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Therapeutic Alliance and Outcomes in Children and Adolescents Served in a Community Mental Health Setting

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THERAPEUTIC ALLIANCE AND OUTCOMES IN CHILDREN AND
ADOLESCENTS SERVED IN A COMMUNITY
MENTAL HEALTH SETTING

By

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A dissertation submitted to the faculty of
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ABSTRACT

THERAPEUTIC ALLIANCE AND OUTCOMES IN CHILDREN AND ADOLESCENTS SERVED IN A COMMUNITY MENTAL HEALTH SETTING

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Doctor of Philosophy

This study examined the association between the therapeutic alliance and psychotherapy outcomes in 350 children and adolescents receiving outpatient therapy at a community mental health clinic. Therapeutic alliance and psychosocial distress were measured at intake 3 week, 2 month, 4 month and 6 month intervals. Participants aged 12 and older completed self report versions of the outcome and alliance measures and the parents of participants aged 4-17 completed the outcome measure. Therapists completed alliance measures for each participant. Analyses examined the relation between youth-rated therapeutic alliance and psychotherapy outcomes, premature termination, problem type, age of client, and clinician-rated alliance. Results indicated that early therapeutic alliance ratings were not related to premature termination from therapy. With the exception of the 3-week time point problem type was not found to be related to the

formation of the alliance. A relationship between age of the client and the formation of a therapeutic alliance was true at the 6 month time point indicating that the therapists rated their relationships with youth under 12 years old more favorably than youth over 13 years old. Finally, the therapist's ratings of the alliance were not correlated with psychotherapy outcome. These findings indicate that associations between therapeutic alliance and psychotherapy outcomes may be less pronounced in youth treatment than in adult treatment.

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Introduction to Literature Review

The therapeutic alliance in psychotherapy has been an area of interest for clinicians and researchers for decades (Gaston, 1990; Horvath & Symonds, 1991; Marmar et al., 1986; Martin, Garske & Davis, 2000). The therapeutic alliance can be defined as the quality of the helping relationship, an emotional bond between the therapist and the client, the level of agreement between the two parties on the therapeutic tasks, and/or the agreement between the two parties on the expectations and goals of therapy (Bickman et al., 2004; Bordin, 1979). Another conceptualization of the therapeutic alliance is the combination of: 1) the patient's capacity to work purposefully in therapy, 2) the emotional bond of the client to the therapist, 3) the therapist's empathic understanding and involvement and 4) the agreement of the patient and therapist of tasks and goals (Thomas, Werner-Wilson, & Murphy, 2005). Although there are varying definitions for the construct of therapeutic alliance, the affective quality shared between the therapist and the client is a central component (DeVet, Young, & Charlot-Swilley, 2003).

The quality of the relationship between the therapist and client has been identified as an important factor by researchers and practicing clinicians alike. The therapeutic alliance is considered to be a common factor found in most mental health treatments and does not rely on a specific diagnosis or theory (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003). For this reason the strength of the relationship between the client and the therapist is a universal concern. In addition, the therapeutic alliance has been consistently demonstrated to be an influential factor in the outcome of adult treatment (Horvath, 2001; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Orlinsky,

Grawe, & Parks, 1994; Puschner et al., 2005). Preliminary studies of the alliance between child and adolescent clients and their therapists have indicated the same trend in relation to therapy outcomes (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003; Dew, & Bickman, 2005; Kazdin, Whitley, & Marciano, 2005). Moreover, practicing clinicians report that the therapeutic alliance is one of the essential components of effective therapy (Bickman et al., 2004). Likewise, clients report more investment in therapy when they feel the bond with their therapist is stronger (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003; Dew, & Bickman, 2005; Kazdin, Whitley, & Marciano, 2005).

Although the overall importance of the therapeutic alliance is supported by clinical and empirical evidence, more work is needed to understand the circumstances under which therapeutic alliance is most important, the populations in which it is most influential, and the mechanisms through which it impacts therapy outcomes. For example, it is unclear at what point during the course of therapy alliance is most predictive of outcomes (Shirk & Karver, 2003; Strauss et al., 2006; Zuroff & Blatt, 2006). Similarly, many studies of therapeutic alliance are limited by the use of measures and methods assessing alliance or outcome that lack sensitivity to change or do not facilitate analysis of the alliance over time (Shirk & Karver, 2003). Although there are preliminary indications to support the notion, research has not yet been able to establish whether a poor therapeutic alliance is related to early termination or “dropout” from therapy (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003; Garcia, & Weisz, 2002; Principe et al., 2006; Strauss et al., 2006; Zuroff & Blatt, 2006). Furthermore, there is a limited understanding of what factors contribute to the

development, or lack of development, of a positive therapeutic bond (Black et al., 2005; Gibbons et al., 2003; Hilliard, Henry, & Strupp, 2005; Martin, Garske, & Davis, 2000; Puschner et al., 2005). Moreover, the great majority of studies of therapeutic alliance have been conducted with adult populations, calling into question the applicability of findings to child and adolescent populations (Shirk & Karver, 2003). Finally, with regard to child therapy, there is little information available as to whether child and therapist ratings have equal predictive value (Hawley, & Weisz, 2005; Kazdin, Whitley, and Marciano 2005).

In light of limitations of previous research on therapeutic alliance generally, and its relation to child and adolescent psychotherapy outcomes specifically, the purpose of this study was fourfold: first, to determine if there is a relationship between premature termination from therapy and the formation of the therapeutic alliance; second, to examine the relationship between internalizing and externalizing behavior problems and the formation of the therapeutic alliance; third, to explore whether the child's age has an influence on the formation of the alliance with the therapist; and fourth, to evaluate the therapeutic alliance ratings of both the child and therapist to gauge differences in their relation to symptom change.

Child Psychotherapy Research

Although there are challenges to researching psychotherapy received by children and adolescents which are beyond the scope of this paper, many gains have been made in understanding how treatments work. The number and quality of child and adolescent therapy studies has greatly increased over the past few decades (Durlak et al., 1995; Kazdin, 2003; Kazdin & Nock, 2003). Further, the variety of disorders for which

treatments have been examined and are available has also increased to include: attention-deficit/hyperactivity disorder, conduct disorder, mood disorders, anxiety, eating disorders, and oppositional defiant disorder, among many others (Nock, Phil, & Kazdin, 2001; Kazdin, 2003; Kazdin, & Nock, 2003; Weisz, & Jensen, 2001). Many of these approaches are empirically based treatments which have been indicated as effective in clinical trials.

Child and adolescent therapy has been demonstrated to be effective, indicating that children who obtain therapeutic services fare better than those children who do not (Angold et al., 2000; Connor-Smith, J.K. & Weisz, J.R., 2003; Kazdin, 2003; Kazdin, & Nock, 2003; Nock, Phil, & Kazdin, 2001; Weersing, & Weisz, 2002; Weisz, & Hawley, 1998). Weisz et al. (1998) reported on four broad based meta-analyses focusing on child therapy and a variety of difficulties and treatments. This, and other, reviews of meta-analyses suggest consistent positive treatment effects with effect size values ranging from .71 to .84 (Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, & Hawley, 1998; Weisz, et al., 1995; Weisz et al., 1998). In light of this finding, it seems imperative that children who need therapy be appropriately identified, and those children who are already participating in the therapeutic process need appropriate services to obtain the best outcomes. Given that only 33% of children and families who need mental health services receive them, information regarding how therapy works for children and adolescents is of great value (Nock, Phil, & Kazdin, 2001).

There are numerous factors which may influence outcomes in child and adolescent psychotherapy. One contributing factor previously investigated is the connection between the type of treatment provided and therapy outcomes. It has been

noted that children treated with behavioral therapies have increased treatment effects as compared to non-behavioral techniques (Kazdin, 2004b; Weisz et al., 1995). However one group of authors suggested caution in this conclusion give that 90% of the studies included in their analysis were behaviorally based treatments (Weisz et al., 1995).

Another contributing factor to outcomes in child therapy is the age of the child.

Examinations of previous studies have indicated that adolescents tend to respond better to psychotherapy than children, although both children and adolescents have exhibited effective responses to treatment (Kazdin, 2004b; Weisz et al., 1995). Female adolescent patients have been described as the most responsive group of children to therapy, and this difference has been attributed to the strong interpersonal skills that they exhibit (Kazdin, 2004b; Weisz et al., 1995). However, in general adolescent females tend to obtain better outcomes from therapy than their male counterparts (Weisz et al., 1995).

Parental variables have also been documented as influential to child therapy outcomes (Daads, Schwartz, & Sanders, 1987; Dew & Bickman, 2005; Kazdin 2003; Kazdin & Whitley, 2003). One study found that when parental stress was decreased children attended therapy more often and had increased therapeutic outcomes (Kazdin & Whitley, 2003). Another study indicated that expectancies regarding the therapeutic process as reported by the child and parent effected therapy outcomes (Dew & Bickman, 2005). Perceived barriers to treatment (i.e. effectiveness of therapy, level of demand in therapy, alliance, and relevance of treatment) have been shown to decrease therapy outcomes (Kazdin & Wassell, 1999).

Outside influences such as parental participation, parental mental health, socioeconomic status, parental marital functioning, and family functioning can also be

greatly influential on the child's therapeutic process (Daads, Schwartz, & Sanders, 1987; Kazdin 2003).

Finally the "common factors" which are present in most, if not all approaches to therapy have been identified as influential on outcomes obtained in child and adolescent therapy (Lambert & Ogles, 2004). These common factors are important components of developing a healthy, productive therapeutic relationship. Common factors are non-specific aspects of the treatment that are non reliant on any modality of therapy; however, different modalities of therapy may focus on different common factors (Lambert & Ogles, 2004). These common factors can include: therapist and client (and parent) expectations regarding positive change in therapy, therapist qualities such as attention, empathy and positive regard and the therapeutic alliance established between the client and the therapist.

While these analyses shed light on interesting potential relationships between child therapy and outcomes, it should be noted that the meta-analyses generally include only a small sub sample of the available studies on child therapy outcomes and therefore more research specifically investigating these relationships is needed to solidify our understanding (Kazdin, 2004b).

