adolescents (ages 13-17) with comorbid conduct disorder and major depression, assigned to either cognitive behavioral group treatment or control life skills course.	***Sample***: recruited from juvenile justice: 51.6% male, 80.6% Caucasian, mean age 15, 15% residing with biological parents. ***Intervention***: Experimental: manualized cognitive-behavioral group treatment program "Coping with Depression for Adolescents" ***Measures*** Specific factors: cognition, relaxation, social skills, pleasant activities, problem solving Non-specific factors: Working alliance (using WAI, adolescents' perception) and group cohesion.	Original study results showed greater reduction of depressive symptoms for youth in experimental condition at posttreatment measure, but no significant differences between groups at 6 and 12 months follow up. Results of this secondary analysis indicate that by the third session TA was higher for experimental group but TA scores did not predict reduction in depressive symptoms. Authors suggest that faster symptom reduction in this group may account for higher alliance scores. Limitation: using only one source (youth) to assess alliance	JJA
30	Kazdin, A.E. & Wassel, G. (1999). Barriers to treatment participation and therapeutic change among children referred for conduct disorder. *Journal of Clinical Child Psychology, 28,* 160-172.	Study examining barriers to treatment and therapeutic change in 200 (n) children (ages 3-13) referred to outpatient treatment for disorders of conduct who completed treatment of problem solving and parent training.	*Sample*: 45 girls, 155 boys; 74% Caucasian, 21.5% African-American, 5% Hispanic, 5% other; Only includes families who completed treatment. Caregiver respondents were 93% biological mothers *Measures*: Family, child, and parent predictors of therapeutic change Barriers to participation in sessions (including relationship with therapist; rated by parents and therapists) Behaviors: CBCL, antisocial behavior interview, parent daily report	Results show that independent of child and family characteristics, perceived barriers to treatment participation were predictive of changes in outcome. Among the domains of perceived barriers (rated by parents and therapists) the relevance of treatment, and demandingness of treatment showed highest correlations with change, followed by relationship with therapist which also had statistically significant correlations to outcomes for both therapist and parent ratings. Perception of low barriers to participation actually served as a protective factor for children with otherwise high barriers stemming from family characteristics like	Engagement/ participation

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				poverty, family psychopathology etc.	
31	Kazdin, A.E. (2005). Treatment outcomes, common factors and continued neglect of mechanisms of change, *Clinical Psychology: Science and Practice, 12,* 184-188.	Conceptual article reviewing and critiquing current views on relationships between outcomes, and common factors like TA.	Three key issues: 1. Differential outcomes for particular treatments do not affect common factors 2. Therapeutic alliance literature can neither refute nor support common factors view 3. Key lines of research continue to be neglected.	Even if some specific treatments produce consistently larger effect sizes than others it does not follow that only specific factors of the treatment account for the difference; for instance, one treatment might produce higher expectancy rates (a common factor). Thus outcome differences between two treatments do not directly bear on the common factors view. Therapeutic alliance studies fail to establish a timeline relation with outcomes. Alliance measures are typically assessed early while outcomes are assessed later. Improved outcomes can thus be the result of improved alliance, or alliance may have improved due to early outcome improvements. Alliance measures may also be proxys for client characteristics or other variables. Thus current alliance literature can neither support nor refute common factors view	Review Not specific to children & adolescents
32	Kendall, P.C., & Southam-Gerow, M.A. (1996). Long-term follow-up of a cognitive-behavioral therapy for anxiety-disordered youth, *Journal of Consulting and Clinical Psychology, 64* (4), 724-730.	Long-term follow up study (3 years post treatment) of randomized C-B treatment study on effects on 36 (n) youth (ages 11-18) with anxiety disorders and their parents, including open ended recall of helpful factors.	***Sample***: 36 (n) of an original 44 (n) participant study; 20 boys, 16 girls; mean age 15.6 years. ***Measures***: Revised children's manifest anxiety scale Coping questionnaire Negative affectivity self-statement questionnaire Depression inventory CBCL (parent rated) State-trait Anxiety inventory Recall interviews open ended phone interviews with youth re. 1. factors that were perceived as helpful, and 2. "theoretical factors" i.e. questions	Results indicate that gains for youth were maintained both for the time period between pre-treatment and long term follow up, and between one-year follow up and this long term follow up. Among the recall items in response to "what was important?" therapeutic relationship was the most popular answer (44%), and also ranked second for the question of what youth liked about therapy (after "games and activities"). Authors report no significant correlations of perceived helpful factors to outcomes but some moderate relation between specific theoretical questions to outcomes. They conclude their finding "merely suggests a relative important role for certain factors in the therapeutic process."	Unclear how open ended interviews were analyzed: Authors report chi-square and correlational procedures being performed after responses were coded.

