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LIST OF ABBREVIATIONS

ADHD - Attention-deficit/Hyperactivity Disorder

ANOVA - Analysis of Variance

AOD - Alcohol and Drug

AOR - Adjusted Odds Ratio

ASDs - Autism Spectrum Disorders

BD - Bipolar Disorder

BEST - Behaviour Exchange Systems Training

CALPAS - California Psychotherapy Alliance Scales

CBT - Cognitive Behavioural Therapy

CT - Cognitive Therapy

CYMHS - Child and Youth Mental Health Service
DASS - Depression, Anxiety and Stress Scales
DCV - Depression Change Variable
df - Degrees of Freedom
DSM-IV - Diagnostic and Statistical Manual of Mental Disorders 4th Edition
ES - Effect Size
F - F Test Statistic
FAD - Family Assessment Device
FPEI - Family Psychoeducation Interventions
HLM - Hierarchical Linear Modelling
IY - Incredible Years Program
K-SADS-PL - Schedule for Affective Disorders and Schizophrenia for School Age Children - Present and Lifetime Version
LDS - Latent Difference Score
M - Mean
Max - Maximum
MCAR - Missing Completely at Random
MDD - Major Depressive Disorder
Min - Minimum
MS - Mean Square Between Groups
MSI - Mood Severity Index
n - Number of Participants
p - p Value
PAST - Parenting Adolescents Support Training
Penn Scales - Pennsylvania Scales
PMT - Parent Management Training
PS - Parenting Scale

PSOC - Parenting Sense of Competence

QoL - Quality of Life

r - Pearson Correlation

RCT - Randomised Controlled Trial

SCID-IV - Structured Clinical Interview for DSM-IV Disorders

SD - Standard Deviation

SDQ - Strengths and Difficulties Questionnaire

SE - Supportive Expressive Therapy

SFP - Strengthening Families Program

SMFQ - Short Moods and Feelings Questionnaire

SS - Sum of Squares

TA - Total Alliance

TARS - Therapeutic Alliance Rating Scale

TAU - Treatment As Usual

TBS - Therapeutic Bond Scales

TEI - Treatment Evaluation Inventories

TP - Triple P Parenting Program

VPPS - Vanderbilt Psychotherapy Process Scale

WAI - Working Alliance Inventory

WAI-L - Working Alliance Inventory Long Form

WAI-Lc - Working Alliance Inventory Long Form (Client version)

WAI-Lo - Working Alliance Inventory Long Form (Observer version)

WAI-Lt - Working Alliance Inventory Long Form (Therapist version)

WAI-S - Working Alliance Inventory Short Form
WAI-Sc - Working Alliance Inventory Short Form (Client version)

WAI-So - Working Alliance Inventory Short Form (Observer version)

WAI-St - Working Alliance Inventory Short Form (Therapist version)
Abstract

Youth mental health is a growing concern in Australia with one in sixteen young people experiencing depression and one in four young people experiencing some form of mental health issue. The increased risk of mental illness common with youth populations is further compounded by the alarming rate of youth treatment dropout, and lack of engagement with mental health services associated with this population. Parent-focussed interventions potentially offer an alternative treatment pathway for families in which a depressed youth is reluctant or refuses to engage with mental health services.

The therapeutic alliance has been shown to be an important factor in treatment outcomes in individual youth therapy; however, very little research has investigated the role of parent and youth therapeutic alliance in parent-focussed interventions for youth mental health issues. The aim of this thesis was to further our understanding of the role of therapeutic alliance within the context of group-based parent-focussed interventions for youth depression. This thesis reports on the outcomes of the Family Options program, which was a multi-center, double-blind, randomised controlled trial comparing two parent-focussed group interventions for youth depression in a sample of 51 families.

Study 1 evaluated the strength of linear growth of therapist alliance across the eight sessions of treatment in relation to post-treatment changes in youth depression. Early- and mid-treatment parent-rated alliance, and mid-treatment youth rated alliance were also assessed for their associations with changes in youth depression scores. Results indicated that linear change of alliance and early- and mid-treatment alliance ratings were generally weakly associated with post-treatment youth depression change. Study 2 was a qualitative analysis of 12 semi-structured parent interviews. The objective of this study was to gather rich data about parents’ experiences of alliance. The study aimed to more fully explore the alliance from the parent’s perspective, specifically in relation to alliance development and maintenance, and
how these processes might interact with parent individual differences and therapeutic engagement. Results of the thematic analysis indicated that the parents’ alliance with the group facilitators was an important factor orienting the parents to engage meaningfully with both the facilitators and other group members, in addition to engaging successfully in therapeutic processes. Individual family-based factors, such as parent treatment expectations, degree of prior engagement with mental health services, and young person symptom severity were also found to impact upon the alliance in important ways. The results suggest that while therapist alliance ratings are likely not clinically important in parent-focussed interventions for youth depression, alliance plays an essential role in parents benefitting therapeutically from parent-focussed interventions.
Overview Of Thesis

Chapter one of this thesis provides a theoretical framework to the entire thesis. It begins with a discussion on the historical origins of therapeutic alliance and its theoretical development since its inception. The chapter initially outlines the psychodynamic development of the concept of therapeutic alliance. This is followed by a discussion of subsequently developed competing theories of alliance, including the client-centred model of alliance, dialectical and ego-based models of alliance, and finally negotiation-based alliance.

Chapter two outlines the development and characteristics of the most well-established alliance measures used throughout alliance research. The initial applications of these scales are discussed, in addition to their subsequent adaptations to include alliance measures from multiple perspectives. The correlations between these scales are outlined, in addition to their respective predictive validities and reliabilities. The chapter ends with a more detailed discussion of the Working Alliance Inventory (WAI), as this is the alliance measure used in Study 1 of this thesis. The theoretical basis and general structure of the WAI is outlined, in addition to its different versions and their respective reliabilities and predictive validities.

Chapter three reviews the literature conducted assessing the relationship between therapist and client ratings of the therapeutic alliance within individual adult therapy and their associations with various therapeutic outcomes. Several meta-analytic reviews are discussed and critiqued in relation to the relationship between alliance at specific treatment time points (early-, mid-, and late treatment). The findings for the overall effect sizes in relation to alliance in individual adult therapy and treatment outcomes are also discussed.

Chapter four reviews the research assessing the temporal properties of the alliance and its relationship to treatment outcomes. Initially, the relationship between alliance at specific stages of therapy and treatment outcomes is discussed. Following this, theories informing research into investigating patterns and trajectories of alliance are examined. Finally, the
Chapter reviews research assessing patterns and trajectories of alliance across therapy and their relationships with various treatment outcomes.

Chapter five reviews literature pertaining to studies that assess the relationship between various raters of the therapeutic alliance and therapeutic outcomes in the treatment of youth mental health issues. Initially, the chapter outlines various factors associated with youth therapy that contribute to the complexity of alliance research in this area in addition to treatment barriers associated with the youth population. Several meta-analytic reviews examining therapist-, parent-, and youth-alliance and their relationship to youth treatment outcomes are then discussed and critiqued.

Chapter six discusses the role of the therapeutic alliance and group cohesion in the context of group therapy. Initially, the development of the concept of group cohesion is explored, as group cohesion has featured predominantly in research investigating relationship processes within group therapy contexts. Limitations associated with the theoretical basis of cohesion theory are also outlined, in addition to research into the relationship between measures of group cohesion and therapeutic outcomes. The constructs of group cohesion and therapeutic alliance are then compared within the literature, before the chapter concludes with a review of the literature assessing therapeutic alliance and its association with treatment outcomes in group therapy.

Chapter seven presents a review and critique of qualitative research into the therapeutic alliance. Initially, research exploring the parent’s perception and experience of the therapeutic alliance is discussed, including therapist behaviours that parents perceive as being important in alliance development. Following this, qualitative research examining ‘rupture and repair’ events within therapy is critiqued and its relevance to alliance processes is explored.
Chapter eight discusses the role of families in the treatment of youth mental health issues. Factors associated with difficulties in treating youth populations are outlined. Following this, parent and family factors associated with increased risks in youth developing mental health issues are reviewed. The chapter then provides a rationale for utilising family and parent-focussed interventions in the treatment of youth mental health issues. The theoretical underpinnings of family and parent-focussed treatments are then outlined. Finally, the efficacy of family and parent-focussed interventions in the treatment of youth mental health issues is discussed. Specifically, studies examining family psychoeducation interventions, followed by studies examining family therapy and parent-focussed interventions are reviewed and critiqued.

Chapter nine reviews and critiques the literature in relation to parent therapeutic alliance and therapeutic outcomes in the treatment of youth mental health issues with parent-focussed interventions. Initially, the relationship between parent alliance and youth alliance is discussed, in addition to the relationship between parent alliance and youth retention in therapy. Following this, the research investigating parent alliance and its association with primary youth treatment outcomes is reviewed and critiqued. Specifically, parent alliance is examined within the context of parent-focussed interventions working with families individually, and then parent alliance is examined within the context of parent-focussed interventions working with parents in a group therapy context.

Chapter 10 presents Study 1, which was designed to evaluate the pattern of the therapist-parent alliance and its predictive relationship with treatment dependant changes in the young persons’ depression. In addition, early- and mid-treatment alliances for therapists and parents, and mid-treatment alliance for young people, were assessed for their associations with treatment dependant changes in the young persons’ depression. Initially, the chapter provides a rationale for the study, followed by the aims and hypotheses of the study, the
method, procedure, results, and discussion of the findings of the study and their implications for therapeutic alliance research and parent-focused interventions.

Chapter 11 presents Study 2, which is based upon a qualitative analysis of 12 parent interviews. The study was designed to gather rich data in relation to aspects pertinent to parent alliance development and maintenance that may not have been captured by the alliance measure used in Study 1. Initially, the rationale for the study is presented, followed by the method, and study and analysis procedures. The analysis is then presented, followed by a discussion examining the main findings and their implications for therapeutic alliance research and parent-focused interventions.

Finally, chapter 12, which is divided into three sections, is the final discussion. The first section presents a summary of the thesis’ findings and discusses these findings in relation to the study hypotheses, and prior theories and literature. Section two outlines and discusses the limitations of the studies completed in the thesis, in addition to discussing how these limitations may be addressed in future studies. Section three concludes the thesis and presents directions for future research.
CHAPTER ONE

The Historical and Theoretical Development of the Therapeutic Alliance

Throughout the history of psychology, therapeutic alliance has been theorised to be one of the most important factors facilitating therapeutic change, and its impact upon therapeutic outcomes has been widely established within the field (Allen, Tarnoff, & Coyne, 1985; Ardito & Rabellino, 2011; Bibring, 1937; Bordin, 1979; Freud, 1913, 1958). Also referred to as working alliance and helping alliance (here forth referred to simply as alliance), the construct refers to a number of therapist-client interactional and relational factors that operate within therapeutic treatment. These factors have been shown to have therapeutic properties independent of different therapeutic techniques and approaches (Geen, 2008). A major finding within therapeutic research is the observation that although there are different therapeutic approaches, these can often result in similar therapeutic gains (Hovarth & Luborsky, 1997; Stiles, Shapiro, & Elliott, 1986). For example, research results have indicated that there is little difference in treatment outcomes for depression and anxiety between established adult psychotherapies (Ahn & Wampld, 2001; Drisko, 2004; Elliott, 1996). This suggests that a major component of therapeutic change is not determined by the specific therapeutic modalities and techniques employed by the different psychotherapies, but rather factors common to all therapeutic approaches. It is not surprising then that interest has focused upon the alliance between the therapist and client as a potential pantheoretical factor accounting for a significant portion of the variance seen in therapeutic outcomes (L. N. Johnson & Wright, 2002).

The origins of the concept of the alliance were formed within a psychoanalytical framework. Freud (1913) is often cited as the first person to seriously address the nature and functional importance of the alliance through his theories of transference. In Freud’s (1912) work *The Dynamics of Transference*, he discussed the importance of the therapist
maintaining a serious interest and sympathetic understanding towards the client. The reason for this was to facilitate what Freud saw as the “healthy” part of the client as a means of forming a positive attachment with the therapist. Freud asserted that the therapist-patient bond facilitates ‘good will’ and alleviates doubt, thereby creating motivation for the client to continue therapy (Freud, 1913). Freud also proposed that this process involved positive transference, which is a process where the client unconsciously links the therapist to other people in the client’s life who have also treated them with affection. The process of positive transference represents a distortion of the actual or real therapist/client relationship, as the client’s experience is unconsciously formed based upon prior relationships rather than the actual relational transactions taking place.