The Construct of Therapeutic Alliance

One of the most frequently studied common factors in psychotherapy is the therapeutic alliance. The therapeutic alliance is a concept which originated from psychoanalytic theories regarding the importance of the relationship with the client (Gaston, 1990; Horvath, 2001; Martin, Garske, & Davis, 2000). The alliance is considered to be a common factor found in most mental health treatments and does not

rely on a specific client diagnosis or theoretical approach to therapy (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003). However, clinicians of practically all theoretical orientations recognize its importance, and research has consistently demonstrated that the alliance is an important component of therapy (Gaston, 1990; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

The therapeutic alliance has been defined as the quality of the helping relationship between the client and therapist (Bickman et al., 2004; Gaston, 1990; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In one commonly accepted definition, Bordin (1979) described the therapeutic alliance as 3 factors: 1) an emotional bond between the therapist and the client, 2) the agreement between the two parties on the therapeutic tasks, and 3) the agreement between the two parties on the expectations and/or goals of therapy. Another conceptualization of the therapeutic alliance is the combination of: 1) the patient's capacity to work purposefully in therapy, 2) the emotional bond of the client to the therapist, 3) the therapist's empathic understanding and involvement and 4) the agreement of the patient and therapist of tasks and goals (Thomas, Werner-Wilson, & Murphy, 2005). Although there are varying definitions for the therapeutic alliance, the affective quality shared between the therapist and the client is a central component (DeVet, Young, & Charlot-Swilley, 2003; Horvath & Symonds, 1991).

The most pressing reason the therapeutic alliance has received so much attention is that it has consistently demonstrated to be an influential factor in the outcome of adult treatment, and the growing body of evidence for child and adolescent treatment provides similar evidence (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003; Kazdin,

& Wassell, 1999; Orlinsky, Grawe, & Parks, 1994; Martin, Garske, & Davis, 2000; Puschner et al., 2005). Bickman et al. (2004) stated that “the factor found to be most predictive of outcome in the adult literature is the quality of the helping relationship, i.e., therapeutic alliance (p.135).” The extent of the alliance’s relationship to therapy outcomes will be discussed in detail below. In addition, the common understanding of the alliance as a concept of importance to all theoretical approaches to therapy makes the therapeutic relationship of interest to all mental health professionals (Gaston, 1990; Krupnick et al., 1996; Martin, Garske, & Davis, 2000).

Also of great importance is the finding within the literature that the perception of a strong relationship with the therapist early in therapy contributes to the completion of treatment (Garcia & Weisz, 2002; Horvath, 2001; Principe et al., 2006; Robbins et al., 2006). For example, one study examining the therapeutic relationship in 344 youth outpatient clients indicated that the therapeutic alliance accounted for the most variance (other than financial issues) and was the only issue that distinguished those who terminated prematurely from therapy and those who completed (Garcia & Weisz, 2002). Robbins et al. (2006) echoed this finding by indicating that adolescent ratings of positive alliance distinguished the treatment completers and premature terminators. Assuming that the client’s perception of the early relationship is significant, the clinician would be advised to pay close attention early in the development of the relationship to avoid the loss of a client in need of services. Furthermore, given the fact that dropout rates in outpatient therapy are estimated to be between 40 and 60% in community mental health centers, this information could serve to reduce the number of clients who discontinue treatment before their needs are met (Kazdin, 2003; Principe et al., 2006).

Research has identified a number of client characteristics that contribute to the quality of the therapeutic alliance. For example, education level (Marmar, Weiss, & Gaston, 1989), being female (Gibbons et al., 2003), optimistic outlook on therapy (Gibbons et al., 2003), and pre-treatment interpersonal functioning (Mallinckrodt, 1991) have all been found to be related to the formation of a positive therapeutic alliance. Other research has indicated that problem severity, and type of impairment and quality of attachments impact the formation of the alliance in general (Horvath, 2001; Mallinckrodt, 1991). However, it may be that these client factors are interacting with the therapist's ability to form a relationship with severely impaired clients (Horvath, 2001). It has been suggested that the factors which are influential on the formation of a positive therapeutic alliance may be different at the beginning of therapy as compared to those that develop during the course of treatment, and the development of a negative therapeutic alliance at the beginning of treatment does not necessarily mean that the relationship will remain poor until the end of treatment (Martin, Garske, & Davis, 2000; Puschner et al., 2005). Puschner et al. (2005) conclude that "the therapeutic relationship can be modified during treatment, so that an initially negative relationship can be repaired and can perhaps lead to a more favorable therapeutic outcome (p. 426)." Contrastingly, other researchers have indicated the stability of the therapeutic alliance over the course of therapy stating that there are minimal fluctuations in the ratings of the relationship (Martin, Garske, & Davis, 2000).

Further investigation of the alliance and these constructs will allow understanding of the contributing factors in building a positive therapeutic alliance and will allow

clinicians to anticipate which clients will build an alliance with ease and which should receive special attention.

In addition to identifying patient variables of importance to the formation of the therapeutic alliance, some research has been conducted to identify therapist variables which might contribute to the relationship. This research indicates that the attachment style of the therapist is a factor in the formation of a bond and the ability to respond empathically to the client (Black et al., 2005; Hilliard, Henry, & Strupp, 2005). Black et al. (2005) provided tentative information indicating that therapists who have more secure attachment styles reported better alliance ratings of their relationship with clients and conversely, those who reported more insecure attachment styles significantly reported lower alliance ratings. Another study also found initial support for the connection between therapists' parental attachment and the strength of the alliance with the client (Hilliard, Henry, & Strupp, 2005). This area of research is not yet well developed, but suggests important directions in further understanding of the development of the therapeutic alliance, and may allow clinicians to adjust their contribution to the therapeutic relationship to be more conducive to developing a good therapeutic alliance (Horvath, 2001).

The construct of the therapeutic alliance as it relates to child therapy carries all of the considerations of concern with adults, and adds a few more which are specific to children. Child therapy is complicated by the fact that children and adolescents are often brought to treatment against their will which changes the dynamic of the therapeutic process from the beginning of treatment (Kazdin, 2003; McLeod & Weisz, 2005). Another distinctive challenge of child therapists is the task of building an alliance with

both the parent and the child (McLeod & Weisz, 2005; Weersing & Weisz, 2002). The child may be involuntarily placed in therapy and the parent then becomes an important ally (Weersing & Weisz, 2002). Further, it is for this reason that it is important to collect alliance ratings between the parent and therapist as well as the child and therapist in order to gain a more complete picture of the therapeutic relationships (McLeod & Weisz, 2005).

Therapeutic Alliance and Adult Psychotherapy Outcomes

The therapeutic alliance has been consistently demonstrated to be an influential factor in the outcome of adult treatment (Bickman et al., 2004; DeVet, Young, & Charlotte-Swilley, 2003; Gaston, 1990; Kazdin, & Wassell, 1999; Orlinsky, Grawe, & Parks, 1994; Martin, Garske, & Davis, 2000; Puschner et al., 2005). Bickman et al. (2004) stated that “the factor found to be most predictive of outcome in the adult literature is the quality of the helping relationship, i.e., therapeutic alliance (p.135).” The notion of therapeutic alliance being the primary predictor of treatment success is echoed by other researchers as well (Barber et al., 2000; Martin, Garske, & Davis, 2000). Moreover, practicing clinicians report that the therapeutic alliance is one of the essential components of effective therapy (Bickman et al., 2004).

To date, two significant meta-analyses have been conducted on the relationship between the therapeutic alliance and psychotherapy outcomes (Horvath & Symonds, 1991; Martin, Garskye & Davis, 2000). The meta-analyses generated consistent effect sizes falling in the moderate range according to Cohen’s criteria (1992). These studies used correlation coefficients as effect size estimates because the data in the studies reviewed were ratio and interval data thus allowing interpretation across the studies. The

studies found effect sizes of (r) .22 (Martin, Garskye & Davis, 2000) and (r) .26 (Horvath & Symonds, 1991) after evaluating 20 and 79 studies respectively (Horvath & Symonds, 1991; Martin, Garskye & Davis, 2000). Both analyses were conducted on studies with the following criteria: published articles, adult outpatient individual therapy participants, non-analogue data, and used quantifiable measures of the therapeutic alliance.

A subsequent study combined the findings from two of the above mentioned meta-analysis (Horvath & Symonds, 1991; Martin, Garskye & Davis, 2000) and added 10 more recent studies examining the relationship of the alliance and outcome finding an overall effect size of .21 (Horvath, 2001). The general similarity in the findings of these analyses provides support for the relationship between the alliance and therapy outcomes (Beutler et al., 2004).

Furthering the importance of studying the therapeutic alliance is the finding that alliance is influential in the prediction of outcome not only in individual therapy but in couples therapy (Symonds & Horvath, 2004), family therapy (Symonds & Horvath, 2004), and pharmacotherapy (Krupnick et al., 1996) as well. One study including 47 couples in brief therapy suggested that the outcome was stronger in three conditions: when the couple agreed on the strength of the alliance, when the strength of the alliance as reported by both increased as therapy progressed and when the male partners alliance was stronger than the females (Symonds & Horvath, 2004). Research investigating the therapeutic alliance in family therapy has shown that the relationship between therapy outcomes and the alliance are steady and important (Diamond et al., 1999; Johnson et al., 2006). One family therapy study examining the alliance and attachment found that the alliance was predicted by the mothers' report of trust in their oldest child, and the

relationship between the therapeutic alliance and symptoms distress was moderated by the adolescents rating of trust in their mother and father (Johnson et al., 2006). The relationship between therapeutic alliance and treatment outcome in pharmacotherapy has also been established (Krupnick et al., 1996). A study investigating depressed adult patients in individual therapy who were taking no medication, imipramine or placebo found that the alliance had a significant effect for all conditions (Krupnick et al., 1996). This finding is especially interesting in that there seems to be a nonspecific effect beyond the influence of the drug itself and this effect is attributed to the therapeutic alliance.

In spite of these findings, it is not yet possible to safely assume that a positive alliance causes beneficial therapeutic outcomes (Beutler et al., 2004). Some researchers have postulated that early client changes in symptoms lead to the development of a good alliance with the therapist (Tang & DeRubies, 1999). Yet others have indicated that while early alliance ratings may be affected by early improvement in symptoms, the alliance itself can remain an independent predictor of outcome even with symptom change partialled out (Barber et al., 2000; Martin, Garske, Davis, 2000). Undoubtedly, more work is needed in this area to clarify the role and sequence of the relationship between client and therapist, although the alliance is predictive of outcome regardless of the underlying mechanism of action (Beutler et al., 2004; Martin, Garske, Davis, 2000).

The therapeutic alliance has been found to predict outcome regardless of the type of outcome measure used, when the rating was taken and who took the rating (Martin, 2000). After conducting an important meta-analytic review of the therapeutic alliance literature, Martin et al. (2000) reported that the relationship between a strong therapeutic alliance and positive treatment outcomes was not the product of a confound in the body

of data (Martin et al., 2000). They established that there is a direct relationship between the alliance and outcome, concluding that the alliance itself may have therapeutic value (Henry et al., 1994; Martin et al., 2000). Meta-analyses conducted on the reliabilities of the various therapeutic alliance measures have repeatedly demonstrated the acceptable reliability of all alliance scales (Horvath, 2001; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In fact, Martin et al. stated that even scales that are not well established have demonstrated adequate reliabilities (2000).