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			about specific skills taught in the course of treatment.		
33	Kroll, L., & Green, J. (1997). The therapeutic alliance in child inpatient treatment: Development and initial validation of a Family Engagement Questionnaire, *Clinical Child Psychology and Psychiatry, 2* (3), 431-447.	Article outlining development and initial validation study of Family Engagement Questionnaire for clinicians on inpatient treatment team in England.	Outline of TA in inpatient setting; 20 item family engagement questionnaire pilot tested with sample of 30 youth (16 male, mean age 13.8 years) on three different inpatient units specializing in different symptoms. FEQ covered four main areas: child's engagement with ward staff; child's engagement in therapeutic activities; child's engagement with peers on unit; personal and task-related engagement of parents with ward staff. Ratings for each child were provided from two nurses within first month of admission, along with a structured assessment of engagement provided by clinician.	Initial interrater reliability was poor but improved when items were revised. Validity was good. Parent and child subscales showed internal consistency and were distinctive from each other indicating the usefulness of assessing both. Combined child and parental scales were correlated with clinician assessment. Limitation: small n, using only professionals as sources	Instrument Engagement See related study Green, J., Kroll, L, Imrie et al (2001)
34	Kronmüller, K. T., Victor, D., Horn, H., Winkelmann, K., Reck, C., Geiser-Elze, A., & Hartmann, M. (2002). Therapeutic relationship patterns in child and adolescent psychotherapy / Muster der therapeutischen Beziehung in der Kinder- und Jugendlichen-Psychotherapie, *Zeitschrift für Klinische Psychologie, Psychiatrie und Psychotherapie., 50* (3), 267-280. [in German]	German study evaluating typical alliance patterns of 80 (n) youth (ages 6-18) in psychoanalytic treatment and their therapists	***Sample***: 52% girls, mean age 11., 60.8% living with biological families (25% single parent households); all diagnosed with emotional or behavioral disorders Intervention: psychoanalytic treatment ***Measures***: Therapeutic Alliance Scales for Children (translated from Shirk & Saiz) capturing child and therapist views; A scale capturing psycho-social communication (therapist view; based on psychoanalytic concepts), and CBCL (parent view).	Results: five distinct clusters of relationship patterns show varying agreements of therapist and child views on the working alliance and bond aspects of the relationship, (and also varying agreements of therapist and parents on the severity of symptoms). The largest group (n=27 pairs) consisted of therapists and children agreeing that bond and working alliance are positive. In a second group therapist and child agreed about a good working alliance but disagreed on quality of bond with child having more negative views (n=22 pairs). In a third group, showing high discrepancies of therapist and child views (n=15 pairs), children viewed both aspects of relationship as good while therapists viewed the bond as bad. The fourth cluster consists of children viewing working alliance and bond as negative while therapist saw bond as significantly better. (n=8 pairs). This cluster showed	

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				highest disturbances on CBCL, especially externalizing behaviors, from parents perspective (but not from therapists). The highest disturbance rating from therapists correlated to the fifth cluster of relationships in which both therapist and child viewed bond and working alliance as bad (n=8 pairs). Developmental aspects of TA are highlighted in that young children regarded emotional bond as positive while adolescents found working alliance positive but less often the bond.	
35	Littell, J. H. (2001). Client participation and outcomes of intensive family preservation services, *Social Work Research, 25* (2), 103-113.	Study examining collaboration and compliance as variables for client participation and outcomes in family preservation, using case worker ratings available for 2,194 (n) cases.	Illinois family preservation program from 1989 to 1993, mean length of service 106 days. 3 point rating scale completed by worker at termination—to what extent did primary caregiver participate in the development of a service plan, agree to the plan, initiate contact, keep appointments, complete assigned tasks, cooperate with services. Outcomes derived from state data: subsequent reports, out of home placements, case closings. Two points in time: duration of FPS involvement, one year follow-up.	Greater collaboration (in treatment planning?) leads to better compliance with program expectations, which in turn predicts reductions in subsequent reports and out of home placements.	Child welfare Poor measures of compliance and collaboration. Statistical significance, but what about effect size? No direct link to TA.
36	Martin, G. R., & Allison, S. (1993). Therapist alliance: A view constructed by a family therapy team, *Australian and New Zealand Journal of Family Therapy, 14* (4), 205-214.	Pilot study describing development of a 15-item Family Therapeutic Alliance Scale (FTAS) by a team of family therapists in New Zealand, and results of instrument testing with 31 family therapists	Items designed to parallel bonds component of TAI, but not tasks or goals. Experts used FTAS 36 item draft to rate 10 videotaped interviews. Statistical analysis reduced to 2 factor 15 item scale. 31 therapists rated tape segments and reliability assessed.	FTAS found reliable re: interrater reliability and test-re test. Scores able to differentiate between families.	Instrument for TA with families. Pilot testing. Bonds component only; no family ratings.
37	McLeod, B. & Weisz, J. R. (2005). The Therapy Process Observational Coding System—Alliance Scale: Measure	Description of Therapy Process Observational Coding System—Alliance Scale and results of alliance relation to	***Sample***: 22 children (13 girls) participating in outpatient community mental health clinic Youth Anxiety and Depression Study. 41% Caucasian, 36% Latino, 18% African American,	***Results***: outcomes showed reduction of symptoms similar to EST studies. Bond and task items showed substantial overlap (suggesting these two dimensions may not be distinct constructs).	instrument