The question of whether the alliance is rooted in transference processes, and is therefore a distortion-based relationship, has been a central debate throughout the development of alliance theory. Other analytic authors, such as Gelso and Carter (1985) view the alliance as being totally dependent upon transference and as such consider it as ‘unreal’ or distorted as any other relationship the client may have. They posited that the client’s emotions and thoughts from previously unresolved relationships are inevitably transferred to the therapist. However, several theories have been developed from within a psychodynamic framework that position the alliance as being distinct from a transference-based relationship. Greenson (1965) took Freud’s theory of transference and expanded upon it to include the ‘real relationship’ and the ‘working alliance’, as being distinct and separate components of the relationship that exist in addition to the transference-based relationship. He theorised that the ‘real relationship’ consisted of those verbal and non-verbal aspects of each person’s interactions that represented the authentic and genuine aspects of that person, rather than the transference-based projections constructed from prior relationships that one person imposes onto the other person. The working alliance component referred to the process by which the
patient used the therapist’s interpretations and skills to understand and distinguish between past dysfunctional relationships and the ‘real’ relationship with the therapist. In this way, Greenson’s theory of the ‘real relationship’ referred to a reality-based relationship between the therapist and client, which was distinct from and co-existed with the distortion-based transference relationship.

Perhaps the first model of alliance not based upon a psychodynamic framework of understanding was introduced by Rogers, who offered a client-centred view of the therapeutic relationship (Rogers, 1957). Rogers presented a series of conditions that were sufficient for “therapeutic personality change” to take place, which involved specific relational qualities that the therapist offered to the therapist-client relationship. These conditions included the therapist being congruent or appropriately integrated within the relationship, offering unconditional positive regard for the client, and empathically understanding the client’s internal frame of reference, which is then reflected back to the client. Rogers asserted that the most important factor in successful therapy is the therapist adopting these attitudes and stances towards the client, which then engender a relational climate in which the client is able to openly express their true feelings without fear of judgement. These relationship conditions then facilitate the client engaging in meaningful self-exploration, in which the client is able to resolve their own issues (Rogers, 1951).

In the 1970’s research into alliance gained further traction through a growing interest outside of the psychodynamic community, and in particular from the psychotherapists Bordin (1979) and Luborsky (1976). Both Bordin and Luborsky developed models of alliance based upon the conscious engagement of the relationship as opposed to the unconscious transference processes most of the previous theoretical work on alliance had focussed on. While Bordin and Luborsky’s conceptions of alliance differed in important ways, both models posited alliance as a dialectical, ego-based process where both parties come together...
through a commitment to important therapeutic tasks, and the development of an affective bond between the therapist and client (Krause, Altimir, & Hovarth, 2011). In addition, both Bordin and Luborsky’s models of alliance were a response to research indicating that different types of psychotherapy tended to yield similar results, suggesting the presence of a therapeutic variable common to all therapeutic modalities (Ardito & Rabellino, 2011). Bordin and Luborsky’s models of alliance were important as they each established the alliance as being independent of the specific therapeutic approach used.

Luborsky proposed that the alliance was a dynamic construct that changed in response to the early and late stages of therapy, and each of these stages was associated with a particular kind of positive alliance (Luborsky, 1976). Type one positive alliance in the early stages of therapy was seen as being associated with the client believing that the therapy will be helpful; the client feeling a sense of change since the commencement of therapy; the client feeling a positive rapport with the therapist; and the client feeling understood and accepted. As the therapy progressed and more challenging material was being addressed, Luborsky identified type two positive alliance, which was a different type of positive alliance that was associated with the latter stages of therapy. Type two positive alliance involved the client having a sense of working together with the therapist in a joint struggle against what has been impeding the client; the client experiencing the treatment as working together with the therapist as part of a collaborative team; the client and therapist sharing similar views on causes of the client’s issues; and the client sharing similar qualities to those of the therapist, particularly in relation to tools for understanding. Luborsky developed these alliance concepts through observing clients within therapy and identifying important alliance factors. He then scored clients in subsequent observational sessions to confirm that those clients who scored higher in these factors at various stages of therapy tended to achieve greater therapeutic outcomes.
Bordin’s model of alliance is based upon the theory that every therapy has a set of expectations and demands that circumscribe how the client and therapist will work and engage with one another (Bordin, 1979). These expectations and demands are largely determined by the theoretical underpinnings of the therapeutic approach employed. However, the general requirements for successful engagement and therapist-client transactions throughout therapy relate to factors that can be generalised across all therapies and alliances. Based upon psychodynamic theories of the alliance constituting a real relationship (as opposed to a transference-based relationship), Bordin distilled the alliance into three main features: 1) an agreement on goals, 2) an assignment of a task or series of tasks, and 3) the development of bonds (Bordin, 1979). The first feature ‘agreement on goals’ is based on a mutual agreement that the client’s mental health issues are to a significant extent a function of the client’s thoughts, feelings and behaviours. The quality of the therapeutic alliance, then, is partly determined by the degree to which the client agrees that his/her contributions to any mental health issues need to be addressed. This can be negatively or positively impacted by factors such as client insight, and distracting external life pressures. Bordin describes the second feature ‘assignment of tasks’ as involving an agreed upon contract between therapist and client that includes payment of services and the client’s agreement to engage in specific tasks that constitute the therapeutic processes of change. The collaboration and implementation of these tasks involves “activity-passivity, empathic understanding, communicating, interpreting, self disclosing, etc.,” that can all contribute to the quality of the alliance. A further feature of the theory involves the development of bonds between the therapist and client. Due to the requirement of intimate self-disclosure and openness often required in therapeutic treatment, Bordin asserted that a level of client trust and positive personal attachment is required for a strong therapeutic relationship. This feature is more associated with the ‘human relationship’ formed between the client and therapist and the
client’s feelings and attitudes towards the therapist. Here concepts such as the client’s trust in the therapist, how safe the client feels in the relationship, and degree to which the client has confidence in the therapist to help contribute to the bond the client feels towards the therapist. Bond also involves the compatibility between multiple therapist and client factors, such as personality, personal style and general attitudes and individual idiosyncrasies (Bordin, 1979).

Bordin’s model of the alliance has endured since its inception in the 1970’s, and is the predominant model of alliance used in research to this day. Bordin’s model established the alliance as a collaborative dyadic process between the therapist and client. Several authors, such as Hatcher (1999) and Meissner (2007), have emphasised the collaborative aspects of Bordin’s alliance as being potentially more important when compared to task, goal, or bond alliance factors. Hatcher, for example, showed that the therapists’ degree of confidence in collaboration with the client was most correlated with both the therapists’ and clients’ estimates of improvement \( r = .64 \) when compared to goals \( r = .42 \), bond \( r = .31 \) or goal and task disagreement \( r = -.38 \). This research was conducted predominantly using psychodynamic research; however, where less emphasis is typically placed upon specific therapeutic tasks and goals.

Perhaps the most significant development in alliance theory since Bordin’s contribution has been the work of Safran and Muran (2006). Rather than viewing the alliance as a collaborative process, as established by Bordin’s model, Safran and Muran view the alliance as an ongoing negotiation between the therapist and client. As such, the alliance is not a static variable that is needed for the intervention to work, but instead an ongoing process that is constantly shifting throughout therapy. This ongoing negotiation involves both conscious and unconscious processes that constitute the therapist’s and the client’s characteristic ways of relating to themselves and others, including both functional and dysfunctional patterns and schemas. The authors propose that this process is itself an
important change mechanism involving the client learning to negotiate the needs of self and others by developing the capacity for intimacy and authentic relatedness through the resolution of dysfunctional schemas. While Bordin’s model of alliance suggests that the overall strength of alliance is most relevant to successful therapy, the work of Safran and Muran provided a rationale for considering how changes in alliance across therapy may have an important relationship to outcomes.

This chapter outlined the historical origins and theoretical development of the therapeutic alliance, and discussed the most prominent models of alliance developed since its inception. The following chapter discusses the development of the most well established psychometric tests commonly used to measure alliance in psychological research. The correlations between these scales, in addition to their respective predictive validities and reliabilities are also outlined. The following chapter concludes with a more detailed discussion of the Working Alliance Inventory, as this was the alliance measure used in Study 1 of this thesis.
CHAPTER TWO

The Measurement of the Therapeutic Alliance

There has been a proliferation of alliance measures over the last few decades, with a systematic search identifying 32 alliance measures for adult, child and family contexts (Elvins & Green, 2008). The most frequently used scales in alliance research in order of frequency of use are the Working Alliance Inventory (WAI), the California Psychotherapy Alliance Scales (CALPAS), the Pennsylvania Scales (Penn Scales), followed by the Vanderbilt Psychotherapy Process Scale (VPPS), the Therapeutic Alliance Rating Scale (TARS), and the Therapeutic Bond Scales (TBS) (Fenton, Cecero, Nich, Frankforter, & Carroll, 2001; Martin, Garske, & Davis, 2000). The first alliance scales (including the VPPS in 1978, the WAI in 1981, the Penn Scales in 1983, and the TBS in 1989) were developed to measure alliance in individual adult psychotherapy situations, and were designed to be completed by trained clinical judges or independent observers (Martin et al., 2000). Since their initial development, these scales have now been adapted to include observer, therapist and client versions in order to avoid possible limitations associated with a perspective drawn from a single rating.

Confirmatory factor analysis has been conducted on the CALPAS to assess its construct validity and ensure the scale does not correlate with related constructs (Sabourin, Coallier, Cournoyer, & Gaston, 1990). The study assessed the four CALPAS scales, along with three subscales of related constructs; attractiveness, expertness, and trustworthiness. The results showed two factors; with one factor including the four CALPAS scales and the other factor showing loading of the related constructs, and as such, the findings support the construct validity of the CALPAS. While factor analysis has not been conducted on the Penn Scales, the initial version of the scale has been revised to refine its specificity to alliance constructs. The revised version of the Penn Scales removed items that related more to positive symptom
changes and also introduced negatively worded items (Luborsky et al., 1994). The construct validity of the Penn Scales is further supported by studies showing that the CALPAS and Penn Scales are highly correlated, $r = .74$ (Ardito & Rabellino, 2011). The other commonly used scales have also been shown to be highly correlated, with CALPAS and WAI, $r = .85$, and WAI and Penn, $r = .74$, suggesting that they appear to be measuring the same underlying processes (Ardito & Rabellino, 2011; Hatcher & Barends, 1996a). Fenton (2001) compared the predictive validity of the WAI ($r = .39$), CALPAS ($r = .37$), Penn scales ($r = .50$) and VPPS ($r = .49$) and found that all measures were significantly correlated with therapeutic outcomes. In addition, a meta-analysis comparing data from 79 studies using a range of commonly used alliance measures found all the scales to have adequate reliability (0.79), and this was generally consistent across all scales used (Martin et al., 2000). With the exception of the TARS, which failed to reach predictive significance, the WAI, Penn Scales, VPPS and CALPAS were all found to be moderately predictive of treatment outcomes to a similar degree, with an overall effect size of 0.22.

The WAI was developed by Hovarth and Greenberg (1989) and is the most widely studied and used measure of alliance within the research literature (Busseri & Tyler, 2003; Hovarth, Fluckiger, Del Re, & Symonds, 2011; Martin et al., 2000). Hovarth and Greenberg sought to develop a measure that could be applied across all types of therapy, and had a clear connection to a well established theoretical construct of alliance and a general theory of therapeutic change. Bordin’s (1979) pantheoretical model of alliance was selected as the basis of the measure, and the WAI was developed to capture each of Bordin’s aspects of alliance, being bond (the extent of therapist/client mutual trust, acceptance and confidence), task (degree of agreement on the behaviours and cognitions that constitute the therapeutic processes of the intervention), and goals (outcomes that are the target of the intervention)
Thus, alliance was conceptualised as one general alliance factor, composed of three secondary factors (goal, task, and bond).

The WAI was developed as a 36-item measure (12 items for each of Bordin’s alliance dimensions). The latest version rates each item on a 7-point Likert scale ranging from 1 (never) to 7 (always) (Hovarth & Greenberg, 1989). Examples of questions measuring the dimensions of alliance include: bond: “I believe (client) likes me”, “I appreciate (client) as a person”, and “(client) and I have built a mutual trust”; task: “(client) and I agree about the steps to be taken to improve his/her situation”, “My client and I both feel confident about the usefulness of our current activity in therapy”, and “(client) believes the way we are working with her/his problem is correct”; goal: “I have doubts about what we are trying to accomplish in therapy”, “We are working towards mutually agreed upon goals”, and “We have established a good understanding between us of the kind of changes that would be good for (client)”.

The 32-item version of the WAI, now known as the long-form of the measure (WAI-L), has been produced in therapist- (WAI-Lt), client- (WAI-Lc) and observer-versions (WAI-Lo). Internal consistency estimates of the three subscale scores were found to range from .85 to .92 (client version) and .68 to .87 (therapist version). Estimates of internal consistency of total scores were .93 (client version) and .87 (therapist version) (Hovarth & Greenberg, 1989). The WAI-Lo was not included in Hovarth and Greenberg’s original publication; however, research has shown the WAI-Lo to have similar internal consistency and inter-rater reliability with scores of .98 and .92, respectively (Tichenor & Hill, 1989).