Measures have been developed to assess the therapeutic alliance from several points of view including the client, the therapist, parents of the client and other observers. Some studies have found that the participant's perception of the therapeutic alliance is more predictive of outcome than the therapist's perception (DeVet, Young, & Charlot-Swilley, 2003; Kazdin, Whitley, & Marciano, 2005; Orlinsky, Ronnestad, & Willutzki, 2004; Martin, Garske, & Davis, 2000). Furthermore, the outside observer's ratings of the relationship between the client and therapist have also been found to be more predictive of outcome than the therapist ratings (Horvath, 2001). Overall, patient, therapist and raters alliance ratings have demonstrated adequate reliability (Horvath, 2001; Martin, Garske, & Davis, 2000).

One interesting finding identified in the literature is that client perceptions of the alliance early in treatment (i.e. between the 3rd and 5th session) are better predictors of outcome than therapist ratings or ratings made by the client further in the course of treatment (Bickman et al., 2004; Cloitre et al., 2004; Strauss et al., 2006; Zuroff & Blatt, 2006). Studies have also indicated that early high ratings of alliance were correlated with early clinical improvement, completion of treatment, and lower levels of maladjustment

in the months following treatment (Strauss et al., 2006; Zuroff & Blatt, 2006). These findings indicate that the perceived quality of the early therapeutic relationship on the part of the client can be a contributor to various dimensions of treatment outcomes (Zuroff & Blatt, 2006). Furthermore, when the alliance is perceived as strong early, rupture-repair in the relationship is more successful thereby increasing the potential for positive outcomes in spite of negative events that may occur during the course of treatment (Strauss et al., 2006). Yet, other findings have indicated that alliance ratings from later in treatment are more indicative of outcome (Shirk & Karver, 2003). But these findings may be influenced by treatment gains made towards the end of therapy which could impact the client's view on therapy and the therapeutic alliance (Creed & Kendall, 2005; Horvath, 2001).

Also of great importance is the finding within the literature that the perception of a strong relationship with the therapist early in therapy contributes to the completion of treatment (Principe et al., 2006; Zuroff & Blatt, 2006). For example, Principe et al. found that there was a relationship between the therapeutic alliance rating and returning to therapy. Their study was based on a sample of adult outpatient therapy clients who had either self-referred or been referred by an employer to receive mental health services. The participants were given therapeutic alliance measures at the end of their first therapy session. A significant correlation for returning to subsequent appointments was found for those individuals who had rated the alliance with the therapist more positively after their meeting. Interestingly these authors also concluded that reported symptom distress by the client was not related to the formation of the alliance or the likelihood of return for subsequent sessions. Given that dropout rates in outpatient therapy are relatively high,

awareness of this contributing factor could be of great importance to the delivery of adequate services (Principe et al., 2006).

Therapeutic Alliance and Outcomes in Child and Adolescent Psychotherapy

In following the developments of the adult therapeutic alliance there are a growing number of studies being conducted on the alliance in child psychotherapy. A recent meta-analysis indicated that there have been 23 studies examining therapeutic alliance in psychotherapy with children, as opposed to over 2000 adult studies as of 2000 (Kazdin, Whitley, & Marciano, 2006). In examining the studies which examined the therapeutic alliance, a correlation of .24 was found between the quality of the child-therapist alliance and therapy outcome (Kazdin Whitley, & Marciano, 2006; Shirk & Karver, 2003). Although these results suggest that the variance in treatment outcomes accounted for by the therapeutic alliance is comparable for adult and child/adolescent populations, it is unclear to what extent adult research on the therapeutic alliance is generalizable to child and adolescent psychotherapy (Kazdin, Whitley, Marciano, 2006).

Based on 9 of the 23 studies in their meta-analytic review of the therapeutic alliance in children and adolescents, the alliance was a stronger predictor of outcome for children who had externalizing problems compared to those who had internalizing problems (Shirk & Karver, 2003). This could be because the externalizing behavior treatments are more effective, or that there is a systematic difference in children with externalizing behaviors and how they relate to the therapist (Shirk & Karver, 2003). Further support for this was indicated by Kaufman et al. (2005) who found that higher alliance ratings of depressed adolescents did not indicate better outcomes.

In contrast, Bickman et al. (2004) found that children in their study with more aggressive behavior patterns reported lower alliance ratings and poorer outcomes. A study examining alliance formation in children who had been previously abused indicated that severity of interpersonal problems was the best predictor of poorer outcomes in the children they examined (Eltz, Shirk, & Sarlin, 1995). Because of the importance of the development of the alliance and outcomes it has been recommended that this area of research be continued (Bickman et al. 2004; Eltz, Shirk, & Sarlin, 1995; Shirk & Karver, 2003).

In child psychotherapy research the data currently available regarding the consistency of therapeutic alliance ratings is still preliminary. At this time, there is support for the notion that the child alliance ratings remain stable once established and do not fluctuate during the course of treatment. In a literature review of the few studies on the alliance with children, it was suggested that overall the quality of the alliance from the child's perspective does not change significantly over time (Green, 2006). Other researchers have also supported the notion that there is consistency in the child's ratings of the alliance over time (Bickman et al., 2004; Eltz, Shirk, & Sarlin, 1995).

Some attention in the literature has been directed at the question of the influence of age in developing an alliance with children and adolescents. Several authors have noted the inherent difficulty in working with adolescent clients due to developmental needs for autonomy (Bickman et al., 2004; Oetzel & Scherer, 2001; Shirk & Karver, 2003). Many therapists report feeling intimidated by teenage clients, which can also hinder the development of a positive therapeutic alliance (Oetzel & Scherer, 2001). It has been reported that many adolescents begin therapy in the pre-contemplative stage,

making it all the more important for the therapist to quickly develop a positive relationship in order to maintain engagement (Oetzel & Scherer, 2001). One study indicated that the adolescent alliance improved if by the third session the therapist attended to the client's experience, presented themselves as an ally, and helped develop goals meaningful to the client (Diamond et al., 1999). In spite of these findings, a meta-analytic review indicated that thus far there is no relationship between the age of the child and the alliance-outcome relationship, as no significant alliance predictors have been found in the context of child therapy (Shirk & Karver, 2003). The studies reviewed in this meta-analysis consisted of individual and family outpatient therapy with adolescents (13 years-old and older) and children (under 13 years old). Manualized and non-manualized therapy modalities were included and the therapy was provided in research as well as service settings. The measures used to gauge outcome in these studies were reportedly assessing several areas including: symptomatology (15 studies), global functioning (11 studies), and family functioning (4 studies). The remaining 11 studies used divergent ratings that could not be categorized. Furthermore, the authors noted that they were not able to group the therapeutic alliance measures as there were too many various scales used. Given that there was a lack of uniformity with regard to the alliance and outcome measures, it may be that underlying relationships have been obscured by inappropriate evaluations of the constructs of interest.

Another area of interest in the child alliance and outcome realm is the understanding of therapist differences in forming a positive helping relationship with clients. The level of the experience of the therapist is one topic of interest, yet there is little empirical evidence to answer this question (Bickman et al., 2004; Wintersteen &

Mensingher, 2005; Shirk & Karver, 2003). Wintersteen and Mensinger (2005) conducted an examination on 600 adolescent's ratings of the therapeutic alliance and found that youth rated the alliance higher with less experienced therapists.

Gender differences between therapists and child ratings of the alliance have been examined in one study. In general, girls rated the alliance as higher and this was hypothesized to be related to adolescent girl's tendency to related well socially, and express themselves verbally (Wintersteen & Mensinger, 2005). This same study examined youth matched on gender with their therapist and found higher ratings of the therapeutic relationship than with those children who were gender matched with their therapist (Wintersteen & Mensinger, 2005). Furthermore, adolescents responded that being matched on race with their therapist did not make a difference in alliance ratings (Wintersteen & Mensinger, 2005). None of these evaluations included comparisons of the alliance to outcome. Although some alliance preferences have been reported more work is need to understand how they affect psychotherapy outcomes.

Due to the high rate of premature termination (dropout) from child therapy, some research has begun to explore the potential underlying reasons. One study examined child, parent and family factors that predict dropout from therapy with children (Kazdin & Mazurick, 1994). This study indicated that severity and chronicity of an antisocial behavior, low IQ, parental stress and life events, parental history of anti-social behavior and family socioeconomics and adverse child rearing tactics predicted dropping out from therapy prematurely (Kazdin & Mazurick, 1994). Another study examining child therapy indicated that level of child dysfunction, parental stress and socioeconomic disadvantage were related to dropping out prematurely (Kazdin & Wassell, 1998). This study also

found a relationship between ratings of treatment improvement and completion whether measured by parent or therapist (Kazdin & Wassell 1998).

A study investigating motivation for the termination (timely or early) of therapy indicated that 16% of the variance was accounted for by therapeutic relationship problems (Garcia & Weisz, 2002). This was by far the largest predictor variable identified for both timely and early termination of therapy. This study had many strengths in that it was conducted at a community clinic suggesting accurate representation of the therapy, child, parents and therapists observed in the “real-world,” but much more research in this area is needed to further support the findings indicated here (Garcia & Weisz, 2002).

Some studies have examined whether alliance and child outcome can be better predicted by including multiple rater’s view of the relationship. One study has given preliminary support for the association of a better parent-therapist relationship leading to improvements in child therapeutic outcome (Kazdin & Whitley, 2006). Further it assumed that the therapeutic alliance may play a role of influence the extent to which parenting practices improve (Kazdin & Whitley, 2006). While much more investigation is needed to clarify this point, Kazdin, Whitley, & Marciano (2006) have emphasized the importance of evaluating more than one perspective when assessing alliance ratings and outcome in child therapy.

Because multiple parties are influential in the child therapeutic process, some have focused on whose ratings of the alliance are the most predictive. Parents, children and therapists have all been identified as believing that the alliance is important to outcome, yet it is still unknown if child ratings, therapist ratings or parent ratings are

more predictive of outcome for child and adolescent therapy (Bickman et al., 2004). Based on the few studies that have compared different raters, it seems that different informants of child functioning show only modest agreement (Kazdin, Marciano & Whitley, 2005; Kazdin, Whitley & Marciano, 2006).

With regard to therapist ratings of the alliance, so far there is minimal support for their predictive value of outcome (Bickman et al., 2004; Kazdin, Marciano, Whitley, 2005). One study indicated that the average ratings of the therapist and child differed significantly, and the counselor's ratings were not accurately depicting how the child viewed the relationship (Bickman et al., 2004). Another analysis of the alliance concluded that the predictions were generally supported across all raters, although more consistent and stronger relations to outcome were evident for child and parent rather than therapist ratings (Kazdin, Marciano, Whitley, 2005).