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	characteristics and prediction of outcome in usual clinical practice, *Journal of Consulting and Clinical Psychology, 73* (2), 323–333.	outcomes for 22 (n) children (ages 9-13) with internalizing disorders and 20 (n) therapists providing outpatient treatment as usual.	majority from low income families, with substantially comorbid conditions combining anxiety and depressive disorders. ***Alliance measures***: New TPOCS-A Scale using observation ratings to assess two main dimensions of TA, bond and task, for child-therapist and parent-therapist relationship. Nine items: experience therapist as supportive, act hostile toward therapist, demonstrate positive affect toward therapist, share experience with therapist, uncomfortable interacting with therapist, degree of difficulty of interaction between client and therapist, use learned skills outside of therapy, not comply with tasks, work together equally on tasks. Four session tapes for each case (one beginning phase, two middle, one ending phase) were selected at random to be independently coded by two trained coders. Their mean rating score was used for analysis for a total of 87 child sessions and 49 parent sessions. Therapeutic Alliance Scale for Children (self-report) ***Other measures***: Diagnostic Interview for children, CBCL, State-Trait Anxiety inventory, Depression, inventory, therapist background questionnaire, ***Treatment***: as usual. Eclectic blend of approaches, favoring nonbehavioral strategies.	Parent-therapist and child-therapist rating forms appeared to be independent (not showing significant correlations). The child form showed internal consistency and moderate stability of scores over time. The parent form was also internally consistent with high stability over time. TPOCS showed convergent results with self-report alliance measure (but significantly only for the child ratings).	
38	Motta, R. & Lynch, C. (1990). Therapeutic techniques vs therapeutic relationship in child behavior therapy, *Psychological Reports, 67,* 315-322.	Study of parents' and therapists' rating relative importance of therapeutic relationship and techniques for behavioral therapy of 56 children	Children had behavior and/or learning problems. One month to 1 ½ years post termination, parents rated how important relationship and techniques were to the treatment, as well as	Parents rated relationship between therapist and child as of highest importance. Correlation between technique and outcome significant, but between relationship and outcome was not.	Measures not standardized. Parent ratings long after the fact.

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		(ages 4-17) (44 boys)	improvement on goals and current functioning. 42 therapists in 3rd year internship. Rated outcome immediately upon termination.	Therapist rating of outcome higher than parents'.	
39	Motta, R., & Tobin, M. (1992). The relative importance of specific and nonspecific factors in child behavior therapy. *Psychotherapy in Private Practice, 11*, 51-61.	Survey study of parent and therapist ratings of the relative importance of techniques versus relationship in behavioral therapy for children (n=47; ages 4-19; 31 boys, 16 girls), and correlates to outcomes.	*Sample*: 31 boys, 16 girls with behavioral and/or academic problems, mean age 10.7. No ethnicity indicated. *Intervention*: Behavioral techniques and social skills training. Mean number of sessions: 21.5 *Measures*: Questionnaire to parents after termination inquiring about relative importance of specific and nonspecific factors, Therapists' appraisal of goal accomplishment.	A majority of parents (66%) perceived relationship of their child with therapist as more important than particular techniques, about 25% saw both factors as equally important, none viewed technique as more important. Analysis of nonspecific and specific factors with therapist rated outcomes indicated that only specific factors were correlated with better outcomes (for male clients, not for female clients whose data showed no correlations of factors and outcomes). Limitations: small sample, poor measures.	
40	Quinn, W.H, Dotson, D., & Jordan, K. (1997). Dimensions of therapeutic alliance and their associations with outcome in family therapy, *Psychotherapy Research, 7* (4), 429-438.	Study about aspects of therapeutic alliance in outcomes in family therapy with 17 (n) couples, rated and analyzed individually for male and female spouses.	***Sample***: 17 couples participating in marital or family therapy at university-based clinic (no further sample characteristics given), no information about presence or involvement of children. ***Measures***: TA: Pinsof and Catherall's IPAS Scale combining individual, family and couple scale each of which assess content dimensions (bond, tasks and goals) and interpersonal dimensions of self-to-therapist, other-to-therapist, and group-to-therapist. Collected immediately after the third session. Outcome measure: client report of the extend to which treatment goals had been met, and confidence that changes would last for 3-6 months.	Authors report two main differential findings: (1) When women reported higher task alliances than their husbands therapy outcomes tended to be better. When husband reported higher tasks alliances than their wives outcomes of therapy were rated worse. (2) When wives thought that other family members had strong alliances, outcomes were more positive. Poorer outcomes were found when husbands thought their wives had good alliances with the therapist, while wives at the same time rated their husbands' alliance as lower. As expected all scales and dimensions showed statistically significant correlations (although lower than in previous studies using IPAS). High level of correlations between subdimensions of scale suggest that they may indeed not be separate constructs. The study is limited by small sample size, and a very general, client-source only outcome measure.	