The WAI-L was adapted to a short-form of the measure (WAI-S) that also included observer (WAI-So), therapist (WAI-St) and client (WAI-Sc) versions (Tracey & Kokotovic, 1989). The short version was constructed by retaining those items that loaded the highest on each of the subscales, resulting in a total of 12 items (4 items per subscale). Internal
consistency estimates of the WAI-S versions are comparable to those of the WAI-L, with ranges of .83 to .91 (therapist version), and .90 to .92 (client version), as are the reliability estimates with ranges of .92 to .98 (client version), and .90 to .95 (therapist version) (Hanson, Curry, & Bandalos, 2002; Tracey & Kokotovic, 1989). Comparisons between the WAI-L and WAI-S have found them to have highly correlated scores, internal consistency, and subscale intercorrelations (Busseri & Tyler, 2003). In addition, both the WAI-L and WAI-S were both found to have good predictive validity to a similar degree (WAI-Lt, \( r = .40 \), and WAI-St, \( r = .42 \); WAI-Lc, \( r = .36 \), and WAI-Sc, \( r = .34 \)), and as such the short version is presently the most commonly used WAI due to its comparatively greater ease of use (Busseri & Tyler, 2003; Elvins & Green, 2008; Samstag, Batchelder, Muran, Safran, & Winston, 1998).

Hovarth and Greenberg (1989) showed that the three subscales of the WAI are highly correlated, with very high correlations between goal and task (.88), and high correlations between bond and goal (.84), and bond and task (.79). The authors suggested that the very high correlations between goal and task may be due to the possibility that the subtle differences between these constructs is not being adequately distinguished by therapists and clients, or alternatively, that agreement on one component likely leads to an agreement on the other. The latter relationship may also explain the high correlations between bond and the other subscales.

The use of factor analysis has shed some more light onto the validity of the WAI’s alliance structure. In order to assess the validity of this conceptualisation of alliance, Tracey and Kokotovic (1989) conducted confirmatory factor analysis assessing the factor structure of the WAI by comparing two competing models of therapeutic alliance. One model posited alliance as a general alliance construct, while the other model viewed alliance as consisting of goal, task, and bond components, which are correlated but distinct constructs. Results showed that the WAI appeared to primarily measure a general alliance factor, and secondarily three
specific aspects of alliance (goal, task, and bond), overall indicating a general alliance factor with three subfactors.

Hatcher and Barends (1996b) employed exploratory factor analysis to examine three different alliance scales, including the WAI, within psychodynamic therapy. Their results, contrary to Tracey and Kokotovic, indicated that the WAI has two independent factors, with goal and task loading on one factor, and bond loading on the other factor. This result was supported by further research conducted by Andrusyna, Tang, DeRubeis, & Luborsky (2001), who conducted an exploratory factor analysis assessing the WAI in cognitive behavioural therapy (CBT). They also found that the WAI had a factor structure consisting of two components, in which the goal and task items grouped on one factor, while the bond items grouped on the other factor. The somewhat inconsistent results in the factor analysis studies may indicate variation associated with the different therapeutic interventions or populations used in each study. It may be that alliance components function differently in different therapeutic modalities, in addition to functioning differently with various client pathologies.

Given the WAI’s robust predictive validity, in addition to the measure’s utility offered by its many forms, the WAI compares well to the other commonly used alliance measures. In addition, the WAI offers further potential advantages over other alliance measures. For example, the Penn scales, CALPAS, Vanderbilt scales and TARS are all based on transference-based psychodynamic theories of the alliance (Martin et al., 2000). It is therefore debatable whether these psychodynamic-based measures can be generalised to all other therapeutic approaches, and in particular the behavioural-based therapies. One advantage in using the WAI is that its theoretical foundations are not tied to a particular psychotherapeutic paradigm, and therefore may offer more utility in producing meaningful results when comparing alliance across different therapeutic contexts and approaches. In addition, studies using the WAI may facilitate the development of techniques and skills based on Bordin’s
goals, tasks, and bonds that are more easily applicable and operationalised across a range of therapies and interventions in order to improve alliance development and treatment outcomes.

This chapter presented the development and characteristics of the most commonly used alliance measures used in psychological research, with a particular focus upon the WAI. The following chapter reviews the literature examining the relationship between measures of alliance at specific points within therapy and treatment outcomes in individual therapy within the adult population. Several meta-analytic reviews are discussed and critiqued. The findings for the overall effect sizes in relation to alliance in individual adult therapy and treatment outcomes are also discussed.
CHAPTER THREE

The Role of the Therapeutic Alliance in Individual Adult Therapy

The vast majority of research into the contribution of the alliance to treatment outcomes has focused upon individual adult therapy. Over the last 30 years, over 2000 studies have been published investigating alliance (Hovarth et al., 2011). In recent years, the use of meta-analysis has been a very effective method in identifying studies of acceptable quality within a given area and then statistically assessing and comparing each independent study using parametric measures of their effect size (eg. $R$ or Cohen’s $d$) (Ferguson & Brannick, 2012).

The first meta-analysis examining alliance within the adult population was published in 1991 by Hovarth and Symonds (1991) and involved an analysis of 24 studies of high quality design. The inclusion criteria for the study was (a) the relationship construct measured had to be either a “working”, “helping” or “therapeutic” alliance, (b) there needed be a quantifiable relationship between alliance and some indices of outcome measurement, (c) research had to be clinical, and (d) studies had to have a minimum of five subjects in individual treatment (Hovarth & Symonds, 1991). The authors found a moderate and reliable effect size of 0.26 and found a positive alliance rating by the observer to be the best predictor of positive treatment outcomes (Hovarth & Symonds, 1991). Further, client and observer alliance ratings were found to be more predictive of outcomes generally than therapist ratings. The analysis also showed that the relationship between alliance and outcome was not significantly influenced by the type of therapy used.

Meta-analytic, and research reviews generally, can be biased because they often do not take into account studies that may be unpublished due to negative results or results that may be contrary to the established literature (Ferguson & Brannick, 2012). Hovarth and Bendi attempted to address this by assessing three unpublished studies and found the effect size to be identical to analyses of previously published studies (0.26). While these three
studies certainly under represent the totality of unpublished studies, they do provide further supporting evidence for the generalisability of the main findings of the meta-analysis.

Three other major meta-analytic studies have been conducted assessing the role of the alliance in adult therapy. Martin et al. (2000) published a meta-analysis using more sophisticated and up to date techniques (homogeneity of variance tests) and included significantly more studies than the Hovarth and Symonds (1991) analysis. The 79 studies analysed included over 60 additional new studies, which consisted of 58 published and 21 unpublished studies to control for publication bias. They used the same inclusion criteria as the Hovarth and Symonds study and found that alliance is moderately related to outcome with an $r = 0.22$. The relationship of alliance to outcome was found to be independent of therapeutic approach and the effect sizes were found to represent a single homogenous population, indicating no mediator or moderator effects (Martin et al., 2000). Alliance ratings from observer (.80), therapist (.72) and client (.82) were all found to have adequate reliability. Test-retest reliability scores also indicated that clients (.78) rated the alliance more consistently than observers (.49) and therapists (.49), and tended to view the alliance as more stable over time than both observers and therapists. This suggests that if clients view the alliance as positive early in therapy they are more likely to have a positive view of the alliance at the end of therapy. Consequently, ensuring a positive initial alliance during treatment may be an important factor in obtaining better therapeutic outcomes. However, the small sample size used in this comparison due to the limited number of studies providing these statistics means these implications should be taken tentatively, and further research is needed to confirm these assertions. In addition, all alliance scales assessed had similar reliability and predictive validity to one another, aside from the TARS, which failed to receive support.
Hovarth and Bedi (2002) completed another meta-analysis in 2002, extending Martin et al.’s analysis by three years of research involving the inclusion of a further 10 studies. They found a similar association between alliance and therapeutic outcome to the prior meta-analyses with an effect size of 0.21 (weighted by sample size). Contrary to the findings in the Martin et al. study, Hovarth and Bedi (2002) found the effect sizes in the data set to not be homogenous. Further assessment located this heterogeneity to be associated with six substance abuse studies included in the analysis (Hovarth & Bedi, 2002). While this is a relatively small amount of studies to draw conclusions from, it may indicate that clinical populations may have distinct alliance characteristics; however, further research is required to clarify this. Hovarth and Bedi’s analysis also found client and observer ratings to be more associated with outcomes than therapist ratings, and while the therapist association was less predictive it was still significant.

Hovarth and Bendi (2002) also investigated whether alliance ratings early in therapy are more predictive of outcome than mid or late therapy alliance ratings. The majority of the effect sizes from studies were from early therapy (n=130), and these yielded an average effect size of 0.22. Mid-therapy alliance ratings (n=38) produced an effect size of 0.19, while late-therapy alliance ratings (n=42) produced an effect size of 0.25. The comparatively fewer studies available for mid- and late-therapy alliance scores may impact upon their accuracy compared to the early alliance results; however, early alliance ratings appear to be a better predictor of outcome than mid-therapy alliance ratings. This may reflect the increased strain on therapist-client relations as more difficult client issues are addressed and worked on as the therapy progresses. The authors also commented that beneficial therapeutic effects have likely inflated the client ratings of late-therapy alliance scores, and further research is needed to clarify this in light of the higher scores within this phase.
Finally, Hovarth, Fluckiger, Del Re and Symonds (2011) extended the previous meta-analysis conducted to include more recent relevant studies, in addition to including searches of German, Italian and French publications. This study approximately doubled the included cases of previous analyses, consisting of 158 published and 53 unpublished research papers and represents the most comprehensive analysis of adult alliance to date. Results indicated a marginally greater alliance effect size of 0.275, which accounted for approximately 7.5% of the variance in treatment outcomes. In addition, the effect was independent of therapy modality, the alliance measure employed, the time of measurement or the rating perspective (therapist-, observer, or client-rating). The consistency of results obtained with these meta-analyses indicates a robust and predictable effect of the alliance on psychotherapeutic outcomes of a moderate strength in individual adult treatment.

This chapter outlined and discussed the available meta-analyses assessing the research to date examining the relationship between alliance and treatment outcomes in individual adult therapy. The chapter focussed upon the relationship between alliance at specific points within therapy (early-, mid-, and late-therapy) and their association with treatment outcomes. The following chapter aims to expand upon this by discussing research examining the temporal properties of alliance. This involves a discussion outlining research examining individual time points during therapy, in addition to research examining overall patterns of alliance across therapy and their associations with treatment outcomes.
CHAPTER FOUR

The Therapeutic Alliance Over Time and its Relationship to Treatment Outcomes

Research investigating the temporal properties of the alliance has struggled to find consistent relationships between specific patterns of alliance and treatment outcomes. Most research has generally focussed on examining the association of alliance ratings in early, mid, and late phases of therapy to treatment outcomes rather than assessing the overall pattern of alliance across treatment (Hovarth & Bedi, 2002; Hovarth & Symonds, 1991; Piper, Azim, Joyce, & McCallum, 1991). In assessing the importance of particular points throughout therapy, there is most support for a stronger alliance rating in the early phase of therapy generally being more important for positive outcomes (Kramer, de Roten, Beretta, Michel, & Despland, 2009). In particular, studies have shown ratings between the third and fifth session to be a consistent predictor of outcome across a range of mental health issues, such as depression, addiction, anxiety and personality disorders (Castonguay & Goldfried, 1996; Crits-Christoph et al., 1999; Gaston, Gallagher, Cournoyer, & Gagnon, 1998; Hersoug, Monsen, Havik, & Hoglend, 2002). These studies have found that a higher alliance rating in the early phase is a better predictor of positive outcomes than the later phase of therapy. However, several studies have also found this not to be the case. One study reported that high alliance ratings at session three from a sample of adolescent inpatients predicted negative outcome, whereas high alliance at three months predicted positive outcome (Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000). In addition, Paivio and Patterson (1999) conducted a study in which survivors of childhood sexual abuse were treated with emotion-focussed therapy. Results showed that session four alliance ratings were positively correlated with some treatment outcomes, whereas post treatment alliance ratings were positively correlated with all treatment outcomes. Another study investigating the treatment of 86 patients with generalised anxiety disorders, chronic depression, or avoidant or
obsessive-compulsive personality disorder with supportive-expressive dynamic therapy found that alliance ratings at sessions two, five and ten all predicted changes in depression to a similar degree (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000). These conflicting results are not easily explained and may be due to a number of factors. While the literature shows a consistent relationship between alliance and treatment outcomes regardless of treatment modality and specific diagnosis, it may be that variations in these factors impact upon the functional properties of the alliance over the course of treatment. For example, Florsheim et al. used an adolescent sample compared to the other studies using adult samples; Paivio and Patterson’s sample had different issues (sexual abuse); and the Barber et al. study used a different intervention (supportive expressive dynamic therapy). In addition, other variables such as therapist skill and experience, treatment setting and pre-treatment levels of psychopathology may also have an impact on the way the alliance develops over time and its relationship to outcomes.