With regard to parent ratings of the alliance there is preliminary support for the importance of positive parent ratings of the therapist in therapy retention (i.e. family participation, dropout's, cancellation) where as youth alliance ratings were not associated with retention (Hawley & Weisz, 2005). This is a likely finding given that the parent plays the primary role in the child receiving mental health services (Hawley & Weisz, 2005). In addition, this may play a factor in the relatively high attrition rates observed in child therapy (Hawley & Weisz, 2005). With regard to outcome a few researchers have established that the more positive the parent-therapist alliance is, the greater the therapeutic changes of the children (Kazdin, Marciano, Whitley, 2005; Kazdin, Whitley, Marciano, 2006).

While parents generally maintain the primary responsibility for the retention of therapy, the youth has an important role in engaging in the therapeutic process in a meaningful manner and the alliance can be a major factor in gaining treatment compliance from a child (Hawley & Weisz, 2005). A few studies have indicated that those children who rated the alliance as stronger exhibited greater therapeutic change (Hawley & Weisz, 2005; Kazdin, Whitley, Marciano, 2006).

The continuation of this area of research is vital to our understanding of clinical improvements as previous investigators have stated that the relationship of the alliance and child improvements cannot be explained by common rater variance among the predictors (alliances) and criteria (e.g., therapeutic change, treatment acceptability) or by other domains (socioeconomic disadvantage, parent psychopathology and stress, and severity of child dysfunction) that might predict therapeutic change. (Kazdin, Whitley, Marciano, 2006).

In summary, the limited available research on the therapeutic alliance in child and adolescent psychotherapy suggest that youth–therapist and parent–therapist alliances may be associated with therapy maintenance, and symptom improvement. Although many other areas of research still need attention, the alliance should not be disregarded as an important contributor to the understanding of child therapy processes.

Limitations of Previous Research

Although the area of child and adolescent outcome research is growing, we have much less information regarding this population as compared to what is known in the adult therapy literature. One major limitation in the body of research is that there is minimal consistency with regard to the measures used to assess the alliance. A meta-

analytic review and a few studies conducted since the review have noted that there is little overlap in the measures used across studies (Green 2006; Kaufman et al., 2005; Shirk & Karver, 2003). The measures used to rate the therapeutic alliance in child therapy range from scales intended for adults, scales developed for children, and other scales not specifically intended for gauging the therapeutic relationship. By reducing the amount of variability in the measures used child therapeutic alliance studies would become more comparable with one another.

Another limitation in the child therapeutic alliance literature is the understanding of contributing factors to premature termination, or dropout from therapy. While there is some preliminary support for the notion that a poor therapeutic relationship is related to premature termination, the link in the relationship is not well-understood. Previous researchers have measured the therapeutic alliance at the end of therapy, thereby losing valuable information about the relationship during the course of treatment (Kazdin, 2003). By measuring the alliance during the course of therapy, investigators can decipher if the clients who leave therapy early do in fact experience a poorer bond with the therapist than those who remain. With estimates of attrition rates for child therapy between 40% and 60%, understanding of why clients leave therapy early is of the utmost importance (Kazdin, 2003).

Knowledge of the client characteristics contributing to the formation of a positive working alliance is also lacking. While some research has been conducted to understand if there is a difference in alliance development in children with internalizing or externalizing behaviors, there are conflicting results. Shirk and Karvers' (2003) meta-analysis indicated that externalizing clients had a higher alliance-outcome relationship

than internalizing clients. Similarly, Kaufman et al. (2005) indicated that depressed (internalizing) adolescents in their study reported lower alliance ratings. In contrast, Bickman et al. (2004) reported that the more aggressive children in their sample had lower alliance ratings and poorer outcomes. An understanding of how the presenting problem relates to the formation of the alliance would allow clinicians to pay special attention to those clients who have been identified as being less likely to form a strong therapeutic alliance.

Another limitation in the literature is an understanding of the influence of the child's age in the formation of the therapeutic alliance. Therapists have reported difficulty in forming an alliance with teenagers and this may be due to the uncertainty in motivation experienced by these clients. While a meta-analysis indicated that there was no significant relationship between age and alliance formation, the authors noted limitations in the studies included in the analysis which may conceal potential differences between age groups.

Finally, there is a limited understanding of whose ratings of the therapeutic alliance are the most predictive of symptom change. There has been preliminary support for the general predictive power for the client, parent and therapists ratings, but variations have been found with regard to what degree each rater's evaluation is correlated to the therapeutic outcome. Most recent findings suggest that the client's alliance ratings are the best predictor of the relationship, yet the studies have used varying measurements of the alliance and outcome therefore reducing the ability compare between findings.

Study Aims

In light of limitations in the extant research on the relationship between the therapeutic alliance and child therapy outcomes the purpose of this study was fourfold. First, the investigator sought to understand the relationship between premature termination from therapy and the formation of the therapeutic alliance. Using the adolescent participants' (12 years and older) ratings of the therapeutic alliance, analyses were conducted to assess if the alliance was related to premature termination. Premature termination was operationalized in two ways: as discontinuing treatment before significant symptom change had been observed, and through subjective therapist opinion as to whether the client dropped out prematurely. If a more defined relationship between the therapeutic alliance and premature termination from therapy can be identified, in the future, clinicians could reduce dropout rates from therapy by assessing the alliance after the first few sessions. This would allow those youth who would have left before making sufficient change to be identified and possibly retained until their psychological needs have been met.

Second, the investigator sought to determine if there was a relationship between internalizing and externalizing presenting problems in therapy and the formation of the alliance. Comparisons between each data collection point's alliance rating and internalizing/externalizing scores were evaluated to assess for associations between the two. If a distinction should be made between clients with internalizing and externalizing problems, this information would allow clinicians to identify the susceptible group upon presentation and make specific adjustments to promote the formation of a positive therapeutic alliance early in treatment.

Third, the present study examined if the age of the child influenced the formation of the therapeutic alliance from the perspective of the therapist. The participants were divided into two groups: adolescents (12-18 years old) and children (under 12 years old). The alliance ratings from the therapist were compared at each time point to clarify if there was a distinction between age of the client and development of the therapeutic alliance. Understanding of the influence of age in child therapy will benefit the field by providing insight in advance as to which group will be the most difficult to develop a strong therapeutic alliance with during treatment. Clinicians anticipating difficulty in alliance formation could make changes in their approach to better adapt to the needs of the client.

Lastly, the therapeutic alliance ratings given by the participants 12 and older and the therapists were compared to assess for differences in the perception of the strength of the relationship. By understanding whose alliance ratings are the most predictive, clinicians could switch their focus and pay special attention to those particular ratings in order to gauge the quality of the relationship in order to best provide services for the youth.

Hypotheses

The researcher's hypotheses in this study were fourfold: First, it was hypothesized that those adolescent participants who reported low alliance ratings at the 3 week data collection point would be more likely to prematurely terminate from therapy and/or exhibit no reliable change. Second, it was hypothesized that participants with externalizing problems would have lower alliance ratings as compared to those participants with internalizing problems. Third, it was hypothesized that therapists would

report lower ratings of the therapeutic alliance for adolescents as opposed to children.

Fourth, it was hypothesized that the adolescent participant's ratings of the alliance would have the highest correlation to outcome as compared to the therapist's ratings of the alliance.

Method

Participants

Participants were recruited by BYU research assistants from the Valley Mental Health Center Child Outpatient Clinic in Salt Lake City, UT as part of a broader study on youth psychotherapy outcomes. The participants were individuals seeking services at VMH whose parents had given signed consent for their participation. Three hundred fifty participants were recruited in order to meet requirements for data analysis. Eleven participants were excluded because their treatment was medication management only. The remaining participating youth in the study were 143 females (44%) and 196 males (56%). Their ages ranged from 4 to 17 years old with a mean age of 11.38 years old. Participating youth's parents reported the following ethnicity characteristics: 255 (75.2%) participants identified themselves as White, 55 (16.2%) as Hispanic, 19 (5.6%) as Black, 2 (.59%) as Asian, 1 (.03%) as Native American, 1 (.03%) as Pacific Islander and the 6 (1.8%) remaining participants identified themselves as "Other." All individuals who completed measures were able to speak, read and write in English. The average income for participants who disclosed this information (N=209) was \$948 per month.

Participants received a variety of primary diagnoses, given by their primary therapists, with the most frequent being Attention-Deficit Hyperactivity Disorder (n=97, 28.6%), Oppositional Defiant Disorder (n=27, 7.9%), Depressive Disorder NOS (n=19,

5.6%), Posttraumatic Stress Disorder (n=15, 4.4%) and Adjustment Disorder (n=15, 4.4%). Two-hundred twenty nine (67.6%) participants had a comorbid diagnosis.

Therapists participating in this study self disclosed their disciplines and education credentials. The therapists reported representing disciplines including social work, social services workers, licensed professional counselors and psychologists. Twelve therapists indicated they were masters level clinicians (60%), 3 indicated they did not hold masters degrees (15%), and 5 (25%) therapists indicated they held no bachelors/associate degrees.

Measures

Psychotherapy outcome. The Youth Outcome Questionnaire 2.01 (Y-OQ-2.1) was used as a measure of psychosocial distress to track treatment outcome. The Y-OQ-2.1 is a parent report measure of treatment progress for children and adolescents, aged 4-17 years old, receiving mental health services (Wells, Burlingame, & Lambert, 1999).

Specifically, the Y-OQ-2.1 is a tracking measure of outcome and is intended to track changes during the course of treatment (Wells, Burlingame, & Lambert, 1999). The Y-OQ-2.1 was constructed to be sensitive to change over short periods of time, be brief, and maintain validity and reliability at a high level (Wells, Burlingame, & Lambert, 1999).

Generally, parents are able to complete the measure in approximately 6 minutes (Wells, Burlingame, & Lambert, 1999). The items are each rated on a 5-point Likert scale, which has available options from 0 (never), 1 (rarely), 2 (sometimes), 3 (frequently), 4 (almost always) (Wells, Burlingame, & Lambert, 1999). Of the 64 items, 8 have been presented in a reverse score direction to increase the measures sensitivity to change (Wells, Burlingame, & Lambert, 1999).

The Y-OQ-2.1 consists of 64 items that comprise the six subscales which were found to be optimal in encapsulating change (Wells, Burlingame, & Lambert, 1999). These subscales were created in support from focus groups, literature reviews, and hospital charts (Wells, Burlingame, & Lambert, 1999). The six domains included are: ID: Intrapersonal Distress (i.e. emotional distress including anxiety, depression, hopelessness, and self-harm), S: Somatic (i.e. changes in somatic distress experienced including headaches, dizziness, stomachaches, nausea, bowel difficulty and pain in joints), IR: Interpersonal Relations (i.e. actions and issues relevant to the child's relationship with peers, parents, and others including communication, cooperativeness, aggressiveness, arguing and defiance), SP: Social Problems (i.e. social behaviors including delinquency, truancy, sexual problems, running away, substance abuse, and destruction of property), BD: Behavioral Dysfunction (i.e. ability to organize tasks, concentrate, handle frustration, and complete assignments), and CI: Critical Items (i.e. features which are often found in children in inpatient settings) (Wells, Burlingame, & Lambert, 1999).