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41	Ribner, D.S.. & Knei-Paz, C. (2002). Client's view of a successful helping relationship, *Social Work, 47* (4), 379-387.	Qualitative study analyzing the narratives of success stories of social workers' helping provided by 11 (n) women (ages of 33-50) in Israel heading multi-problem households.	Content analysis resulted in four major categories: Description of life prior to encounter with social worker Description of life after encounter Areas in which worker was helpful Ways in which clients felt worker was successful (including personality characteristics, professional ability, client-worker interaction, client's own success, life circumstances, factors unrelated to intervention, therapeutic factors unrelated to worker)	Authors conclude that clients valued concrete assistance as much as they valued the relationship with the worker. Successful relationships were characterized by the client's sense of having a unique or singularly fitting relationship with a worker to whom they felt close. For many the social worker was the only source of support and attention, and was often described as a friendship. Professionals were described as able to create atmospheres that made clients comfortable, create a sense of equality within the working relationship, use language that did not distance workers from clients, and actively engage in doing things together with the client. Contacts were characterized by flexibility, willingness to go beyond traditional office hours or agency locations, meeting on client's turf, keeping in touch via telephone, and participating beyond traditional roles in aspects clients deemed important (child's birthday party etc.). Clients frequently saw "their" social worker as almost independent from the agency they worked for in effect separating them from the often oppressive bureaucratic welfare structures.	Clients' perspective
42	Robbins, M.S., Turner, C.W, Alexander, J.F., & Perez, G.A. (2003). Alliance and Dropout in Family Therapy for Adolescents With Behavior Problems: Individual and Systemic Effects, *Journal of Family Psychology, 17* (4), 534-544.	Study examining relationship between alliance and retention for 34 (n) families of adolescents (ages 12-18) with behavioral problems (drug use and related problems) who either dropped out or completed functional systemic family therapy.	*Sample*: 20 male, 14 female, Therapists: 34 graduate student trainees *Intervention*: Functional family therapy for adolescents with disruptive behaviors, based on systemic and cognitive-behavioral theories. *Measures*: Vanderbilt therapeutic alliance scale (observer rating) for parent and youth Completion (n=20) /dropout (n=14) Data from videotaped initial sessions,	*Results* indicate that individual ratings for adolescents and parents were not predictive of completion or dropout. In fact parental alliances were generally higher in the dropout group (counter to typical hypotheses). However, discrepancies between parental and youth alliance scores were predictive of dropout status. In particular discrepancies of father-adolescent scores were statistically significant for higher dropout (mother-adolescent discrepancies showed a similar trend but did not reach statistical	

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			divided into two 20-minute segments	significance). The authors conclude that individual alliances in the context of family therapy are not only insufficient indicators for retention but may in fact be misleading. Consistent with the family system view of "the sum being more than its parts," the therapist must attend to and balance the dynamics of alliances between parent-therapist and youth-therapist. The study is limited by its small sample size. No data on ethnicity is provided, and only initial sessions were analyzed.	
43	Shelef, K., Diamond, G.M., Diamond, G.S., & Liddle, H. (2005). Adolescent and Parent Alliance and Treatment outcomes in Multidimensional Family Therapy, *Journal of Consulting and Clinical Psychology, 73* (4), 689-698	Study examining relationship between adolescent and parent ratings of alliance and outcomes of multidimensional family therapy for substance abusers (ages 12-18)	*Sample*: 65 (n) youth with Cannabis abuse or dependency (excluding youth with alcohol problems or severe behavior/conduct problems), mean age 16, majority male (85%), Caucasian (47%), African American (47%), 67% JJA involvement. *Measures*: Self-reported alliance by youth: short version of WAI (measured some point between 2nd and 5th session) Observed alliance (taped session) of therapist-parent and therapist-adolescent, revised version of Vanderbilt TA Scale (scored for same session youth completed the WAI-or session immediately thereafter) Outcomes (at 3, 6, and 9 months) Adolescent functioning (GAIN) Days of cannabis use (youth self report) SPI: Symptoms of substance use	Premature terminations were associated with poorer parent alliances. Strength of observer-rated early youth alliance predicted substance use up to 90 days post treatment and was a stronger and more robust predictor than youth self-rated alliance. Youth self-ratings were so consistently high that statistical tests did not yield correlations. Neither rating predicted outcomes at 6 or 9 months post treatment. Interaction between youth and parent alliance ratings approached statistical significance. Thus, the quality of parent alliance moderated correlations of youth alliance to outcomes. While the strength of parent alliance predicts retention in treatment, youth alliances predicted improved outcomes. This finding emphasizes the need to attend to multiple the alliances in work with families.	
44	Shirk, S. R. & Karver, M., (2003). Prediction of treatment outcomes from relationship variables in child psychotherapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71* (3), 452-464.	Meta-Analysis of 23 (n) studies that examined associations between therapeutic relationships and outcomes in child and adolescent therapy including family therapy.	***Meta-Analysis Sample***: studies from 27 years with analogue samples of at least five participants, published or available on Dissertation Abstracts database, reported outcome measure, not restricted to individual therapy but inclusive of family therapy and parent training.	***Results:*** The average relationship-outcome correlation was modest but consistent, and generally comparable to adult findings. For *individual* child/youth therapy correlations are identical to adult meta-analyses, but *family* therapy also showed comparable correlations. The therapeutic	Meta-analysis Methods similar to Weisz et al (1995)