More recently, studies have also begun to examine the overall trajectory of alliance ratings across therapy in an effort to identify whether a particular temporal pattern is optimal for better outcomes (Kivlighan & Shaughnessy, 2000; Muran & Barber, 2011; Stiles, Glick, & Osatuke, 2004). As discussed, a limitation in the current alliance literature is its minimal use of repeated measures for alliance across treatment, instead focusing on assessing single time points or averaging sessions across early-, mid-, and late-therapy (Chu, Skriner, & Zandberg, 2014). As such, potentially meaningful relationships associated with total score variance may be being missed, in addition to potential relationships associated with overall patterns of alliance and therapeutic processes and outcomes. In addition, theories describing alliance fluctuations across treatment provides a rationale to investigate the temporal properties of alliance and relationships associated with specific patterns of alliance (Mann, 1973; Safran & Muran, 1996).
The two main theories informing research into patterns of alliance were developed by Mann (1973) and Safran and Muran (1996). Mann introduced the notion that alliance development goes through a series of changes associated with the client’s responses to the shifting techniques of the therapist. Mann described an initial period of optimism towards treatment by the client that was based upon somewhat unrealistic expectations. This period was then followed by a decline in alliance as the frustrations and challenges of therapy unfolded and the serious work of the therapy was engaged in. The alliance then rebounded to a more positive alliance that was associated with the client incorporating the therapist’s messages and therapeutic insights that was also more reality-based than the initial positive alliance (Mann, 1973).

Safran and Muran (1996) developed the most descriptive model of alliance volatility throughout therapy. Their model involves taxonomy of different types of alliance ruptures, which are understood to represent deterioration in the relationship between the client and therapist. The authors state that ruptures most often occur when therapists become involved in the client’s maladaptive interpersonal cycles, which then confirm the client’s maladaptive schemas and representations of self/other interactions. Other forms of rupture can also involve empathic failure by the therapist, client resistance, and transference/countertransference processes. Points of rupture within therapy are seen as critical moments that require considered exploration by the therapist and client. Through this process, meaningful therapeutic change can occur by understanding and resolving of alliance ruptures. The authors proposed that this process constitutes a new interpersonal experience that could modify the client’s old maladaptive schemas (Safran & Muran, 1996).

Both Mann’s, and Safran and Muran’s models describe a trajectory of alliance that is curvilinear (quadratic – high, low, high) and some researchers have therefore proposed that a curvilinear alliance trajectory is optimal for positive therapeutic outcomes (Bachelor &
Salame, 2000; Gelso & Carter, 1994). As with efforts to identify optimal alliance points in early, mid or late therapy sessions, the research has been inconsistent in identifying optimal overall trajectories and their relationship with treatment outcomes (Barber et al., 1999; Hovarth & Bedi, 2002; Samstag et al., 1998; Tyron & Kane, 1990).

Some early single case studies have identified curvilinear alliance patterns, but unfortunately they did not assess these for their relationship to therapeutic outcomes (Golden & Robbins, 1990; Hentschel & Bijleveld, 1995; Hovarth & Marx, 1990). Hierarchical linear modelling (HLM) has been used to examine the relationship between alliance trajectory and therapy outcomes. In a small study of 21 adult clients receiving short-term eclectic counselling, Kivlighan and Shaughnessy used HLM to assess the fit of curvilinear and linear therapist- and client-ratings of alliance. Results showed the linear model to be the best fit, and interpersonal outcomes were associated with greater positive linear alliance change by both raters (Kivlighan & Shaughnessy, 1995). Another study used HLM to examine alliance in a group of 16 clients receiving short-term psychodynamic therapy (Patton, Kivlighan, & Multon, 1997). Consistent with the previous study linear (82% of variation in sample) and curvilinear patterns (18% of variation in sample) were identified; however, they found that the curvilinear patterns were associated with treatment outcome whereas the linear growth patterns were not. More recently, a study assessed alliance within a group of 50 clients receiving short-term dynamic psychotherapy for a range of psychiatric conditions. HLM revealed stable, linear and curvilinear alliance patterns; however, only the slope of linear alliance change was found to be associated with treatment outcomes (Kramer et al., 2009). The inconsistent results obtained between studies may be associated with limitations due to small sample sizes. The studies do indicate; however, that specific alliance growth patterns are likely differentially associated with various treatment outcomes.
Cluster analysis has also been used to identify discreet alliance patterns within treatment groups (Morral, Iguchi, Belding, & Lamb, 1997). The first study of this kind gathered alliance scores across four counselling sessions from two groups of university students (n=79) with a variety of interpersonal concerns. Cluster analysis identified stable, linear and quadratic alliance trajectories across both groups. Results indicated that clients in the quadratic cluster had significantly greater therapeutic benefits than those within the stable and linear clusters. Several other studies using cluster analysis have failed to find curvilinear trajectories within their samples at all (Despland et al., 2009; Kramer, de Roten, Beretta, Michel, & Despland, 2008; Kramer et al., 2009; Stiles et al., 2004). Stiles et al. conducted a cluster analysis on a clinical population meeting the criteria for major depressive episode, with patients receiving eight or 16 sessions. Results identified four clusters consisting of a linear positive slope, a high and stable cluster, a linear negative slope, and a pattern indicating a rapid increase from the early session that then remained strong. None of the clusters were found to be distinctively associated with good outcomes. Another study conducted the same year using 70 clinical outpatients identified a stable alliance cluster and a linear growth pattern (de Roten et al., 2004). They found that patients with a linearly increasing alliance did significantly better than patients with a stable alliance.

Despite the convincing theoretical arguments supporting curvilinear alliance development and positive outcomes, the literature has failed to provide compelling support for this. Similarly, linearly increasing trajectories have not consistently been associated with better outcomes. However, within recent cluster analysis studies, linear trajectories appear to be more common and predictive. While these results seem to converge upon the occurrence of a small number of alliance trajectories (stable, curvilinear and linear), their inherent relationships to treatment outcomes appear to be quite variable. Alliance scores may reflect different processes in different cases or at different times that are not being sufficiently
distinguished by current measures. In addition, individual differences within clinical populations may be represented by characteristic alliance trajectories that are optimal for each sub-group. It may be that current alliance measures do not adequately capture the complex variables underlying variability in alliance trajectories. Other considerations such as methodological variations, including sample variation, treatment modalities, durations, rater perspectives, statistical procedures and the measures used may also be confounding results. Future studies may benefit by efforts to more closely replicate previous research to help identify whether these highlighted factors and variables may account for some of the inconsistencies within the current research.

This chapter discussed research into the relationship between measures of alliance at specific points within therapy, in addition to overall patterns of alliance, and their associations with treatment outcomes. The following chapter focuses upon the research literature examining the relationship between alliance and treatment outcomes in individual youth therapy. Initially, factors contributing to the complexity of alliance research within youth therapy are discussed. Following this, the available meta-analyses assessing the relationship between therapist-, parent-, and youth-alliance and youth treatment outcomes are discussed and critiqued.
CHAPTER FIVE

The Role of the Therapeutic Alliance in Youth Therapy

Research to date investigating the relationship between alliance and mental health outcomes within the youth population is comparatively far less than that conducted for adult populations. In addition to this paucity of research, no well-established theory has been developed to specifically describe the therapeutic processes associated with youth populations (Kendall, 2000). It has been suggested that youth alliance may be significantly more complex than adult alliance due to a number of factors. Youth engagement with mental health services occurs across a broad range of youth developmental stages that likely impacts the development and maintenance of the alliance in a number of complex ways. For example, differences in cognitive and social development will impact upon the ways in which youths understand, relate, engage, and respond to the therapeutic relationship (Green, 2006). In addition, the context in which youths engage and participate in therapy is often very different to that of adults. Often youth therapy is conducted as family therapy, parent management training, or individual therapy with parent involvement (Diguiseppe, Linscott, & Robin, 1996). Moreover, several factors associated with youths engender conditions that are often antagonistic to the therapeutic process. Most youths are not self-referred to mental health services, are often resistant to engaging with mental health services, and often do not recognise or acknowledge the existence of problems (Shirk & Russell, 1998). Conflict between child and parents can also interfere with therapy, and many youths undergo developmental stages with oppositional attitudes to adults and authority that may be problematic for therapeutic engagement and alliance development (Diguiseppe et al., 1996). As such, failure to establish a positive alliance early in therapy may lead to early dropout. Research from child and family studies indicate youth dropout rates between 30 – 60 % (Armbruster & Kazdin, 1994). This high dropout rate is particularly concerning in light of
other research indicating that of the 10 – 20 % of youths with mental health issues, fewer than one in five actually receive psychological treatment (Baylis, Collins, & Coleman, 2011). While a proportion of this dropout may be due to symptom improvement in young people, its relatively high occurrence, in addition to the very low percentage of young people with mental health issues seeking treatment, is very concerning. Consequently, understanding the relationship between youth alliance, treatment engagement and positive treatment outcomes is of considerable importance within this population if more effective mental health services are to be developed.

In order to assess the relative contribution of youth alliance to youth treatment outcomes, Shirk and Karver (2003) conducted a meta-analysis using Martin et al.’s (2000) meta-analysis of adult alliance research as a basis for their inclusion criteria (Shirk & Karver, 2003). The analysis included individual youth therapy, family therapy, and parent management training, as these all constitute common forms of youth mental health treatment. The authors found that most of the studies investigating therapeutic relationships within youth mental health do not use the term ‘alliance’. Therefore, the search terms were broadened to include studies that focussed upon particular aspects of the therapeutic relationship that were assessed for their relationship to youth therapeutic outcomes (Shirk & Karver, 2003). The analysis included 23 studies from the preceding 27 years (18 published articles and 5 unpublished doctoral dissertations to control for publication bias) and the main findings were similar to those found of adult research.

Youth alliance was found to have a predictive association with therapeutic outcomes, with an overall effect size of $r = 0.24$ (adults $r = 0.22$). When alliance was assessed for just individual child and adolescent therapy, the results were identical to those obtained in Martin et al.’s (2000) meta analysis for individual adult therapy. In addition, this moderate association was found to be consistent across levels of development and treatment modalities,
including individual, family, parent based treatments, manualised and non-manualised treatments, and behavioural versus non-behavioural treatment (Shirk & Karver, 2003). The relationship between alliance and treatment outcomes was found to be consistent across treatment modalities, but interestingly, the analysis revealed alliance to be moderated by several factors. One factor was the type of condition the child was being treated for; results indicated that children with externalising issues had stronger associations between alliance and treatment outcomes than children with internalising issues. The other moderating factors were methodological in nature; contrary to findings in adult populations, associations were stronger when alliance was measured later in therapy and was reported by the therapist rather than the client. In addition, associations were stronger when outcomes measured global functioning rather than symptoms, thereby highlighting a potential confound between alliance and outcomes (Shirk & Karver, 2003).

While the findings by Shirk and Karver (2003) provide evidence of alliance associations with outcomes to a similar degree to those found in adult populations, some potential issues with the study should be noted. Most of the studies included in the analysis lacked controls and included a broad range of inclusion criteria. The fact that global functioning measures had stronger associations than symptomatology with alliance may be illustrative of the lack of a clearly defined model of youth alliance within the field. Consequently, it may be that many of the alliance terms included in the study were overly broad and may have lacked adequate specificity to the psychopathologic dimensions of therapeutic outcomes. In addition, adult studies show a predictive relationship between early alliance ratings and outcomes; however, Shirk and Karver reported a correlation coefficient of only 0.12 between early ratings and therapeutic outcomes, while alliances recorded later in therapy were only marginally stronger at $r = 0.27$. As such the authors concluded that there is
little support for a predictive relationship between ratings within a particular phase of therapy and outcome in youth therapy.

Karver, Handelsman, Fields and Bickman (2005) published a paper in response to Shirk and Karver's (2003) findings, in addition to general concerns within child and family therapy research of inadequate theoretical formulations of therapeutic processes. They proposed a preliminary model of *common process factors* in youth and family therapy that could be used as a theoretical framework for further research. The model outlines the various relationship variables that interact uni-directionally and bi-directionally to influence treatment outcomes. The model also suggests that therapeutic relationship variables may affect therapeutic outcomes via multiple mediating processes (Karver et al., 2005). Briefly, what is proposed is that client pretreatment characteristics influence the degree to which they are receptive to the therapist and the proposed treatment plan. In addition, the client and therapist characteristics influence the therapist’s views of the client and their feelings and expectations regarding the client. These factors influence the therapist’s behaviours towards the client, which impacts upon the client’s cognitions, emotions and behaviours within therapy. Other factors, such as therapist interpersonal skills, therapist self-disclosure, client autonomy, client hopefulness and client perception of therapist credibility also impact upon the relationship and therapeutic processes. This is an ongoing interactional and transactional dynamic process that occurs throughout therapy and ultimately influences therapeutic outcomes.