The Y-OQ-2.1 is scored by the summation of the item values. This will yield a score ranging from -16 to +240, with a higher score indicating more distress. The individual subscales are calculated in the same manner. This value has the highest validity and reliability, and is therefore the best measure of global change (Wells, Burlingame, & Lambert, 1999). Scoring of the Y-OQ-2.1 at VMH is completed by a computerized scoring program.

Cutoff scores for the Y-OQ have been calculated to compare individuals in treatment to non-treated individuals in the normal population. This score was set at 46, meaning that individuals whose total score falls below this value are functioning at a

level similar to individuals not in treatment. The cutoff scores for the subscales are: Intrapersonal Distress, 16; Somatic, 5; Interpersonal Relations, 4; Social Problems, 3; Behavioral Dysfunction, 12; Critical Items, 5 respectively (Wells, Burlingame, & Lambert, 1999).

A Reliable Change Index (RCI) has been calculated for the Y-OQ in order to determine if changes exhibited by individuals during treatment is reliable. The RCI value is 13, which means that a 13 point change must be present to demonstrate a significant change (Wells, Burlingame, & Lambert, 1999). RCI values for each of the subscales have also been calculated and are as follows: Intrapersonal distress, 8; Somatic, 5; Interpersonal Relations, 4; Social Problems, 5; Behavior Dysfunction, 8; and Critical Items, 5 (Wells, Burlingame, & Lambert, 1999). The Y-OQ has been found to have reliable differences between patient populations (inpatient vs. outpatient), geographic locations, demographic attributes, gender and age (Wells, Burlingame, & Lambert, 1999). Internal consistency reliability estimates for the Y-OQ have been calculated and shown to be far above acceptable standards (Burlingame et al., 2001). Strong test-retest reliability coefficients have also been calculated indicating that the instrument has strong test-retest reliability for the total score and each of the separate subscales (Burlingame et al., 2001). Analyses have also indicated significant correlations between Y-OQ and CBCL total scores indicating convergent validity (Burlingame, 2001; Wells, Burlingame, & Lambert, 1999). The ability of the Y-OQ to be used as a measure of outcome has been documented. The Y-OQ has been found to be relevant to measure outcome for those undergoing various psychological interventions (Wells, Burlingame, & Lambert, 1999) in various settings (Burlingame et al., 2001). Also the Y-OQ has been shown to have ease of

administration by a variety of service professionals and to be easily understood by nonprofessional individuals who the information may be shared with (i.e. parents, teachers) (Wells, Burlingame, & Lambert, 1999).

The Youth Outcome Questionnaire Self-report version (Y-OQ-SR) is a parallel version of the Y-OQ intended to be completed by adolescents aged 12-18 years old. The questions on the Y-OQ-SR were reworded in the first person and also take approximately 7 minutes to complete (Wells et al., 2003). The Y-OQ-SR is also appropriate to administer at intake and prior to each weekly therapy session. The Y-OQ-SR has demonstrated reliability including strong internal consistency (.95) in previous evaluations (Wells et al., 2003; Ridge, 2007). The measure has also demonstrated concurrent validity when compared to other commonly utilized youth self-report measures, such as the BASC-2 and CBCL, with intercorrelations surpassing standards for ‘excellent validity’ (Burlingame et al., 1995; Ridge, 2007)

Therapeutic Alliance. The Therapeutic Alliance Scale for Children-revised (TASC-r) was used as a measure of therapeutic alliance across treatment. It is a 12-item, 4-point Likert scale completed by the adolescent (12 and older) and therapist. Two versions of the TASC have been developed: one written for the adolescent and a parallel version written for the therapist. The questions are the same on each form, but adjusted for the appropriate person completing the form (e.g. “I liked spending time with my therapist,” “The child likes spending time with you, the therapist.” Each item is rated on a 4 point scale ranging from 1 (*not at all*) to 4 (*very much*). The total score equals the ratings of the 12 items on the scale. Originally, the TASC was examined in an inpatient setting with 62 children (Shirk & Saiz, 1992). The TASC is unique among alliance

measures in that it was designed specifically for use with children and adolescents. It assesses positive and negative aspects of the therapeutic alliance (e.g., “I liked spending time with my therapist”; “When I was with my therapist, I wanted the session to end quickly”). The TASC has demonstrated adequate internal consistency reliability ($\alpha=.72$ to $.74$) in previous investigations (DeVet, Charlot-Swilley, & Ireys, 2003; Shirk & Saiz, 1992).

Procedure

A brief description of the study was given to the parent or guardian of the participant, by the VMH case worker, during their initial phone call for scheduling of the intake session (refer to Appendix A). During that description, the parent or guardian was notified of the opportunity to participate in the research study as part of their initial intake session. The parent or guardian was told that the researchers were trying to learn more regarding what factors improve child and adolescent therapy treatment outcomes. Only children aged 12 years-old and older completed the self report version of the Y-OQ and TASC and therapists for all clients completed their version of the TASC.

The parent or guardians were approached by trained research assistants during the standard Valley Mental Health intake session. This intake session is typically comprised of up to ten families interested in receiving services from the clinic. During the introductory information, given by the Valley Mental Health worker, the BYU research assistant briefly described the study to the parents or guardians (refer to Appendix B). At that time the packet of questionnaires was distributed to the potential participants for review. At the end of the intake session the potential participants were invited to return to

the same room after their intake session to complete the questionnaires. If they chose not to participate they were invited to return the packets into a box.

During the description of the study the potential participants were informed that they would be financially compensated for their participation in this study. For the first set of questionnaires completed they received \$10 in gift certificates and the opportunity to choose a gift from a “grab bag” consisting of small prizes, gift certificates, or coupons donated by “Community Partner” businesses in the local area for their child. In addition, a light lunch was provided to the participants as they completed the questionnaires. The potential participants were notified that if they chose to participate, they would be approached again at 3 weeks after intake, 2 months after intake, 4 months after intake and 6 months after intake, to complete the same packet of questionnaires. They were also notified that if they chose to participate in the subsequent data collections they will be compensated with \$5 and a choice from the “grab bag” for each packet of questionnaires. The response rate for participation among families recruited at intake was above 60%.

Data Analysis

Given that one goal of this study was to examine the therapeutic alliance ratings and premature termination, a logistic regression statistical technique was used to examine the relationship between these two. A logistic regression allowed the researcher to predict an outcome from a set of variables. The outcome is a discrete outcome, such as membership in a group (i.e. premature terminator or timely) and can take the value of 1 (premature terminator) or 0 (timely). The set of independent variables may be discrete, continuous, dichotomous or any combination. This is because the logistic regression does

not make an assumption regarding the normal distribution or equivalent variance of the independent variables. It does, however, require that the observations are independent.

The purpose of the logistic regression is to correctly predict the category of outcome by using the most parsimonious model. The logistic regression provides two main uses. First, it predicts group membership in the form of an odds ratio. Second, it provides information regarding the relationships and strengths among the variables (i.e. lower alliance score puts you at higher risk for premature termination).

The logistic regression examined whether early alliance ratings, from the 3-week data collection point, were a significant predictor of premature termination from therapy. Two sets of analyses were conducted using different operationalizations of premature termination (each a dichotomous yes/no variable): For the first set of analyses, premature termination was operationalized as the client having discontinued treatment before reliable symptom change was observed. In the second set of analyses, premature termination was based on a subjective clinician judgment as to whether the client had dropped out of treatment prematurely.

For the first set of analyses, reliable symptom change was assessed using the Reliable Change Index (RCI) criteria developed by Jacobson and Truax (1991). The RCI is used to determine whether the magnitude of change made during therapy is sufficient enough to be considered statistically reliable (Jacobson & Truax, 1991). Evaluation of change was based on the clients' Y-OQ scores, and the developers of the scale have calculated the RCI value of the Y-OQ as 13 points (Wells, Burlingame, & Lambert, 1999). A cut off score was used to determine whether the client's distress level was representative of an individual in the clinical population versus the community normal

range. The cut off score assigned participants to one of four categories: Recovered (reliable change, and below cut off score), Improved (reliable change only), Unchanged (criteria for reliable change not met) or Deteriorated (reliably worse) (Jacobson & Truax, 1991). Premature terminators from therapy were defined as individuals who discontinued treatment and met criteria for the Unchanged or Deteriorated groups. The client's scores were examined at their final Y-OQ provided, meaning either the last one taken before discontinuation of treatment or at the final data collection point. For the second set of analyses on premature termination, therapist judgment of premature termination was obtained from archival discharge data. As part of routine clinic procedures when a case is closed, the primary clinician is asked to provide a judgment as to whether the client discontinued treatment prematurely. This dichotomous judgment was used as the dependent variable in a logistic regression.

The definitions of premature termination are varied in the literature. Many previous investigators have chosen criteria for premature termination that are not founded in the progression of the client throughout the therapeutic process. Rather, these studies base "completion" of therapy on more arbitrary definitions such as therapist opinion of whether termination was "timely" or "advised" (Chung, Pardeck, & Murphy, 1995; Kazdin & Mazurick, 1994). Another means by which premature termination has been often defined is a preset number of sessions required, without consideration of the particular client's needs or progression throughout the therapeutic process (Venable & Thompson, 1998). Given that it is possible that clients achieve adequate symptom relief after a varied number of sessions, it seems reasonable to seek a more empirical definition of premature termination from therapy. In the current study, premature termination was

defined by criteria rooted in both pragmatic and empirical methods. Defining premature termination in the manner utilized in this study, based on both clinician judgment and self-reported symptom reduction, is advantageous as it allows for a more individualized and specific appraisal of where each client was when they discontinued treatment.

The second question addressed in this study was whether youth with externalizing problems had lower alliance ratings as compared to those with internalizing problems. Behavior type was classified by examining the six domains of the Y-OQ to determine if the presenting problem was internalizing or externalizing in nature. Each participant's responses to the Y-OQ provided internalizing and externalizing subscale scores for the participants who had contributed at the respective time points. Given that there was a high level of comorbidity in diagnoses for this sample both of these scores for each participant were utilized in the analysis to avoid an arbitrary split into two separate groups. Although internalizing and externalizing domains are often discussed separately there is often considerable overlap in the type of presenting symptoms, creating complexity in identifying an individual as exclusively internalizing or externalizing. These scores were examined with relation to the alliance rating given by the client at data collection time points. The relationship between problem type and alliance formation was examined using a multiple regression statistical technique to determine if either internalizing or externalizing had an influence on ratings of the alliance.