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			Measures: (1) Overall strength of association (2) Moderating variables: (a) patient and treatment factors: child age (12 and younger or 13 and above), type of presenting problem (externalizing, internalizing, mixed) type of treatment (behavioral, nonbehavioral, eclectic) mode of treatment (individual, family, parent training) target relationship (client-therapist, family-therapist, parent-therapist) level of structure in treatment (manualized/ non manualized) context of treatment (service-as-usual therapy or research trial/demonstration therapy) (b) methodological factors: timing and source of relational measure content and source of outcome measure shared vs. cross-sources measures study design (controlled/uncontrolled) extent of beneficial effects	relationship is "reasonably robust and consistent" (p. 461) across divergent types of treatment (individual, family, parent; non-behavioral and behavioral approaches; manualized and non-manualized treatments; service vs. research treatments) and developmental levels. There is some evidence that outcome-relationship correlations may be moderated by type of client (age) and problem, (stronger associations with externalizing problems), as well as by methodological factors: (a) time of relationship measurement—in contrast to adult findings, relationship measures taken later rather than earlier had stronger associations (raising questions about the relative speed of alliance building with children, and confounding effects of relationship and outcome measures); (b) source of relationship measure (stronger associations with therapists' ratings, and stronger for shared vs. cross-source informants); (c) type of measured outcome (stronger associations found in global functioning than specific measures). ***Participant study samples typically*** consisted of 47 (n), majority boys (65%), treated in outpatient settings (14 of 23 studies), 8 studies included or focused on families, mostly (14) with mixed target problems (5 externalizing; 4 internalizing). There was no common relationship measure or dominant relationship construct across studies. Relationship data were gathered from more than one source in 12 studies, most often from therapists (13), youth (12), parents (7),	

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				observers (2), family members (2). Outcome measures focused on symptoms (15), global functioning (11), family functioning (4) and a mixture of measures (11) typically reported by more than one source. This variety led to 20 possible "relationship to outcome" combinations. Heavy reliance on outcome ratings from people directly involved in the treatment may result in ratings that are influenced by desirability or general satisfaction with the process.	
45	Shirk, S.R. & Saiz, C.C. (1992). Clinical, empirical and developmental perspectives on the therapeutic relationship in child psychotherapy, *Development and Psychopathology, 4,* 713-728.	Conceptual article reviewing clinical and empirical literature on TA, and proposing a developmental social-cognitive model of TA formation	Historical views on therapeutic relationship Research perspectives on TR Therapeutic Alliance Scales Developmental perspective on alliance formation	Distinguishes two main views on therapeutic relationship: (1) the dynamic/play therapy perspective which assumes that TR is both necessary and sufficient condition for growth, and (2) the TR as means to more specific end which assumes there is a necessary emotional bond and collaborative aspect of alliance to which other techniques are added to achieve defined therapeutic goals. Therapeutic Alliance Scales, developed by authors, was piloted with 62 (n) children (ages 7-12) in inpatient setting, and elicit child and therapist views (child scale items are elicited from child by staff member other than therapist). Results showed acceptable internal consistencies of scales. The two perspectives, though at time convergent, are not interchangeable. Affective items showed stronger conversion between child and therapist than task/collaboration items. A developmental perspective suggests the need to assess children's age, as well as social and cognitive factors along with familial and social context to arrive at are better understanding of mediating factors for TA.	