Using the common process factors theory as a framework, the same research team then conducted a more extensive meta-analysis, including an assessment of which specific relationship variables in youth and family therapy were the strongest predictors in child and adolescent treatment outcomes (Karver, Handelsman, Fields, & Bickman, 2006). Forty-nine studies were included in the analysis encompassing a total of 44 identified relationship
constructs, which were then assessed for their associations with treatment outcomes. Similar to Shirk and Karver’s 2003 analysis, the strength of the alliance-outcome association was found to have an overall effect size of 0.21, but was only based upon 10 studies. The largest associations with treatment outcomes were found between therapist direct influence skills ($r = 0.19$) and the therapeutic relationship ($r = 0.21$) with the client. In addition, counsellor interpersonal skills ($r = 0.35$), youth willingness to participate in treatment ($r = 0.27$) and youth participation in treatment ($r = 0.27$) were all moderately related to outcomes. Further findings, which may reflect important differences between adult and youth therapeutic processes, showed that parent willingness to participate in treatment and parent participation in treatment were both moderately predictive of youth outcomes, yet parent therapeutic alliance was found to have a poor effect size (0.11). This result may have been affected by the limited number of studies included, as only 10 studies were used in the parent therapeutic alliance analysis and effect sizes varied considerably (0.09 – 0.67). One of the included studies with an effect size of 0.05 had a sample size comprising half of the total sample analysed. In addition, four of the included studies were unpublished dissertations that may not have passed peer review. Given the moderate associations parent willingness and participation was found to have with youth outcomes, it would be surprising if the strength of parent alliance had no relationship to youth outcomes. Clearly, more research is needed to establish the role of parent therapeutic processes in youth mental health treatments, as they may represent an effective target for future treatment development.

The most recent meta-analysis was conducted by McLeod (2011), who also highlighted some shortcomings of the meta-analyses completed previously (Karver et al., 2006). Of primary concern was the observation that the two most recent prior analyses had based their ES estimates of alliance-outcome associations on 9 and 10 studies, and as such were prone to inaccuracies. In addition, there were substantial differences across the studies
in relation to how alliance was conceptualised and assessed, and from who’s perspective the alliance was measured (therapist, observer, client, or parent). Based on these issues, McLeod suggested that caution is warranted when interpreting the findings of these previous analyses (McLeod, 2011). To address these concerns, McLeod conducted another meta-analysis including all the relevant studies completed since Karver et al’s (2006) analysis. The inclusion criteria limited the analysis to include only those studies that used alliance measures adequately measuring Bordin’s (1979) task, goal, or bond dimensions of the alliance. The analysis included 38 studies that fitted this criteria, which was a significant increase from the 10 studies meeting this criteria in the Karver et al (2006) meta-analysis. Results showed that the association between alliance and outcome had a small effect size (0.14), which was lower than previously conducted meta-analyses. In addition, there was not a significant difference in the strength of association between youth alliance ($r = 0.12$) or parent alliance ($r = 0.15$) and outcomes, suggesting that both are similarly predictive of therapeutic change. Potential moderators were also assessed, and the alliance-outcome association was found to vary according to child age, problem type, referral source, and treatment modality. With regard to rater perspective, the weighted mean ES varied between parents (0.28), therapists (0.18), observers (0.06), and young people (0.14), with contrasts showing a significant difference between the parent ratings compared to the observer and child ratings. Later alliance ratings (ES = 0.34) also accounted for significantly greater variance in outcomes than early alliance ratings (ES = 0.06).

Research into the role of alliance processes in youth therapeutic outcomes suffers from a lack of clarity and consistency among studies with regard to the concepts of alliance and measures used to capture alliance processes. The majority of meta-analyses to date suggest that the strength of association between alliance and outcomes has a similar effect size to that found in individual adult therapy. However, Mcleod’s (2011) latest analysis,
which attempts to address the aforementioned issues within the literature provides evidence that the alliance may play a relatively smaller role in youth therapy than previously thought. One finding that has been consistent throughout, is the stronger association between later ratings of alliance and outcomes compared to early alliance ratings, which is the opposite trend to that seen in adult therapy. Alliance processes, then, may function differently within youth therapy; however, more research using consistent alliance measures and adequate controls are needed to clarify this.

This chapter discussed the research to date examining the relationship between alliance and treatment outcomes within youth therapy. The following chapter provides a discussion of how alliance and relationship processes are conceptualised and applied within a group therapy setting. Specifically, the chapter discusses the theoretical basis of the construct of group cohesion, in addition to research investigating the association between measures of group cohesion and treatment outcomes. The chapter then presents a comparison between group cohesion and alliance in group therapy within the literature, before the chapter concludes with a review of the literature assessing measures of alliance and their associations with treatment outcomes within group therapy.
CHAPTER SIX

Therapeutic Alliance and Group Cohesion in Group Therapy

Therapeutic alliance is a concept established within individual therapy, which describes the relationship between the therapist and client. However, when considering alliance within the context of group therapy, its role in and impact upon therapeutic processes and outcomes potentially becomes more complex as several different types of relationship interact. In addition to the client-therapist relationship, group therapy also consists of multiple client-client relationships and client-group relationships. Within the field of group therapy, the notion of group cohesion has historically been the primary construct used to understand and investigate the role of relationships, and has commonly been viewed as being the group therapy analogue to therapeutic alliance within individual therapy (Budman, Soldz, Semby, & Davis, 1993; Marziali, Munroe-Blum, & McCleary, 1997).

The concept of group cohesion was first formally defined in 1950, and was a term used to encapsulate the field of forces that bind members to a group (Festinger, 1950). The concept underwent several changes early in its conception such as cohesion being the pooled forces that act on group members to remain in the group, but the concept somewhat solidified when conceptualised as the sum effect of the group members’ attraction to other group members and the group as a whole (Budge, 1981; Evans & Jarvis, 1980; Hogg, 1993). Later, Yalom (1995) described group cohesion as the primary curative factor in group therapy, which involved the interrelation of group self-esteem and self-esteem. Group self-esteem included factors such as how members think outsiders view their group, how members value the group, how members value their own personal worth as a group member, and how much group members internalise the group and perceive the group as part of themselves (Crocker, Luhtanen, Blaine, & Broadnax, 1994). Yalom posited that group cohesion enabled members
to engage in necessary self-disclosure and personal exploration, and that cohesiveness engenders improved self-esteem through acceptance and empathy from the group as a whole.

Within group cohesion research; however, the construct of cohesion has suffered from the lack of a well-developed theoretical foundation, and there is significant variation in commonly used measures of cohesion. Instruments measuring group acceptance, emotional well-being, self-disclosure, interpersonal liking, tolerance for personal space, attendance, verbal content, early termination, physical seating distance, and amount of eye contact, have all been used to assess group cohesion (Berlingame, Fuhriman, & Johnson, 2002; Berlingame, McClendon, & Alonso, 2011; Hornsey, Dwyer, & Oei, 2007). Some authors have criticised the construct of cohesion as being too general a term for a consensus in its definition to be reached, and this lack of consensus has therefore led to inconsistencies in its measurement (Albert, 1953; Bednar & Kaul, 1994; Braaten, 1991; Drescher, Burlingham, & Fuhriman, 1985).

Research into the relationship between measures of group cohesion and therapeutic outcomes has been quite inconsistent. While past narrative reviews assessing group cohesion have generally made claims of an overwhelming positive relationship with therapeutic outcomes, a recent meta-analysis by Burlingame, McClendon and Alonso (2011) found that only 43% of the 40 studies that met inclusion criteria reported a statistically significant correlation between the two (Berlingame et al., 2002; Tschuschke & Dies, 1994). Even so, the authors found an overall effect size of 0.21, which is comparable to that of alliance observed in individual adult and youth therapy. However, the number of studies used in the analysis is much lower than research completed on alliance, with the most recent analysis completed on adult alliance including over 200 studies (Hovarth et al., 2011).

Research also indicates that the constructs of group cohesion (relationship with group as a whole) and alliance (client-therapist relationship) are highly related and likely perform
equivalent functions within the group therapy setting (J. Johnson, Burlingame, Olsen, Davies, & Gleave, 2005). Several studies have shown significant correlations between the two constructs with Budman et al. (1989) finding a correlation of .90, and Marziali, Munroe-Blum and McCleary (1997) finding a correlation of .60. In addition, the latter research group found that alliance accounted for more outcome variance than cohesion. Other studies have also found that client completed measures of the client-therapist, client-client, and client-group relationships are correlated (Kipnes, Piper, & Joyce, 2002; McCallum, Piper, Ogrodniczuk, & Joyce, 2002). These results suggest that cohesion likely involves alliance processes, and that alliance constructs appear to function similarly to cohesion constructs within group therapy. This apparent crossover between cohesion and alliance may reflect the identified issues with the theoretical underpinnings of cohesion, in addition the lack of consistency between cohesion measures, and to a lesser but still significant degree a lack of consistency between alliance measures. These findings indicate that alliance processes are likely important within a group therapy setting.

Given the clear predictive relationship between alliance and treatment outcomes established in individual therapy and the evidence indicating significant correlations between alliance and group cohesion measures, in addition to the fact that alliance is a comparatively much less complex construct compared to group cohesion, some have argued that researchers may be able to make more progress by initially investigating alliance within group therapy (Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005). It is somewhat surprising, then, that very little research has investigated the role of alliance within a group therapy context; however, this may be due to the concept of cohesion taking historical precedence within group therapy research and a resistance to conceptualising groups as therapist centered (Piper et al., 2005). While the little research completed to date investigating the role of alliance in group therapy suggests it is associated with a range of treatment outcomes, the results have
been somewhat inconsistent with regard to the comparative predictive effectiveness of different raters (client, therapist, and observer), and the consistency of alliance measures in predicting main treatment outcomes.

Several studies have investigated alliance within the area of group treatments for relationship problems. Two studies have examined the importance of alliance in group relationship education programs (Owen, Antle, & Barbee, 2013; Owen, Rhoades, Stanley, & Markman, 2011). One pre-marital education study found that post-treatment client-rated alliance predicted the relationship functioning outcome measures of relationship satisfaction ($r = .24$) and confidence ($r = .24$) (Owen et al., 2011). In contrast, a subsequent study by the same group investigating a relationship education program found post-treatment client ratings of alliance were not related to post-treatment changes in relationship functioning (Owen et al., 2013). The studies differed in that both partners participated in the pre-marital treatment study, whereas only one partner participated in the relationship treatment. It may be that the association between alliance and outcome in relationship treatments may be impacted by factors associated with both partners participating. For example, there may be more accountability and investment in therapeutic processes when a participant’s partner is present. Another study found that both male-client- and therapist-rated alliance predicted treatment outcomes in group marital therapy, while female-rated alliance was a comparatively weak predictor (Bourgeois, Sabourin, & Wright, 1990). These studies suggest that male ratings of alliance are a better predictor of outcome than female alliance ratings in couples-based therapy.

Two studies have also examined the role of alliance in group treatments for spousal abuse (Brown & O’Leary, 2000; Taft & Murphy, 2003). One study found that observer-rated alliance for men but not women predicted reductions in post-treatment mild ($r = .25$) and severe ($r = .08$) male psychological aggression (Taft & Murphy, 2003). Another study found
that therapist-rated alliance measures predicted post-treatment reductions in both physical and psychological aggression, but male client-rated alliance did not (Brown & O'Leary, 2000). The latter study also found that alliance was a stronger predictor of outcomes than group cohesion measures. The discrepancies between these studies may also indicate effects related to the presence or absence of a partner in the couples treatment. Consistent with the results found by Owen et al. (Owen et al., 2013; 2011), client alliance ratings were predictive of outcomes when both partners were present and not predictive when only one partner was present in treatment. Particularly in cases of spousal abuse, males may be more likely to underplay or minimise their aggression if their partner is not present, which could confound the relationship between their ratings of alliance and treatment outcomes. The fact that therapist alliance ratings were predictive of outcomes in this case may reflect the therapists’ ratings reflecting this observed discrepancy in relation to the alliance goals and tasks of therapy.