The third question addressed in this study was whether therapists reported lower alliance ratings for adolescent participants as opposed to child participants. The participants were split into two age groups; participants 12 years old and older were classified as adolescents, and participants under 12 years old were classified as children.

Dividing the participants in this manner allowed for comparisons between two different age groups within the youth sample as therapists may have had different approaches to alliance formation with them. The therapist's ratings of the alliance were examined at each of the data collection points for differences between groups for the participants who had contributed at the respective time points. This comparison was also conducted by using a multiple regression statistical technique.

Finally, this study examined the hypothesis that the adolescent (12 and older) participants' ratings had the highest correlation to psychotherapy outcome as compared to the therapists' ratings. A correlation of the adolescents' and therapists' ratings of the alliance and outcome change scores was conducted respectively to assess for differences between the two raters.

Results

Table 1 provides means and standard deviations of Y-OQ scores, from the parents and youth, and alliance ratings from youth and therapists. Intake Y-OQ and Y-OQ-SR scores are comparable to those found at intake in previous investigations (Hagan, 2003; Robinson & Rapport, 2003; Russell, 2003). Of the 194 cases for which discharge data were available, 89 cases (46%) were judged by the primary therapist to have discontinued treatment prematurely

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Table 1
Means, Standard Deviations, and Sample Sizes for Outcome and Alliance Measures

Y-OQ			Y-OQ			TASC			TASC		
Youth			Parent			Youth			Therapist		
<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>N</i>
Intake											
71.2	35.3	157	87.6	35.8	323	---	---	---	---	---	---
3 weeks											
75.3	40.2	49	77.3	35.5	155	30.57	.83	39	27.35	.79	127
2 month											
70.3	35.4	46	76.5	36.1	116	31.38	.82	40	27.04	.70	53
4 month											
56.6	39.4	42	68.7	37.6	103	30.61	.81	23	27.79	.71	46
6 month											
61.7	36.6	53	68.1	37.8	135	28.73	.96	35	26.91	.88	33

*N for each subsample was different at each data collection point

Because premature termination was conceptualized as a dichotomous variable, prediction using alliance ratings was analyzed by means of logistic regression. Table 2 provides the prediction of premature termination from therapy given the client and therapist's ratings of the therapeutic alliance from the 3 week data collection point. Premature termination from therapy, as defined by symptom reduction, was not predicted by client alliance ratings from the 3 week data collection point ($p = .363$) nor did therapist ratings ($p=.640$). Premature termination from therapy, as defined by therapist's

judgment, was not predicted by client alliance ratings from the 3 week data collection point ($p = .641$) nor did the therapist ratings ($p = .176$). These findings do not support the hypothesis that client's or therapist's early alliance ratings are predictive of premature termination from therapy.

Table 2

Logistic Regression Predictors for Premature Termination

Variable	b	SE	Wald ratio	p	Odds ratio
Symptom Reduction					
Client's alliance rating	-.075	.083	.810	.368	.928
Therapist's alliance rating	.016	.035	.218	.641	1.017
Therapist's Judgment					
Client's alliance rating	.336	.722	.216	.642	1.399
Therapist's alliance rating	.496	.369	1.803	.179	1.642

The influence of client's primary behavior problem type (internalizing versus externalizing) on the therapeutic alliance, as reported by the adolescent participant, was examined using multiple regression. Analyses were conducted separately for each data collection time point and internalizing and externalizing scores for the participants who had contributed at the respective time points were entered together. Using the Enter method, a significant model emerged for participant behavior influence on ratings of the therapeutic alliance at the 3 week data collection point ($F_{3,33} = 5.538$, $p < .008$. Adjusted

R square = .206) indicating that those who were classified as externalizing behavior provided lower alliance scores ($\beta = -.647, p=.005$). Participant's behavior type did not have a significant influence on their ratings of the alliance at the 2 month data collection point ($F_{2,26} = 1.031, p < .371$), at the 4 month data collection point ($F_{2,18} = .560, p < .581$), or at the 6 month data collection point ($F_{2,15} = .675, p < .524$).

The third hypothesis was that therapists would report lower ratings of the therapeutic alliance for adolescents than for children. The influence of client's age category, adolescent or child, on the therapeutic alliance at each time point was examined by means of a multiple regression statistical technique for the participants who had contributed measures at each respective time point. Using the Enter method, a significant model emerged for client age and therapist's ratings of the therapeutic alliance at the 6 month data collection point ($F_{1,32} = 4.232, p < .048$. Adjusted R square = .089) indicating that the therapists rated their relationships with youth under 12 years old more favorably than youth over 13 years old ($\beta = -.342, p=.048$). Client's age did not have a significant influence on therapist's ratings of the alliance at the 3 week data collection point ($F_{1,123} = .135, p < .714$), the 2 month data collection point ($F_{1,94} = .156, p < .694$) or the 4 month data collection point ($F_{1,55} = .250, p < .619$).

The fourth hypothesis was that the participant's ratings of the alliance would be more significantly correlated to the overall change in symptoms, as measured by a Y-OQ change score, than the therapist's ratings. The Y-OQ change score was the difference between Y-OQ at intake and the final Y-OQ available for each participant. Results are provided in Table 3. There was no significant correlation of the therapist's alliance ratings at 3 weeks and the parent-reported Y-OQ change score $r(201) = -.08, p = .453$.

There was also no significant correlation of the therapist's alliance ratings at 3 weeks and the adolescents' Y-OQ change score $r(43) = -.116, p = .453$. Finally, there was no significant correlation of the adolescent's alliance ratings at 3 weeks and their Y-OQ change score $r(49) = -.203, p = .156$.

Table 3

Correlations Between Adolescent's and Therapist's 3 Week TASC Ratings and Y-OQ Change Score.

	Y-OQ-y change score	Y-OQ-p change score
Adolescent's 3 week TASC	-.203	
Therapist's 3 week TASC	-.116	-.080

TASC Therapeutic Alliance Scale for Children
 Y-OQ-y Youth Outcome Questionnaire Youth
 Y-OQ-p Youth Outcome Questionnaire Parent

Discussion

In examining the range of therapeutic alliance scores obtained in this study it became apparent that there was minimal variability in the ratings on the TASC. Low variability in the scores measuring the alliance is problematic when trying to discern a potential relationship between the alliance and psychotherapy outcomes as correlations become more difficult to find. It is possible that if there was not a restricted range in scores of the alliance that the associations examined in this study would be more

pronounced. Consequently, interpretation of results should be made in the context of the limited variability observed in therapeutic alliance scores.

This observation of the data lends support to the notion that investigating the therapeutic alliance in psychotherapy with youth may be more complex than with adults. Given this, it is reasonable to seek a greater understanding of the factors which are unique to psychotherapy with children and adolescents before directly assessing the alliance-outcome relationship. The multiple additional influences on youth psychotherapy, such as parental commitment, finances, type of treatment, problem type and parental alliance with the therapist, may be influential in outcomes (Shirk & Karver, 2003). It is therefore important for investigators to have an understanding of the influence of factors unique to children and adolescents when proceeding to investigate the potential influences on youth psychotherapy.

Contrary to the first hypothesis in this study, early therapeutic alliance ratings did not predict premature termination from therapy. Although there is support in the literature for the notion that there is a predictive relationship between early alliance ratings and completion of treatment in the adult realm (Horvath and Symonds, 1991; Principe et al., 2006; Zurroff & Blatt, 2006), preliminary findings with youth are inconsistent (Hawley & Weisz, 2005; Chung, Pardeck, & Murphy, 1995; Kazdin, Holland, & Crowley, 1997; Venable & Thompson, 1998). Some child and adolescent therapy studies have cited difficulty in establishing early alliance as a predictor of premature termination (Hawley & Weisz, 2005; Kazdin & Mazurick, 1994). One potential reason for the lack of a significant relationship between early alliance and premature termination in youth could be that children and adolescents may differ in the manner in which they develop the

therapeutic alliance compared to adults. Youth may take longer to form a bond with their therapist and therefore early alliance may not be the most telling predictor of participation in therapy (Shirk & Karver, 2003). Other unique aspects of youth treatment may also explain why early alliance between the youth and therapist was not related to premature termination. For example, given that youth rarely refer themselves for treatment, a strong alliance between the parent and the child's therapist may prolong treatment even if the child-therapist alliance is poor. Similarly, if the parent feels dissatisfied with the therapist, the parent may discontinue treatment even if the child-therapist alliance was strong (Garber, 2004; Garcia & Weisz, 2002). In addition, parental commitment to therapy, finances and family dynamics are some of the many added contributors to the therapeutic process with youth (Hawley & Weisz, 2005, Kazdin, 2003; McLeod & Weisz, 2005; Weersing & Weisz, 2002). Factors such as these may have had a greater influence on the duration of participation in therapy in this study than early alliance did. Clients may have left early from therapy for a variety of reasons, or may have continued participation in spite of a poor alliance. Understanding the factors contributing to therapeutic commitment is important given that drop out from community based child therapy is estimated to be between 40% and 60% (Kazdin, Holland, & Crowley, 1997; Shirk, 2001). Any factors which could be found to reduce treatment efficacy would be helpful in identifying those who would terminate before receiving the care they needed.

With regard to the finding that externalizing clients rated the alliance lower than internalizing clients at the 3 week time point, there is some support for this finding in previously conducted research (Eltz, Shirk, & Sarlin, 1995; Green, 2006; Johansson &

Eklund, 2006). At such an early point in the therapeutic process the externalizing clients may have had difficulty establishing a trusting bond with their therapist but eventually came to develop a relationship similar to the internalizing clients at the later time points.

One reason for this finding may be the difficulty that therapists express in establishing relationships with youth who have externalizing problems (Bickman et al., 2004; Eltz, Shirk, & Sarlin, 1995; Johansson & Eklund, 2006; Shirk & Karver, 2003). Eltz, Shirk, & Sarlin (1995) found that children and adolescents with interpersonal issues had more difficulty forming positive relationships with their treatment providers than youth without interpersonal issues. Additionally, it has been postulated that it may take therapists more time to understand the meanings behind externalizing behavior presentations and therefore early ratings of the relationship were rated lower by the clients as they may not have felt immediate support from their treatment provider (Eltz, Shirk & Sarlin, 1995; Puschner et al., 2005; Shirk & Karver, 2003). Interpersonal problems may hinder relationship formation and create more of a challenge for treatment providers and this could have important effects on therapeutic outcomes for children and adolescents (Johansson & Eklund, 2006; Kaufman et al., 2005; Shirk & Karver, 2003). As more work is conducted in this realm future researchers should clearly identify the specific problematic behaviors within the labels of internalizing and externalizing in order to allow a more accurate understanding of the constructs of interest. As noted by other investigators in the field, given that so many contradictory findings have been reported, it is apparent that more research is needed to clarify the impact, if any, of problem type and the formation of the therapeutic alliance.