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46	Steinberg, K.L., Levine, M. & Douecek, H. J. (1997). Effects of legally mandated child abuse reports on the therapeutic relationship: a survey of psychotherapists, *American Journal of Orthopsychiatry, 67* (1), 112-122.	Study presenting results of a survey of 303 (n) psychologists regarding effects of mandated reporting on therapeutic relationship.	*Sample*: mean age 47.6, 62% male, 67% in private practice, 87% voluntary cases. Primary allegation in cases was sexual abuse (40%). *Measure*: Four scales asked about impact of mandated reporting on Prevention of further maltreatment Family situation Therapeutic relationship Therapist variables included: Explicitness of informed consent Role strain Resentment Attitudes toward child protective services Locus of reporting responsibility Reporting history Strength of working alliance Client variables and retention	Results indicated that about 25% of therapists viewed mandated reporting as harmful or very harmful to TA. At the same time 78% maintained that reporting was helpful or very helpful to prevent further abuse. Although 25% of clients dropped out of treatment following a report the majority remained in treatment. The stronger the TA was before reporting, the better the response (reaction and retention) after reporting. The more explicit the therapist was about consent and confidentiality rules the better the response to a mandated report. The higher the experienced role strain, the more negative impact reporting had on the TA. Limitation: entirely based on therapist self-reports, sample mostly male, private practitioners.	Legal context
47	Tetzlaff, B.T, Kahn, J. H., Godley, S.H., Godley, M. D., Diamond, G.S., & Funk, R.R. (2005). Working alliance, treatment satisfaction, and patterns of posttreatment use among adolescent substance users, *Psychology of Addictive Behaviors, 19* (2), 199-207.	Secondary data analysis examining longitudinal outcomes and relation to working alliance and satisfaction of 353-440 (n, varied) adolescents who participated in family-focused substance abuse program.	*Sample* 83% male, 61% Caucasian, 30% African Am. 80% with co-occuring psychiatric disorder, 62% involved with criminal justice system. *Data set* from Cannabis Youth Treatment study, 3 year study of effectiveness of 5 different short term treatment models. *Outcome measures* focused on 4 categories: little/no relapse, minor relapse, moderate relapse, major relapse, as self reported at 3, 6, 9, 12, and 30 months. *Working Alliance* measured by WAI-short form adapted for adolescents, completed between 2nd and 5th session. Used only total score, not subscales. *Treatment Satisfaction Index*, collected at 3 months post intake Also measured *Initial severity*	Claims to be the first to look at TA for youth substance abusers. **Results** 1. Working alliance(WA) and treatment satisfaction moderately correlated (r=.36) 2. No correlation between WA and initial severity. 3.Initial Severity and WA were the only predictors of posttreatment use at 3 and 6 months. 4. Only initial severity predicted outcomes at 9,12, and 30 months. **Conclusion**: 1. "Adolescents who have stronger alliances with their therapist early in treatment are slightly less likely to experience relapse within the first 6 months after intake". 2. "treatment satisfaction was unrelated to posttreatment use."	Substance abuse No analysis of interaction of WA with a variety of treatment models and settings (although data set is capable of providing)

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				Limited by use of only adolescent source of WAI and self-report substance use data.	
48	Tolan, P.H., McKay, M.M., & Dickey, M. (2002). Evaluating process in child and family interventions: Aggression prevention as an example. *Journal of Family Psychology, 16,* 220-236.	Reports results from two studies designed to develop scale measures for evaluating processes in child and family interventions for children with behavior problems, including child and family alliance in urban, low income families.	Combined samples consisted mostly of African-American and Hispanic children, mean age 10.8 years. Measure of Alliance was composed of scale items about relationship with worker and satisfaction with program (rated by parents) Outcomes were measured through a parenting practices scale (rated by parents). Study 1 (n=187 families) included alliance, parent skill attainment, child cooperation, child pro-social and aggressive behaviors. Study 2 analyzed score patterns (on same factors) of 78 (n) families participating in prevention program. Ratings were completed in five intervals between 6th and 20th session.	Scales appeared robust and consistent, showing convergent and discriminant validity. Application of the scales in study 2 showed empirical evidence for the link of alliance, change in parenting practices and child symptom outcomes. Alliance is a multidimensional construct (encompassing emotional relationship and satisfaction with program including such things as skills training, information etc.). While parent alliances was predictive of better parenting outcomes, child alliances seemed less critical to determine outcomes which may be a function of the relatively young age of children in the sample.	Instrument/ measure development
49	Weisz, J.R., Huey, S.J., & Weersing, V.R. (1998). Psychotherapy outcome research with children and adolescents: The state of the art, *Advances in Clinical Child Psychology, 20*, 49-91.	Article reviewing state of the art evidence about effective treatment for youth, especially meta-analyses, includes review of research on therapeutic relationship and suggestions for future directions.	Sections include: Distinctive features of child therapy Evidence of effectiveness Representativeness of outcome research vis-á-vis clinical practice Assessment of therapy process in practice Ethnicity and culture Social and Family contexts Enriching research design	The role of TA may be particularly important with children and adolescents who are rarely voluntary clients but few studies have actually studied TA in this context. Unlike consistently positive findings in the adult literature studies on TA with children have been mixed. This lack of agreement is difficult to interpret because measures of TA vary across studies. Little attention has been given to the child's perspective, and only recent research begins to assess TA from various sources. The field needs a well-validated set of measures that can be adapted to the varying developmental levels of child clients, and can also assess the family-therapist relationship along with the therapist-child dyad.	Review
50	Weisz, J.R., Weiss, B., Han, S.,	Meta-analysis of 150 (n) treatment outcome studies	Selected were controlled studies published in peer reviewed journals that	***Overall***, receiving therapy had a significant impact on outcomes versus	Meta-analysis