Alliance has also been shown to be predictive of various outcomes within the area of group interventions for psychosis. One study found that therapist ratings of early alliance were predictive of overall patient functioning at post-treatment (Svensson & Hansson, 1999). Another study involving group therapy for individuals with treatment-resistant auditory hallucinations found that stronger client-rated alliance was associated with higher attendance rates and therapists’ ratings of treatment compliance (D. P. Johnson, Penn, Bauer, Meyer, & Evans, 2008). Two studies have assessed alliance in group interventions for early psychosis; Bentall et al. (2008) and found that while client and therapist ratings of alliance correlated poorly, both client and therapist alliance ratings predicted duration of treatment, which in turn predicted therapy response; Laferriere-Simard, and Leclere (2012) also found that client-rated alliance predicted post-treatment total symptoms and self-esteem while both client and therapist ratings predicted group attendance and participation.
Within the field of drug and alcohol treatment, client-rated alliance has been found to be predictive of client-ratings of reduced psychological distress, but was not associated with reductions in post-treatment drug and alcohol abuse or depressive symptoms (Gillaspy, Wright, Campbell, Stokes, & Adinoff, 2002). In a study employing group-based network therapy it was found that observer-rated alliance predicted decreased cocaine use (Glazer, Galanter, Megwinoff, Dermatis, & Keller, 2003).

Two studies investigating the role of alliance in social anxiety disorders have been less successful. One of the studies found that client-rated alliance failed to predict treatment outcomes, while the other study attempted to assess the trajectory of client-rated alliance in relation to outcomes, but again failed to detect an association (Mortberg, 2014; Woody & Adessky, 2002).

The results have also been inconsistent within the area of affective disorders. One study investigating the role of alliance and group cohesion in group psychotherapy for adults with major depression found that client-rated alliance and cohesion measures were not associated with treatment outcomes (Crowe & Grenyer, 2008). Another study examined the role of client- and therapist-rated alliance in short-term group psychotherapy for complicated grief. Both the client-rated initial level of alliance and linear pattern of alliance were found to be directly and significantly related to better outcomes however, therapist-rated alliance was not directly related to outcomes (Piper et al., 2005). The same group then compared alliance and group cohesion in group psychotherapy for complicated grief and again found client-rated alliance predicted all three outcome measures, while the therapist-rated alliance only predicted one of the outcome measures. A number of cohesion variables approached significance; however, only the therapist’s rating of the patient’s cohesion variable of compatibility was directly associated with an outcome (Joyce, Piper, & Ogrodniczuk, 2007).
A study investigating both alliance and group cohesion in a cognitive-behavioural treatment for cardiac patients found that therapist-rated alliance and the bond subscale in the cohesion measure at mid-treatment predicted changes in blood pressure, while only therapist-rated alliance predicted quality of life improvements (Andel, Erdman, Karsdorp, Appels, & Trijsburg, 2003). Finally, a preliminary study investigating alliance and cohesion in a long-term analytic group treating clients with affective and anxiety disorders found that the therapists early alliance ratings positively predicted improvements in symptoms, while the client ratings of alliance did not. Furthermore, cohesion was not related to symptom improvement (Andel et al., 2003).

While there is a paucity of research into the role of alliance within a group therapy context, the research conducted to date suggests that alliance is an important factor in treatment outcomes and may be at least as important as group cohesion in contributing to therapeutic change. However, more research is needed in order to establish whether alliance in a group setting contributes to therapeutic outcomes to a similar degree to that found in individual adult therapy. The research completed to date indicates that alliance is a good predictor of outcomes for group treatments for couples issues, and that the presence of both partners in therapy may play an important role in this relationship. In addition, several studies have shown alliance to predict a range of outcomes for group treatments of schizophrenia. Results are mixed in relation to the association between alliance and outcome in group treatments for drug and alcohol abuse, anxiety, and depression. These inconsistencies may reflect limitations associated with the small number of studies completed in addition to factors such as small sample sizes used in some of the studies and differences in treatments, population characteristics, and disorder specific effects. It also may be that the relationship between alliance and treatment outcomes is weaker or clinically insignificant in group treatments for internalising disorders.
The majority of studies investigating alliance in group therapy to date have only used client ratings of alliance, likely based upon Hovarth and Bedi’s (2002) meta-analysis of alliance in adult therapy, in which the authors found client-rated alliance to be a better predictor of outcomes than therapist- or observer-rated alliance. However, Martin et al’s (2000) meta-analysis, which included only ten fewer studies than Hovarth and Bedi’s analysis, found that rater-type failed to account for additional variance in their model, suggesting that client, therapist and observer ratings of alliance have equivalent reliability in predicting outcomes.

Of the 17 studies that were found examining alliance within a group setting, only seven studies also included therapist rated alliance. Client-rated alliance was found to be a better predictor of treatment outcomes in three of these studies compared to therapist-rated alliance, while therapist-rated alliance was found to be a better predictor of outcomes than client-rated alliance in three of the studies. The remaining study found client- and therapist-rated alliance to be both predictive of outcomes. Given these findings and the possibility that the predictive capacity of rater perspectives may be different in a group context compared to individual therapy, more research is needed to assess both therapist- and observer-rated alliance in group settings.

This chapter provided a discussion examining the constructs of group cohesion and alliance within group therapy. The following chapter provides a review and critique of qualitative research into the therapeutic alliance. Initially, research exploring the parent’s perception and experience of the therapeutic alliance is discussed, including therapist behaviours that parents perceive as being important in alliance development. Following this, qualitative research examining ‘rupture and repair’ events within therapy is critiqued and its relevance to alliance processes is explored.
CHAPTER SEVEN

Qualitative Research into Therapeutic Alliance

Few studies have employed qualitative approaches when researching alliance processes, however this method of analysis potentially offers an important contribution in understanding the richness and complexities of the client experience that may reveal important factors in alliance formation and maintenance. In addition, alliance constructs have largely been based upon theories developed from the therapists’ views of what factors are important in alliance processes, and as such these theories may be missing important components that can only be understood through exploring the client’s experience of the therapeutic process (Bachelor, 1995; Bedi, 2006b).

Some qualitative research has been conducted in exploring the client’s view of what factors are important in creating an early positive alliance with the therapist. Bachelor (1995) conducted a phenomenological analysis on 34 clients’ accounts of their perceptions of the alliance, and what aspects of their relationship with the therapist they found the most therapeutically helpful. The analysis identified 3 distinct types of perceived alliance, which were labelled nurturant (46% of reports), insight-oriented (39% of reports), and collaborative (15% of reports). Nurturant alliance was associated with the therapist-offered attributes of being non-judgemental, offering empathic understanding, and attentive listening. Clients identifying nurturant alliance found these therapist attributes to be conducive to them feeling more comfortable in disclosing personal experiences, and viewed themselves more as receiving beneficial therapeutic outcomes from the therapist. Insight-oriented alliance was associated with improvements in the client’s self-understanding gained through clarification of significant client material. These clients were generally more focussed upon understanding themselves better through gaining greater insight and understanding into their underlying maladaptive patterns and behaviours. Collaborative alliance was characterised by the client’s
active role in the therapeutic process, and their acknowledgement of their active role in this process. These clients’ viewed their role in therapy, while different to the therapist’s, just as active and important as the therapists’ role.

Bedi, Davis, and Arvay (2005) interviewed nine adult participants receiving general counselling with regard to what events and behaviours in their counselling sessions were most beneficial in alliance formation. A clear majority of critical factors that clients identified fell within the category of ‘general counselling skills’, which involved therapist behaviours such as sharing personal experiences, reflective listening, verbal support, offering opinions, challenging clients, and clarification questions. All of the interviewed clients identified critical factors within this category, and 50.6% of the total number of factors clients identified fell within this category. Other categories identified were therapist expression of positive affect and sentiment (66.6% of clients), tracking the counselling process (directing client towards goals, linking between session content, soliciting and responding to feedback, 44.4% of clients), counselling environment (33.3% of clients), punctuality and use of time (33.3% of clients), going beyond normative expectations (sharing food or drink, therapist not charging client for absence, 33.3% of clients), personal attributes of the therapist (22.2% of clients), and positive first encounter (22.2% of clients).

Bedi (2006a) interviewed 40 adults who received counselling services and asked them to identify what behaviours and verbalisations they felt helped establish an alliance with their therapist. Results identified 11 categories, with validation, education, non-verbal therapist gestures, and therapist presentation and body language being rated as the most important factors by clients. Consistent with Bedi et al’s (2005) findings, the clients’ also identified the setting as an important factor in alliance formation.

Fitzpatrick, Janzen, Chamodraka, and Park (2006) also explored client-perceived critical incidents in early alliance formation in a group of 20 university students receiving
general counselling. Analysis of the client responses were organised into five domains, which consisted of ‘description of the critical incident’, ‘meaning of the incident’, ‘client contribution to the incident’, ‘impact of incident on the relationship’, and ‘general outcome of the incident’. Clients identified three main categories of critical incidents; the therapist helped clients think in a new way (made observations or facilitated client insight), the therapist gave clients adequate space to engage in therapy (encouraged collaboration and gave room for client expression), and the therapist disclosed something meaningful (therapist disclosure of either positive view of client or personal information). The authors also identified different categories of meaning that the clients ascribed to these critical incidents, such as “I’m important, I’m the center”, “my therapist can help me”, “I’m ok”, and I can do this myself”. Clients reported that these incidents resulted in them trusting and believing in the therapists, feeling positive emotions, and feeling comfortable. In addition, the clients felt as though these factors led to them being more productive in the therapy, more open in disclosing in sessions, and increasing positive emotions and expectations. The authors postulated a “spiral” effect, in which the initial critical incidents facilitate greater client openness and positive orientation towards the therapist, thereby favouring further critical incidents and a continuation and building of this therapeutic pattern.

To address the possible limitations of the study utilising student therapists working with a non-clinical student sample, the same group conducted a similar analysis with a sample of 15 clinically depressed adults being treated by experienced clinicians (Fitzpatrick, Janzen, Chamodraka, Gamberg, & Blake, 2009). Consistent with their previous findings, the most common critical incident cited by clients was that the therapist helped the client think or act in a new way. Other identified critical incidents were the therapist demonstrated interest; provided emotional support; communicated understanding; met the clients’ unexpressed needs.
More recently, another two studies examined the client’s perception of alliance formation. Bedi and Duff (2014) conducted a Delphi poll with 42 clients who had received individual psychotherapy. A Delphi poll is designed to capture the consensus of opinion from a group of participants, and is based on the assumption that interactive group judgements can be more trustworthy than individual opinions. The client identified variables were placed into 11 categories, with validation, honesty, ‘presentation and body language’, and ‘guidance and challenging’ comprising the top 4 categories of importance. The 23 most consensual, highest rated variables by the client’s also align with prior research indicating that general counselling skills involving positive physical and verbal orientation towards the client, active and reflective listening, and providing adequate space for client expression and exploration were most beneficial in alliance development.

MacFarlane, Anderson, and McClintock (2015) analysed the responses of 54 students with an average age of 21 years who completed an alliance workbook after receiving psychotherapy for a range of common mental health issues such as depression and anxiety. The alliance workbook consisted of 4 sections, which asked questions in relation to Bordin’s (1979) conception of the alliance involving task, goals, and bond. Responses were analysed and organised into four clusters being ‘client’s initial misgivings about psychotherapy’, ‘organisation and meaning-making’, ‘psychotherapist supportive activities’, and ‘client appreciation of techniques’ (MacFarlane et al., 2015, pp. 67-69). The authors reported that many clients had initial difficulties engaging in therapy due to issues such as having difficulty opening up, concerns about the psychotherapist, apprehension due to the novelty of the situation, and fears about starting to cry. However, most clients were able to work through these initial difficulties and move towards the active processes of psychotherapy, which appeared to emerge as the therapist continued to clarify and reflect the client’s content. Consistent with prior qualitative studies, therapist-based supportive behaviours such as
normalising the client’s experience, empathising and sympathising with the client, and offering praise were seen as important factors by the clients in building the relationship. In addition, clients felt as though this process was important in bond formation and developing therapeutic goals within the therapy. Clients also felt as though the use of techniques by the therapist such as exercises, psychoeducation, and homework further developed their bond with the therapist, in addition to increasing their confidence in the benefits of the therapy.

The findings by MacFarlane et al. (2015) appear to indicate a similar process to that proposed by Fitzpatrick et al. (2006), in which specific ‘critical incidents’ build upon one another to help build a productive alliance and facilitate the therapeutic process to occur, which in turn further contributes to alliance development and subsequent therapeutic progress.

The qualitative research completed to date indicates a consistency in what client’s perceive to be important factors in alliance development. Nurturant therapist behaviours associated with being empathic and sympathetic, supportive, positively oriented towards the client, and helping normalise client experiences appear be important in allowing the client to open up and develop the bond between the therapist and client. In addition, general therapist skills such as active and reflective listening, clarifying and challenging, and allowing space for the client to express themselves have also been consistently important factors identified by clients.

These studies also highlight the interrelations between alliance and therapeutic processes, such that relational processes appear to also be therapeutic and therapeutic processes also help develop the alliance. For example, nurturant therapist behaviours help build the bond between the therapist and client, while simultaneously facilitating the development of more open and expressive communication by the client. In addition, therapist
techniques help the client implement behavioural and cognitive changes, but also appear to have a direct influence on developing the bond within the alliance.