Contrary to the hypothesized result, problem type of the client was related to client-reported alliance ratings at the 3 week time point, but not therapist's ratings. Some prior research was conducted which focused on the notion that problem type may be related to the formation of the therapeutic alliance in child and adolescent therapy and the results were inconsistent (Bickman et al. 2004; Eltz, Shirk, & Sarlin, 1995; Shirk & Karver, 2003; Weisz et al., 1995b; Weisz et al., 1987).

One hypothesized reason for the variability of findings in this realm is that therapists likely change their therapeutic approach based on the presentation of the youth in an effort to bond with children and adolescents with problems of many types (Bickman et al., 2004; Shirk & Karver; Weisz et al., 1995b). This may result in a confound when examining the relationship between problem type and alliance formation as gains made later in the course of treatment could influence assessment of the relationship by all parties involved (Shirk & Karver, 2003). Given that the therapeutic alliance is thought to be a universal construct, factors contributing to the alliance, such as empathy and collaboration, may have helped all youth in this study feel bonded to their therapist regardless of their presenting problem; however, because significant findings in this realm were found at one time point it is clear that more efforts are needed to have a sufficient understanding of the dynamic (Bickman et al., 2004; Shirk & Karver, 2003).

Although age was hypothesized to predict alliance ratings, in this study the association was only observed at one time point. The lack of association is not surprising given the tentative nature of the relationship between age and alliance development in the literature (Hogue et al., 2006; Shirk & Karver, 2003). In an important meta-analysis Shirk and Karver (2003) identified only 23 published studies and dissertations addressing the

therapeutic alliance with youth. Although they found a similar effect size for alliance in youth psychotherapy as compared to the adult literature, they were not able to identify a moderating effect for a number of potential variables, including age of the client. Given that many of the studies included in the meta-analysis were complicated by shortfalls in methodology, measures used, and lack real world representation, it is clear that there is an absence of adequate research in the realm of youth psychotherapy.

While children and teenagers or internalizers and externalizers did exhibit an effect on the therapeutic alliance in this study, there may be an encouraging dynamic to draw attention to. One positive consequence is that regardless of problem type or age high alliance ratings were still reported by clients and their therapists. This indicates that it may be possible for all types of youth clients to achieve a healthy therapeutic relationship.

Contrary to hypothesis, neither therapist alliance ratings nor youth alliance ratings significantly predicted change in parent-report or self-report of youth symptoms. The lack of an observed relationship between alliance and symptom change was unexpected given that prior research findings have found alliance to be influential on treatment outcomes in varying degrees (Bickman et al., 2004; DeVet, Young, & Charlot-Swilley, 2003; Gaston, 1990; Kazdin, & Wassell, 1999; Orlinsky, Grawe, & Parks, 1994; Martin, Garske, & Davis, 2000; Puschner et al., 2005). The therapeutic alliance has been consistently established as an influential factor in the adult therapy realm and some research supports the alliance as the factor most predictive of outcome (Bickman et al., 2004; Kazdin, & Wassell, 1999; Orlinsky, Grawe, & Parks, 1994; Martin, Garske, & Davis, 2000; Puschner et al., 2005); however, this relationship has not been consistently demonstrated

in child and adolescent studies (Shirk & Karver, 2003; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). The variability in the findings may be due to the additional factors which influence child and adolescent psychotherapy specifically. For example, children are often compelled to attend treatment by their caregivers, therapy with youth often involves the client as well as the parents or the entire family, and children may form relationships in a different manner than adults (Kazdin, 2003; McLeod & Weisz, 2005). It is therefore unclear to what degree we can expect to find parallel results across adult and youth research on the therapeutic alliance (Kazdin, 2004b; Kazdin, Whitley, & Marciano, 2006). Given that there are multiple extraneous factors influencing therapy with children and adolescents the lack of significant findings may be more a result of the other factors influence the therapeutic process and less a result of differences in alliance ratings.

Although it makes clinical and intuitive sense to assume that the importance of a common factor such as the alliance is similar in various populations, more research is necessary to demonstrate if and to what degree the relationship exists in therapy with youth. The complex nature of child and adolescent psychotherapy may be more affected by the factors which are unique to this population, therefore, an important first step in better understanding outcomes in therapy with youth is investigating factors such as parental commitment to therapy, finances, concurrent treatments and therapist variables to determine if these are significant predictors of beneficial outcomes.

Another possible explanation for the findings in this study was that the sample was comprised of patients from an outpatient community mental health center. Historically, research on child and adolescent therapy has been conducted in university-

based research clinics through controlled trials (Burns et al., 1999; Kazdin et al., 1990; Southam et al., 2003). Many researchers and practicing clinicians have raised concerns about the lack of external validity of clinical trial studies due to important differences in how therapy is conducted in research settings compared to treatment provided in usual-care settings (Burns, 1999; Kazdin, 1978; Kazdin et al., 1990; Shirk & Karver, 2003; Weisz et al 1995). Consequently, it is unknown how well results of therapeutic alliance studies conducted in usual-care settings may compare to results obtained under more highly controlled conditions. Future research in this realm should expand upon the work which has been conducted in community mental health centers as this is a more generalizable population than controlled studies. Furthermore, when attempting to assess the relationship between alliance and outcome investigators would be advised to utilize measures specifically intended for assessment of outcome, such as the Y-OQ, as many other studies have utilized variety of measures which are not specified for this purpose such as the CBCL and BASC. In general, more studies investigating the potential influences on therapy are needed with the child and adolescent population.

The present study had several strengths that warrant emphasis. One useful strength was the collection of alliance ratings from multiple perspectives including the youth participants and the therapists. Another strength of this study was that data regarding the alliance and symptom change was collected at multiple points for the duration of therapy which allowed for a more dynamic understanding of these aspects through the course of treatment. Finally, this study sampled from youth, parents, and therapists in a real-world community-based mental health system.

Although this study had several strengths, it was not without some limitations. One important limitation of the current study is the lack of variability in alliance scores rated by the adolescents as well as the therapists. The finding that the relationship was rated highly across all raters at all time points maybe due to a difference in the manner which this construct manifests in psychotherapy with youth, or may simply indicate that alliance ratings tend to be uniform and relatively high for the large majority of cases.

Additionally, high variability in the types of procedures utilized during therapy, which is typical of practice in real-world settings, and therapist-related aspects of the treatment process such as training level and theoretic orientation were not taken into account and this may be just as influential on the therapeutic relationship and outcomes as the variables examined (Feeley et al., 1999; Stevens, Hynan, & Allen, 2000; Shirk & Karver, 2003; Weisz et al., 1995). Lastly, in this study concurrent treatments were not accounted for in these analyses. It is possible that the alliance would form differently given certain extraneous factors such as participation in family therapy or usage of medications (Kazdin, Holland & Crowley, 1997; Shirk & Karver, 2003).

Due to the lack of knowledge in the field of the influences on therapy with youth more research is needed, especially on those variables outside of the therapeutic relationship. In light of the historical importance of the therapeutic alliance and client treatment it would also be desirable to expand our understanding of the various influences which are unique to child and adolescent therapy. In order to have an understanding of if and how the therapeutic alliance has an effect future researchers could include this common factor in their investigations of therapy with children and adolescents. To facilitate the understanding of the alliance influence on psychotherapy

with youth future research will need to include investigations of the potential influence of age, behavior type, various raters of the relationship and the development of the relationship over time (Bickman et al., 2004; Diamond et al., 1999; Green, 2006; Hawley & Weisz, 2005; Kaufman et al., 2005; Kazdin & Nock, 2003; Shirk & Karver, 2003).

Although these areas of interest have been suggested in previous research to be potential influences on the development of the alliance, a compelling base of literature is not yet available to make these claims with certainty (Shirk & Karver, 2003; Weisz, McCarty, & Valeri, 2006).

There has been some empirical substantiation that early ratings of the alliance are an indicator of completion of treatment in child and adolescent psychotherapy (Garcia & Weisz, 2002; Hogue et al., 2006; Robbins et al., 2006). The early relationship and how the relationship changes over the course of treatment may be a determining factor of whether clients obtain the amount of treatment needed before terminating therapy. Furthermore, there has been recent corroboration for the relationship of alliance and therapeutic outcomes in youth psychotherapy (Eltz, Shirk, & Sarlin, 1995, Hogue et al., 2006; Shirk & Karver, 2003). Given that it may be possible to keep clients from prematurely terminating treatment the fundamentals of this association should be identified by future researchers in order to maximize retention in therapy.

Although some advancements in the field of child and adolescent psychotherapy research have been made in the direction of assessing therapy outside of controlled trials, more movement towards understanding the therapeutic process in real life clinics is needed (Kazdin, Siegel & Bass, 1990; Southam, Weisz & Kendall, 2003; Weisz et al., 1995). To date the majority of research has been executed in settings that differ greatly

from everyday clinical practice (Kazdin, Siegel & Bass, 1990; Southam, Weisz & Kendall, 2003; Weisz et al., 1995b). Additionally, practicing clinicians have asserted that empirical findings are of little relevance to the work they conduct with their clients (Kazdin, Siegel & Bass, 1990a). If professionals in the field are not able to utilize the considerable amount of research being published then a disparity exists which needs to be addressed and by continuing research in real world settings the gap can be minimized (Kazdin, Siegel & Bass, 1990a; Southam, Weisz & Kendall, 2003; Weisz et al., 1995b).

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Appendix A

Script read by VMH case worker during initial phone call:

When you come in for the intake you will have the option to participate in a research study that would involve completing some additional questionnaires. The purpose of this study is to learn how to provide the most effective services for your child. If you choose to participate, it will require an additional 30 minutes of your time after the intake process and you will receive a \$10 gift card and lunch to compensate you for your time in assisting with this study.

Appendix B

Script read by researchers during intake at VMH:

We are part of a research team from Brigham Young University. We are trying to learn more about the things that may improve treatment outcomes in children and youth receiving counseling services. Because your child is receiving services at Valley Mental Health Children's Outpatient Clinic, we are inviting you to participate in this study. We will ask each parent/guardian and youth over 12, to complete some brief questionnaires. For parents/guardians, the questionnaires will take about 30 minutes to complete and for youth participants will take about 20 minutes. Because we want to learn how your thoughts, feelings and behaviors may change over the course of treatment, we will ask you to complete all or most of the same questionnaires periodically during your services at VMH. Each time this will require about 30 minutes for parents and 15-20 minutes for youth.

You and your child may benefit directly from participating in this study because the results of the questionnaires will be made available to your child's therapist. You will receive a \$10 gift card to a large retail store for completing the first set of questionnaires and will receive a \$5 gift card for each subsequent set of questionnaires completed. Youth participants may receive additional incentives such as gift certificates, small prizes or merchandise donated by sponsors in the community.