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	Granger, D. & Morton, T. (1995). Effects of psychotherapy with children and adolescents revisited: A meta-analysis of treatment outcome studies , *Psychological Bulletin, 117* (3), 450-468	with children and adolescents (ages 1.5-17.6 years, mean: 10.7 years) published between 1967-1993, and *not* previously included in meta-analyses (by Weiss & Weisz,1990; Weisz et al., 1987; or Casey & Berman, 1985).	had not been included in previous meta-analyses. Multiple raters coded studies for sample, therapy method, and design features. ***Studies in the sample*** included clinical studies (with youth who would have received treatment anyway, n=41) or analogue (youth specifically recruited, n=104); (5 not coded). ***Methods*** used in studies were mostly behavioral (including cognitive /behavioral; operant, reinforcing, respondent, modeling, social skills, parent training) (197 interventions), some were non-behavioral methods (27 interventions), and few mixed methods (20 interventions). ***Target problems*** were grouped into overcontrolled (internalizing, social withdrawal, etc.) (40 studies), undercontrolled (externalizing, aggressive etc.) (59 studies) and other (55 studies). ***Outcome measures*** were analyzed and grouped by ***source*** (provider of outcome rating) and ***domain*** (area of outcomes). ***Therapist training*** was classified as either professionals (with completed degree in MH field), students (working toward professional degree) or paraprofessional (no graduate level MH training). Two different ways of calculating effect size were employed.	receiving no or attention only treatment with effect sizes in the medium to large range (0.54-0.71). Unlike for adults, treatment outcomes for children show that some treatment methods have greater effects than others. Namely ***behavioral treatments***, (which included a broad range of intervention types) were superior to non-behavioral treatments even when controlled for outcome measures used, target problem, therapist training, or child gender orage. The authors note that this finding could be inflated because the number of studies using behavioral methods was much higher than non-behavioral studies which made up only 10% of the sample. ***Differential analysis*** showed: no overall differences of effectiveness in regards to *type of problems* (over- or undercontrolled behaviors); *age* did not clearly correlate with differences in outcomes; *gender* had a more clear impact in that female majority samples had better outcomes, and samples with a majority of female adolescents had best outcomes. It appears that studies published since 1985 reflect better effectiveness of therapy with girls and adolescent girls in particular. Higher *therapist training* did not show significant effects on outcomes, in fact paraprofessionals (teachers and parents working under guidance of professionals) achieved significantly higher effects than other providers, although they may have been assigned to work with less challenging youth or perform a limited range of activities. Professionals did produce better outcomes than paraprofessionals or students when working with youth exhibiting overcontrolled problems. High variance of	Excellent discussion of meta-analytic methods Does not control for therapeutic relationship.

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				effects sizes was noted when considering the *source* of outcome information by the domain of outcomes. Results indicate that it matters who reports outcome data. Peers, for instance, did not report changes in undercontrolled problems, which may mean changes did not generalize to peer situations, or peers' ratings were influenced by reputation effects. On the other hand, peers noted changes for overcontrolled problems more than did teachers.	
51	Werner-Wilson, R.J. (1997). Is therapeutic alliance influenced by gender in marriage and family therapy?, *Journal of Feminist Family Therapy, 9* (1), 3-16.	Study examining the impact of client and therapist gender, and differences by gender and treatment modality on therapeutic relationship dimensions (goals, tasks, bond) after the third session using WAI scale in couples or family therapy with 46 couples and 19 families	The authors propose that relationship factors require more attention in marriage and family therapy, and incorporate a feminist critique that gender and treatment modality interact. The study uses Horvath's WAI scale to measure differences in outcomes of WAI subscales (goals, tasks, bond) and overall scores for men and women in either couples (n=46) or family therapy (n=19) after the third session. Analysis focuses on interactions of client gender and therapist gender, and of client gender and treatment modality (couple or family therapy). On average, participants were in their early to middle thirties, with two years of college education, 63% were married more than 5 years, 80% had at least one child.	Gender combined with modality show statistical differences between men and women: While women scored higher overall (specifically on the goal and task subscale) in *marital* therapy, while men scored higher overall (specifically on the goal and task subscale) in *family* therapy. There were no differences on the bond subscale. A given combination of client gender and therapist gender does not result in differences in relationship outcomes. Authors conclude that results support the feminist critique that family therapy tends to reify the family and ignores the needs of individual members. Authors recommend that gender be included as a factor of therapeutic relationship research, and that practitioners' training should include reflections and awareness of gendered patterns in therapy.	Diversity focus: Gender

Appendix B.