A consistent finding among these studies is that clients appear to identify therapist-based behaviours as being the most important variables in alliance formation, when compared to client-based behaviours and characteristics. These results indicate that clients view the development of the alliance as being largely dependent upon what the therapist does, rather than a product of both therapist and client factors. In addition, it suggests that clients view themselves as ‘being treated’ by the therapist, rather than working collaboratively with the therapist.

Some qualitative research has also explored the occurrence of ruptures within therapy. Therapeutic ruptures represent points within therapy where the relationship between the therapist and client deteriorates for some reason. Ruptures are thought to primarily occur due to the client’s pathological schemas resulting in idiosyncratic and dysfunctional interpretations of therapist/client interactions within therapy (Safran & Muran, 1996). As a result, the client may become overtly confrontational in expressing their dissatisfaction, or alternatively may become emotionally or cognitively withdrawn within the session. Some research has indicated that a rupture and repair pattern within the alliance across time is associated with greater therapeutic gains for the client (McLaughlin, Keller, Feeny, Youngstrom, & Zoellner, 2014; Muran & Barber, 2011; Safran & Muran, 1996; Stiles et al., 2004). This is generally thought to be due to the rupture providing an important therapeutic opportunity for the therapist and client to explore and resolve the underlying client-based issues that may have precipitated the rupture. Therefore, developing a better understanding of rupture processes and the ways in which they can be optimally negotiated by the therapist may provide more effective treatment approaches.
Binder, Holgersen, and Nielsen (2008) sought to better understand the ways in which therapists work with ruptures when working with adolescents. Nine experienced therapists working with adolescents participated in a semi-structured interview exploring the ways in which the therapists responded to and worked with ruptures with their clients. Analysis of the therapists’ responses revealed five different strategies utilised by them to attempt to reconnect with the client. These strategies were ‘exploring reasons for the rupture from the adolescents’ point of view, ‘to confirm ambivalence, or to handle it directly as a choice’, ‘to establish a language for fluctuations in the adolescent’s experience of motivation and distress’, ‘to interpret not wanting therapy as a sign of autonomy needs and self-protection, and ‘to explore the reasons for the rupture from the point of view of the therapist’s own subjectivity’ (Binder et al., 2008, pp. 241-244).

In Binder et al’s (2008) study, the ways in which the therapists structured their conversations around these approaches appeared to be based upon the therapists’ preconceptions about the nature of adolescent ruptures. Generally, the therapists were found to view the rupture in one of two ways. One group of therapists viewed ruptures as being associated with the dysfunctional ways in which the adolescent normally negotiates relationships in their life, and therefore the underlying cause of the rupture was ascribed to the adolescent rather than a product of the therapeutic relationship itself. These therapists therefore framed their approaches within the broader context of the adolescent’s life and relationships. The other group of therapists viewed the rupture as being a consequence of the therapeutic relationship, and therefore placed more emphasis on their own possible contributions to the rupture as well as the adolescent’s, and the approaches used were discussed within the context of the therapeutic relationship. While the authors identified some potentially useful ways in which therapists’ frame and work with ruptures, the study did not address the efficacy of any of the approaches or the potential differences in outcomes based
upon whether the therapists explored the rupture within the context of the therapeutic relationship or the client’s broader life.

Coutinho, Ribeiro, Hill, and Safran (2011) explored both the therapist’s and the client’s experiences of ruptures in eight cases of adults receiving psychotherapy for personality disorders. The authors were interested in identifying the antecedents of rupture events, the therapists’ and clients’ experiences of these ruptures, and the efficacy of the therapists’ interventions to repair the relationship. The findings showed that in instances where confrontational and withdrawing ruptures occurred, the therapists also reported the occurrence of similar episodes prior to the rupture. These were typically events such as the client previously complaining about having to attend therapy, being previously unmotivated, or being upset prior to attending a session. Thus, ruptures may often be preceded by a history of problematic alliance between the therapist and client. Typical immediate contexts for ruptures were the therapist introducing a new intervention, challenging the client in some way, or discussing a topic that was painful for the client. Client specific factors found to be relevant to ruptures were events such as the client having incidents with significant others, worsening symptoms, dysfunctional interpersonal expectations, and difficulty processing negative emotions. The findings seem to indicate that clients with whom the therapist has not yet established a solid alliance may not be ready for challenging therapeutic work yet, particularly if they are experiencing emotionally distressing life stressors as well.

This chapter presented a discussion of qualitative research into the therapeutic alliance. The following chapter discusses the role of families in the treatment of youth mental health issues. Factors associated with difficulties in treating youth populations are outlined. Following this, parent and family factors associated with increased risks in youth developing mental health issues are reviewed. The chapter then provides a rationale for utilising family and parent-focussed interventions in the treatment of youth mental health issues. The
theoretical underpinnings of family and parent-focussed treatments are then outlined. Finally, the efficacy of family and parent-focussed interventions in the treatment of youth mental health issues is discussed. Specifically, studies examining family psychoeducation interventions, followed by studies examining family therapy and parent-focussed interventions are reviewed and critiqued.
CHAPTER EIGHT
The Role of Families in Youth Mental Health and Treatment

A significant proportion of youths experience depression and emotional distress with research indicating that nearly one in five adolescents will have experienced a major depressive episode by the age of 18 (Kessler, Avenenoli, & Merikangas, 2001). Adolescence has been shown to be a developmental stage with an increased risk of depression and mental health problems (Australian Bureau of Statistics, 2007). In addition, adolescents who experience major depressive episodes are likely to have enduring serious issues in a number of adult domains of functioning (Lewinsohn, Rohde, Seeley, Klein, & Gotlib, 2003).

The increased risk of mental health issues common to youth populations is further compounded by the alarming rate of treatment dropout and lack of engagement with mental health services for this group. A staggering 75% of children and adolescents are estimated to not follow through on referrals or complete therapeutic treatment (Robbins et al., 2006). In addition, within Australia less than 20% of youths with diagnosable mental health problems receive treatment from mental health services (Mental health: 21st century challenges for Australian families, 2011). These issues represent major challenges for youth mental health services, not only in addressing the high youth dropout rate when engaged in treatment, but also in developing strategies that can increase youth engagement with mental health services or provide options for youths and families when the youth refuses to engage.

Another important factor in assessing and treating youth mental health is the established empirical evidence linking a variety of aspects of family functioning to youth depression and mental health problems (Feeny et al., 2009; Guberman & Manassis, 2011; Tamplin & Goodyer, 2001). Research has shown depressed, anxious, and depressed-anxious youths to report their families as significantly more conflictual and enmeshed than normal controls (Stark, Humphrey, Crook, & Lewis, 1990). In addition, a number of studies have
shown that family functioning significantly influences the severity, length and recurrence of youth depressive episodes (Goodyer, Herbert, Tamplin, Secher, & Pearson, 1997; Keitner et al., 1995; Tamplin & Goodyer, 2001). One study showed that depressed adolescents who had not recovered from a depressive episode were significantly more likely to come from a family classified as dysfunctional on the Family Assessment Device (FAD) than those who had recovered (Goodyer, Herbert, Tamplin, & Altham, 2000). It is not clearly established whether family dysfunction is a causative factor for youth depression or a potential mediator when depression arises. A study by Tamplin and Goodyer (2001) assessed children and adolescents who were either at high or low risk of developing major depressive disorder. Each family member, including the child or adolescent, rated family functioning by completing the Family Assessment Device. There was no significant relationship found between high-risk youths and family dysfunction, even in cases where the youth went on to develop depression. As such, it may be that family dysfunction plays a maintaining or antagonistic role in youth depression rather than a causative one.

Parent mental health has also been shown to have an important relationship with youth mental health. Parents of mentally ill children are more likely to suffer from mental health issues themselves, which can compound the added challenges associated with parenting a young person with mental health issues (Gopalan, Dean-Assael, Klingenstein, Chacko, & McKay, 2011). The occurrence of parent depression, anxiety, bipolar disorder, schizophrenia, and attention-deficit hyperactivity disorder have been shown to increase the risk of the same disorder developing in their children when compared to children whose parents do not have these illnesses (Asarnow et al., 2001; Biederman et al., 1995; Birmaher et al., 2009; Weissman et al., 1996). Research also indicates that parental mental health issues are associated with problematic parenting. Parental distress, depression, and anxiety have been shown to be associated with low parental involvement, harsh parenting styles, and
internalising and externalising behavioural issues in children (Petit, Bates, & Dodge, 1993; Schor, 2003; Stormshak, Bierman, McMahon, & Lengua, 2000). Taken together, these findings highlight the important role families and parents play in the development and maintaining of youth mental health issues.

*Youth Mental Health Treatment: Family and Parent-Focussed Interventions*

Given the empirical findings suggesting that families and parents may have etiological and maintaining roles within youth mental health issues, in addition to the significant issues associated with high youth treatment dropout rates and low youth engagement rates in mental health treatment, alternative treatments utilising family- and parent-based interventions are being developed. Parent-focused therapeutic interventions in particular are a very new approach for youths that offer a potentially important treatment option, particularly in cases where the youth has had prior issues with treatment dropout, or is refusing to engage with mental health services completely. Currently, traditional youth mental health services typically do not have any modes of treatment for those families with a youth who refuses to engage in or seek mental health treatment. Therefore, if parent-focused treatments can prove to be efficacious in improving youth mental health and subsequent engagement with mental health services, this approach may provide a viable treatment option for families and help address some of the major issues associated with treating youth populations.

Furthermore, the evidence supporting the relationship between poor parental mental health, problematic parenting styles, and youth mental health issues also provides a rationale for including parents in youth mental health treatment, particularly if treatments include a supportive component for the parents themselves. Studies have shown that parent stress and poor mental health can negatively impact upon child outcomes in youth mental health treatment, and that a resolution of parent issues is associated with a reduction in child symptoms and impairment (Chronis, Chacko, Fabiano, Wymbs, & Pelham, 2004; Weissman
et al., 2006). As such, family- and parent-focussed interventions potentially offer a viable alternative to the current treatment models commonly used in youth mental health services.  

**The Theoretical Basis of Family- and Parent-based Treatments of Youth Mental Health Problems**

A number of approaches have been developed that utilise families and parents in the treatment of youth mental health issues such as behavioural parent training, family skills training, family therapy, and in-home family support. These approaches generally draw upon the psychological theories of cognitive behavioural psychology, social learning theory and family systems theory (Kumpfer, Whiteside, Greene, & Allen, 2010). Family systems theory adapted concepts from general systems theory, which is a theory that gained ascendency in the 1920’s and described biological, physical and then social systems (Bertalanffy, 1950; Bowen, 1966; T. Patterson, 2014). Family systems theory posits that human behaviour is determined primarily by the individual’s relationship contexts rather than unilateral or individual choice. As such, the shifting dynamics of various anxieties and emotions within a family unit fundamentally contribute to the development of the individual’s identity, as development occurs in response to the family’s relationship system (Goldenberg & Goldenberg, 2008). Each family member represents a part of the family system that come together to produce a single ‘unit’, however the system cannot be adequately explained by simply examining one of its component parts as a change in each family member depends on all other members. Subsystems also exist within the overall family system, such as the dyad subsystem between the husband and wife or two siblings. Relationships within the family system are complex and consist of alliances, factions and various tensions or conflicts, and causality within the system is multidirectional (Goldenberg & Goldenberg, 2008). Family members generally follow established patterns of behaviour governed by rules embedded in the family system, that are often covert but demarcate the parameters of each family
member’s acceptable and non-acceptable behaviours. Boundaries govern how and what information travels in and out of the system, and helps differentiate individuals and subsystems within the family system. As such, family systems theory, in the context of youth mental health interventions, suggests that successfully understanding and treating a young person’s mental health issue requires working with the family system rather than just the individual (Feinberg, Solmeyer, & McHale, 2012). This necessarily involves working with the family as a whole, or working with parents as well as the youth.

Social learning theory also provides a theoretical basis and rationale for working beyond individual therapy. Social learning theory posits that child development is fundamentally associated with social observation and imitation, which involves social opportunities for learning, reinforcement systems and the individual’s thoughts and beliefs that influence the learnt behaviour (Bandura & Walters, 1963; Siegler, Deloache, & Eisenberg, 2006). The theory provided additional learning mechanisms associated with child development that accounted for learning that was not purely based upon the well-established theory of behavioural reinforcement through operant conditioning. Social learning theory, which was later renamed to social cognitive theory, accounted for learning such as when children and adolescents learn from books or television, or gained knowledge of how to do things purely by observing others performing the task. Cognitive processes such as attention, and the encoding, storing and retrieving of information to be later acted upon in imitation processes highlighted the active role that children play in their own development. The theory also emphasises perceived self-efficacy, which involves the degree to which an individual believes they can successfully manage their behaviours, emotions and thoughts. For example, perceived self-efficacy for affect regulation involves the individuals sense of how successful they are in expressing and feeling positive emotions, in addition to the perceived ability to
cope with negative emotions in response to challenging or difficult situations (Siegler et al., 2006).