If you would like to participate, we will ask you to complete some questionnaires today. We will hand around a packet of the questionnaires. If you are not interested in participating, please put your folder in this box on the way out. If you would like to participate, please come back to this room to complete the questionnaire after you meet with a therapist today. We think this will take approximately 30 minutes or less. We know this is a long day for you and we will have some food for you here in this room when you come back to complete the questionnaires.

Thank you!

Appendix C
Sample of the Youth Outcome Questionnaire: Parent Version

- 18. Soils or wets self..... 0 1 2 3 4
- 19. Is aggressive toward adults..... 0 1 2 3 4
- 20. Sees, hears, or believes things that are not real..... 0 1 2 3 4
- 21. Has participated in self-harm (e.g. cutting or scratching)..... 0 1 2 3 4
- 22. Uses alcohol or drugs..... 0 1 2 3 4
- 23. Seems unable to get organized..... 0 1 2 3 4
- 24. Enjoys relationships with family and friends..... 2 1 0 -1 -2
- 25. Appears sad or unhappy..... 0 1 2 3 4
- 26. Experiences pain or weakness in muscles or joints..... 0 1 2 3 4
- 27. Has a negative, distrustful attitude toward friends, family members, or other adults..... 0 1 2 3 4
- 28. Believes that others are trying to hurt him/her even when they are not..... 0 1 2 3 4
- 29. Threatens to, or has run away from home..... 0 1 2 3 4
- 30. Experiences rapidly changing and strong emotions..... 0 1 2 3 4

SUBTOTALS					
ID	S	IR	SP	BD	CI

Gary M. Burlingame Ph.D. and Michael J. Lambert, Ph.D.
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Appendix D Youth Outcome Questionnaire: Youth Version

Youth Outcome Questionnaire-Self Report (Y-OQ®-SR 2.0)

Name _____	ID# _____	Today's Date _____
Date of Birth _____ Sex: Male ___ Female ___ Parent/Guardian _____		

PURPOSE: The Y-OQ®-SR 2.0 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but check the "Never or almost never" category. When you begin to complete the Y-OQ®-SR 2.0 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS: - Read each statement carefully. - Check the box that most accurately describes the past week.
 - Decide how true this statement is during the past **7 days**. - Check only one answer for each statement and erase unwanted marks clearly.

PLEASE COMPLETE BOTH SIDES

	Never or Almost Always or					For Office Use Only					
	Never	Rarely	Sometimes	Frequently	Always	ID	S	IR	SP	BD	CI
1. I want to be alone more than others my same age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
2. I have headaches or feel dizzy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
3. I don't participate in activities that used to be fun.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
4. I argue or speak rudely to others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
5. I have more fears than others my same age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
6. I cut classes or skip school altogether.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
7. I cooperate with rules and expectations of adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
8. I have a hard time finishing my assignments or I do them carelessly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
9. I complain about things that are unfair.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
10. I have trouble with constipation or diarrhea.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
11. I have physical fights (hitting, kicking, biting, or scratching) with my family or others my age.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
12. I worry and can't get thoughts out of my mind.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
13. I steal or lie.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
14. I have a hard time sitting still (or I have too much energy).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
15. I feel anxious or nervous.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
16. I talk with others in a friendly way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
17. I am tense and easily startled (jumpy).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
18. I have trouble with wetting or messing my pants or bed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
19. I physically fight with adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
20. I see, hear, or believe in things that are not real.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
21. I have hurt myself on purpose (for example, cut, scratched, or attempted suicide).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
22. I use alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
23. I am disorganized (or I can't seem to get organized).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
24. I enjoy my relationships with family and friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
25. I am sad or unhappy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
26. I have pain or weakness in muscles or joints.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
27. I have a hard time trusting friends, family members, or other adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
28. I think that others are trying to hurt me even when they are not.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
29. I have threatened to, or have run away from home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
30. My emotions are strong and change quickly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
SUBTOTALS											

Developed By: M. Gawain Wells, Ph.D., Gary M. Burlingame, Ph.D., Michael J. Lambert, Ph.D.
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	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always	ID	S	IR	SP	BD	CI
31. I break rules, laws, or don't meet others' expectations on purpose.+	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4				<input type="checkbox"/>		
32. I am happy with myself.	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/>					
33. I pout, cry, or feel sorry for myself more than others my age.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
34. I withdraw from my family and friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
35. My stomach hurts or I feel sick more than others my same age.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
36. I don't have friends or I don't keep friends very long.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>			
37. My parents or guardians don't approve of my friends.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>			
38. I think I can hear other people's thoughts or that they can hear mine.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					<input type="checkbox"/>	
39. I am involved in sexual behavior that my friends or family would not approve of.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4				<input type="checkbox"/>		
40. I have a hard time waiting for my turn in activities or conversations.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					<input type="checkbox"/>	
41. I think about suicide or feel I would be better off dead.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
42. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
43. I complain about or question rules, expectations, or responsibilities	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>			
44. I have times of unusual happiness or excessive energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4						<input type="checkbox"/>
45. I'm generally okay with frustration or boredom.	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1	<input type="checkbox"/> -2					<input type="checkbox"/>	<input type="checkbox"/>
46. I am afraid I am going crazy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4						<input type="checkbox"/>
47. I feel guilty when I do something wrong.	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1	<input type="checkbox"/> -2				<input type="checkbox"/>		
48. I demand a lot from others or I am pushy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					<input type="checkbox"/>	
49. I feel irritated.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
50. I throw-up or feel sick to my stomach more than others my age.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
51. I get angry enough to threaten others.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4						<input type="checkbox"/>
52. I get into trouble when I'm bored.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					<input type="checkbox"/>	
53. I'm hopeful and positive.	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/>					
54. Muscles in my face, arms, or body twitch or jerk.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
55. I destroy property on purpose.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4				<input type="checkbox"/>		
56. I have a hard time concentrating, thinking clearly, or sticking to tasks.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					<input type="checkbox"/>	
57. I get down on myself and blame myself for things that go wrong.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
58. I have lost a lot of weight without being sick.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4						<input type="checkbox"/>
59. I act without thinking and don't worry about what will happen.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4					<input type="checkbox"/>	
60. I am calm	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> -1	<input type="checkbox"/> -2					<input type="checkbox"/>	<input type="checkbox"/>
61. I don't forgive myself for things I've done wrong.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
62. I don't have much energy.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
63. I feel like I don't have any friends or that no one likes me.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
64. I get frustrated or upset easily, and give up.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/>					
This Page Subtotals											
Side 1 Subtotals											
SUBSCALE TOTALS (Sum of Subtotals)											

TOTAL =

Appendix E
Therapeutic Alliance Scale for Children: Therapist Version

TASC-r
(Therapist Form)

Patient's Name

Date

Please rate your patient's current presentation in therapy on the following scales. Circle the number corresponding to your rating for each item.

1. The child likes spending time with you, the therapist.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

2. The child finds it hard to work with you on solving problems in his/her life.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

3. The child considers you to be an ally.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

4. The child works with you on solving his/her problems.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

5. The child appears eager to have sessions end.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

6. The child looks forward to therapy sessions.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

7. The child feels that you spend too much time focusing on his/her problems/issues.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

8. The child is resistant to coming to therapy.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

9. The child uses his/her time with you to make changes in his/her life.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

10. The child expresses positive emotion toward you, the therapist.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

11. The child would rather not work on problems/issues in therapy.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

12. The child is able to work well with you on dealing with his/her problems/issues.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

Appendix F
Therapeutic Alliance Scale for Children: Youth Version

TASC-r

Patient's Name

Date

Please read the sentences below about meeting with your therapist. After reading each sentence, decide how much the sentence is like you. There are no right or wrong answers for this questionnaire, just how you feel.

1. I like spending time with my therapist.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

2. I find it hard to work with my therapist on solving problems in my life.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

3. I feel like my therapist is on my side and tries to help me.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

4. I work with my therapist on solving my problems.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

5. When I'm with my therapist, I want the sessions to end quickly.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

6. I look forward to meeting with my therapist.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

7. I feel like my therapist spends too much time working on my problems.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

8. I'd rather do other things than meet with my therapist.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

9. I use my time with my therapist to make changes in my life.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

10. I like my therapist.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

11. I would rather not work on my problems with my therapist.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

12. I think my therapist and I work well together on dealing with my problems.

1	2	3	4
Not Like Me	A Little Like Me	Mostly Like Me	Very Much Like Me

Appendix G

Therapist Consent Form

Consent to be a Research Participant Therapist Consent Form

Introduction: This research study is being conducted by Dr. Jared S. Warren at Brigham Young University, in collaboration with Valley Mental Health, to learn more about the things that may predict and improve treatment outcomes in children and youth receiving psychological services. You are being invited to participate because you are a therapist of one or more VMH clients who have consented to participate in this study.

Procedures: For each participating client, you will be asked to complete a brief questionnaire (requiring less than five minutes of your time) on your perceptions of the therapeutic relationship between yourself and the child or adolescent in treatment. You will be asked to complete this questionnaire once approximate 3 weeks after the client's intake session, then at 2-months, 4-months, and 6-months after intake. Parents and child/adolescent participants will also be completing a number of questionnaires regarding factors that may be related to successful treatment outcomes. Results of parent and child measures will be made available to the treatment team to aid in treatment planning.

Risks/Discomforts: The risks for participating in this study are minimal. However, it is possible that it may be uncomfortable to answer questions about your therapeutic relationship with clients.

Benefits: You may benefit directly from participating in this study, as considering your therapeutic relationship with your clients may promote insights into how to improve this relationship. At a more general level, it is hoped that through your participation, researchers will learn more about important aspects of treatment that can be used to improve the response of children and adolescents to therapy.

Confidentiality: All information provided will remain confidential and only the study research staff will have access to this information. A study ID number will be assigned to each therapist, and therapist names will not be included in the study database. Only the primary investigator will be able to link study ID's with names of participants, and study results will be reported as a group so that individuals cannot be identified by their responses.

Participation: Participation in this research study is voluntary. You have the right to withdraw at any time or refuse to participate entirely without jeopardy to your employment at Valley Mental Health.

Questions about the Research: If you have questions regarding this study, you may contact Dr. Jared Warren at (801) 422-5600, 291 TLRB, Provo, UT 84602, or by email at jared_warren@byu.edu.

Questions about your Rights as a Research Participant: If you have questions you do not feel comfortable asking the researcher, you may contact Dr. Renea Beckstrand, IRB Chair, 422-3873, 422 SWKT, renea_beckstrand@byu.edu.

I have read, understood, and received a copy of the above consent and desire of my own free will to participate in this study.

Signature of Therapist: _____ Date: _____