Engagement with Children and Families--Brief Summary of Empirical Findings

Engagement typically refers to the initial stages of building an alliance (French, 2003). Similar to the therapeutic alliance literature, research about engagement patterns have not yet identified any clear relationship of engagement to outcome or client characteristics (McKay et al., 2004, 1996). Thus far, findings on engagement interventions show that parents' and/or youths' perceptions of barriers, and ethnic diversity may have some influence on engagement (McKay et al., 2004, 1996). (See pages 53-57 for matrix of engagement literature).

A qualitative study about factors affecting the engagement of youth in mental health services (French et al., 2003) focused on youth's experiences with referral, waitlist, and initial contact. Four main factors emerged in interviews: (1) The young person's beliefs, expectations including problem awareness, self-motivation, knowledge of services, perception of counseling; (2) perceived attractiveness of service, including interactions which influenced the young person to believe the service would meet his/her needs, such as feeling understood; confidentiality; individual sessions rather than family sessions; receiving information; ability to choose level of disclosure; and a physical environment other than office space; (3) sense of accessibility, including responses to practical questions such as free service, extended opening hours, local community setting, outreach efforts etc.; (4) assertive follow-up including actions to maintain contact such as minimal or no wait list, personal contact by counselor etc.

Intervention studies generally show that special engagement efforts lead to better attendance of initial sessions. However, results are mixed in regards to the effectiveness of such efforts for longer-term retention of clients (Coatsworth et al, 2001; Santisteban et al., 1996). Successful strategies to enhance engagement include reminder letters prior to initial session, telephone contact that goes beyond information gathering to strengthen parents' confidence in their ability to bring adolescents to first session, and enhances their perception of potential impact of services; and interventions that clarify to caregivers the need for services, roles of each party, maximize their investment, identify attitudes about services, identify concrete practical issues to be addressed immediately, identify perceived barriers, apply problem-solving approaches with parents and develop strategies to overcome obstacles such as transportation, child care, etc. (McKay et al., 2001; 1996).

A study about a multisystem, longitudinal prevention program for children at risk for conduct disorder assessed the rate and quality of parent participation (Orrell-Valente et al., 1999). Successful therapeutic engagement was found to be highly and positively associated with parents' participation rate and quality of their participation. Greater similarity between the parents' and family coordinators' race, socio-economic status, and life experiences was associated with higher levels of therapeutic engagement. No parent characteristics were related to participation rates, and ethnicity was the only parent characteristic found to be related to the quality of involvement. The study is limited by using only professionals to rate therapeutic engagement which was defined in terms of the family coordinator's sense of her own ability to remain engaged in the therapeutic role and to maintain delivery of services to resistant parents.

Coatsworth et al. (2001) conducted an experimental study of African-American or Hispanic adolescents involved brief strategic family therapy. The model was modified to focus on *joining* (tracking needs, agendas, identifying common goals for all family members etc.), *family pattern diagnosis* (identifying maladaptive family interactions connected to barriers for engagement in treatment) and *restructuring* (altering family patterns to maximize engagement and retention). Results show that participants were 2.3 times more likely to engage in *and* complete treatment than youth in the control group. Better retention and completion effects held even for youth with higher conduct disorder scores thus supporting a family-systems approach to engagement that favors support over early confrontation, and views resistance to engagement as part of a pattern treatable throughout the course of therapy rather than a side issue to the "real" work (Coatsworth et al., 2001).

Santisteban et al. (1996) tested the efficacy of a Strategic Structural System Engagement (SSSE) model and examined its differential effectiveness on Cuban versus other Hispanic ethnic families. The experimental engagement intervention provided family therapy with more active joining, higher levels of restructuring, problem solving during initial phone call, etc. Results show that the SSSE model led to significantly higher engagement rates but did not affect longer term retention rates (defined here as completing at least eight therapy hours and a termination assessment battery). SSSE appeared especially effective for non-Cuban families and failed more frequently with Cuban families. Exploratory analyses for culture/ethnic groups found that Cuban parents had higher resistance to participate in family therapy. Authors speculate that Cuban families have been acculturated to a more individual orientation and prefer individual rather than family treatment. Authors conclude that effective engagement strategies must be responsive to different cultural and communal characteristics.

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