As the family provides a critical learning environment for child development, within family therapy social cognitive theory provides a framework through which to understand how each family member’s behaviours, beliefs and interpretations of familial relational transactions can lead to dysfunction within individual family members and the family as a whole (Hook, 2008). From a social cognitive perspective, the patterns within a family are a product of the member’s past and present learning opportunities how their self-efficacy interacts with those experiences. For example, a father who grew up with a domineering and masculine father might disapprove of his own son’s choice to study music as he feels it is an unreliable career. The father discourages his son’s direction in an abrasive and direct way, however he does so out of love and concern for his son’s future. The son, who is sensitive and softer than his father, interprets this to mean that his father disapproves of him and withdraws from his father, who in turn becomes angry with his son as he feels he is being ignored and rejected, and conflict between them escalates. Eventually the son isolates himself within his room and becomes depressed, while tensions arise between the mother and father after she criticises the father for yelling at their son. Here, the interaction of learnt behaviours, beliefs about the self and others, and interactional interpretations perpetuate patterns of behaviour within the family that led to significant family dysfunction and depression within the young person. The pattern becomes worse over time through a lack of coping skills and as individuals become further discouraged by their ability to positively change things even though they are motivated to improve their situations. Social learning/cognitive approaches work towards gaining new skills and addressing problematic and dysfunctional belief systems (Hook, 2008). In a scenario such as this, effective learning opportunities are provided within therapy that enable family members to learn and implement
new coping skills, develop a positive sense of self-efficacy and become more productive within the family.

Cognitive behavioural approaches have been integrated into family systems and social/cognitive learning frameworks within family therapy, which includes various aspects of behaviour therapy (emphasising and modifying observable behaviours) and cognitive therapy (working on schemas and cognitive distortions via cognitive restructuring). Cognitive behavioural approaches view family interactions as being maintained by environmental events preceding and following each family member’s behaviours and actions (Carr, 2006). Behaviour analysis conducted by the therapist seeks to identify the antecedents and consequences of problematic behaviours within the family, in addition to identifying and working with dysfunctional thinking related to these environmental influences. Behavioural modification strategies are employed to encourage adoption of the desired behaviour, in addition to modifying cognitions so that they are more congruent with and supportive of the desired behaviours (T. Patterson, 2014). This approach can be effectively implemented within a family systems approach, where family structures, subsystems, rules and boundaries inform the behavioural and cognitive analyses and modifications. For example, a therapist might identify overly rigid boundaries within a family in relation to the eldest daughter socialising on weekends, which has been causing a lot of conflict. The therapist can then elicit the entire family’s thoughts and beliefs around the identified issue, and the patterns of behaviour associated with it, and then work towards developing more functional cognitions and behaviours. Cognitive behavioural approaches also compliment social/cognitive frameworks, where cognitive restructuring techniques and behavioural analyses can help identify and modify dysfunctional learnt patterns and beliefs.

These theoretical frameworks provide a rationale for treating youth mental health issues within the context of the family system. Both family systems theory and social learning
theory posit that maladaptive behaviours arise as products inherent to familial social relations and structures, and cognitive behavioural approaches provide a useful way to work with the cognitive and situational factors within the family system that may be engendering and maintaining these issues. If parents and families contribute significantly to the young person’s development across a range of factors such as interpretive skills and coping styles, and the family’s structure itself can be a significant source of stress and conflict, then working with the family system as a whole provides an opportunity to more directly and efficiently address these issues. Furthermore, working with parents and families may have beneficial outcomes in areas such as parental stress and parental depression, which are strong risk factors for youth depression and anxiety (Beardslee, Versage, & Gladstone, 1998).

The Efficacy of Family and Parent-focussed Interventions in the Treatment of Youth Mental Health Issues

Family Psychoeducation Interventions. Evidence supporting the use of family- and parent-based interventions to treat youth mental health issues is beginning to emerge from research within the field of family psychoeducation interventions (FPEI). FPEIs were originally developed for families caring for a schizophrenic family member (McFarlane, Dixon, Lukens, & Lucksted, 2003). The initial goal for FPEI was to improve family functioning and to alleviate the considerable family burden often experienced by families caring for members with a serious mental illness (Amerson & Liberman, 2001). FPEI is based on the premise that most involved family members of individuals with mental illness require information and assistance to effectively support their ill family member and to cope with the added challenges this places on the family system (Lucksted, McFarlane, Downing, Dixon, & Adams, 2012). The approach also assumes that the ways in which family members interact with the individual with a mental illness can have significant impact upon the ill person’s well-being and clinical outcomes; that families need access to each other to learn
from each their failures and successes; that families need to engage in collaborative problem solving; and that families need to develop coping strategies specific to the mental illness.

Several research reviews and meta analyses have been conducted addressing the outcomes general FPEI research, RCTs of FPEIs, and community-based FPEI services. McFarlane et al. (2003) reviewed 11 clinical trials assessing either single- or multi-family FPEIs and found that the relapse rate associated with FPEI treatment was 27.5% compared to a relapse rate of 63% with standard treatments. A meta-analysis by Pfammatter, Junghan and Brenner (2006) included RCTs that included psychoeducation and either problem solving or crisis management for families of a person with schizophrenia. The analysis included 31 RCTs and results indicated that the FPEIs resulted in improvements in the family members’ understanding of schizophrenia (ES = 0.39), improvements in patient’s expressed emotion (ES = 0.59), improvements in patient’s social functioning (ES = 0.38), and improvements in patients’ general psychopathology (ES = 0.40). More recently, a comprehensive systematic review assessed the international published literature for people with longer term mental health problems (Taylor et al., 2009). The analysis included meta analyses, RCTs, and qualitative studies and a strict inclusion criteria was employed based upon the studies’ sample sizes, quality of study design, quality of data analysis, and the relevance of the included studies in reviews. Qualitative studies were assessed based upon the quality of data collection, data inspection, data analysis, and the use of corroborating quantitative methods. The included studies for the treatment of schizophrenia were separated into 13 intervention types such as cognitive behavioural therapy, FPEIs and family therapies, vocational therapies, and social skills training. The category for FPEIs and family therapies consisted of 117 studies and results indicated that, compared to usual care, FPEIs and family-based interventions resulted in a reduced risk of relapse (ES = 0.42) and readmission (ES = 0.22), and improved medication adherence (ES = 0.63). Comparatively, CBT resulted in a small
effect with regard to improving positive symptoms during treatment (ES = 0.27) and 9 to 18 months post-treatment (ES = 0.25) however, CBT was not associated with decreased relapse rates. Of the 13 intervention types included in the study, CBT and FPEIs were the approaches most associated with positive outcomes. Many of the other intervention types included in the comparisons, such as cognitive remediation, arts therapies, compliance therapy, relapse prevention and coping skills training were of a comparatively lower research quality and were generally fewer in number, which may have impacted upon these comparisons.

Due to the relatively robust data supporting the efficacy of FPEIs in significantly reducing patient relapse and rehospitalisation of schizophrenic patients, FPEIs are now increasingly a treatment recommendation for appropriate schizophrenic patients in many mental health services (Amerson & Liberman, 2001; Dixon, Adams, & Lucksted, 2000; McFarlane et al., 2003). FPEIs have subsequently been developed for families and sufferers of bipolar disorder and more recently research has begun to investigate its efficacy in populations with clinical depression (Fristad, Gavazzi, & Mackinaw-Koons, 2003). A recent study investigated the efficacy of FPEI in helping prevent relapse in adult patients with a clinical diagnosis of major depressive disorder. The family psychoeducation consisted of just 4 sessions, but was found to significantly reduce relapse of major depression for up to 9 months when compared to supportive psychotherapy (treatment as usual) (Shimazu et al., 2011).

While research into FPEI has generally focussed upon adult populations, evidence is starting to emerge supporting its efficacy in child and adolescent populations. In the last few years, researchers have begun to adapt traditional FPEI approaches to be used in youth populations and conduct efficacy studies. Three series of RCTs have been conducted assessing the efficacy of an FPEI in the treatment of a similar cohort of children and adolescents (aged 8–12 years) with a diagnosis of bipolar disorder (BD) or major-depressive-
disorder (MDD) (Fristad, Goldberg-Arnold, & Gavazzi, 2002, 2003; Goldberg-Arnold, Fristad, & Gavazzi, 1999). The treatment involved separate sessions for parents, who were given information and education on mood symptoms and disorders, treatment, and helpful/unhelpful family responses to the disorders. Results from all three studies showed significant improvements in parental knowledge of illness symptoms, positive family interactions, child-perceived parental support, and utilisation of support services. One study also resulted in positive clinical outcomes for child depressive symptoms, mania symptoms, mood severity, and global functioning (Fristad et al., 2002).

Another FPEI treatment for adolescents with BD has been adapted from the adult version of the FPEI treatment for BD (Miklowitz et al., 2004). The intervention consists of 21 sessions over a nine-month period focussing upon psychoeducation for the family, communication enhancement training and problem-solving skills training. A pilot study was conducted in 2004 using the intervention with 20 families. Adolescent diagnosis and symptom changes throughout the treatment were assessed by trained clinicians using the Schedule for Affective Disorders and Schizophrenia for School Age Children – Present and Lifetime Version (K-SADS-PL) at three-month intervals. Results indicated that the bipolar adolescents from the families (aged 13 to 17 years) were found to undergo a 38 % drop in depression and a 46 % drop in mania post treatment, in addition to a general reduction in problem behaviours (Miklowitz et al., 2004). Limitations of the study were the small sample size used, and the adolescents were also receiving pharmacotherapy during the FPEI treatment, so it is unclear to what degree symptom reduction was a result of medication. A larger randomised controlled trial investigated the efficacy of a FPEI on 165 children (aged 8 to 12 years) with mood disorders such as major depressive disorder, dysthymia and bipolar disorders, which involved both child and parent participation in separate groups (Fristad, Verducci, Walters, & Young, 2009). Seventy-eight families received FPEI plus treatment as
usual (TAU) and were compared to 87 families on a wait-list condition plus TAU. Parents and young people attended nine sessions separately, with each group receiving a combination of psychoeducation, coping and problem solving skills, and communication skills. Results showed that mood symptom severity, as measured by the Mood Severity Index (MSI), improved in the intervention group by 6.48 points more than the wait-list control group, which was equivalent to a moderate reduction in mood symptoms. The effect size was 0.53 and these improvements were still found to be significant at an 18-month follow up assessment. As a wait list control group was used for the comparison rather than an active control group, non-treatment specific effects such as parents attending the same group together may have confounded the results to a degree. Finally, a study was conducted in 2006, which investigated the use of FPEI in treating adolescent major depressive disorder (Sanford et al., 2006). Forty-one adolescents ranging from 13 to 18 years of age were randomised to a TAU group, or a TAU plus FPEI group. Those youths within the FPEI group showed significant improvement in the primary outcome of social functioning (ES = 0.96), whereas those in just TAU did not. Growth curve modelling also revealed the treatment group to have significantly more positive trajectories than the TAU group in the secondary outcomes of youth-parent relationships and parent reported treatment satisfaction. The results suggest that FPEI approaches may be useful in treating youth depression, however the small sample size used in the study limits the accuracy of treatment effects estimates.

The limited studies to date investigating the efficacy of FPEIs in treating child and adolescent mental health issues are promising, and suggest that FPEIs may be effective in improving family knowledge and support for young peoples’ mental health problems. However, most of the studies suffer from limited sample sizes, and the effect on clinical outcomes for young people across the studies is mixed. In addition, many of the studies lack adequate control groups, and as such the generalisability of the findings to date are limited.
Family and parent-focussed interventions. Perhaps the most significant support for family- and parent-based interventions for youth mental health is the research conducted on family-therapy-based interventions. While these interventions often involve elements of psychoeducation, they primarily draw upon family systems theory, social learning theory, cognitive behavioural theory, and attachment theory to explain and facilitate therapeutic change within the family. Research indicates that these interventions can improve youth and parent mental health symptoms, and improve family functioning.

Research has shown that parent-focussed interventions are the most effective treatment for young people with externalising problems (Stoltz, Van Londen, & Dekovic, 2015). Group-based parent training interventions drawing upon cognitive-behavioural and social learning frameworks have been developed for children with externalising behaviours, such as conduct disorder (Gross & Grady, 2002). Two of the most well established programs within this area are the Triple P (TP) parenting program and the Incredible Years (IY) program. A recent systematic review of these approaches analysing 49 studies found that both the TP and IY programs resulted in post-treatment decreases in problematic child behaviours and negative parenting practices, and an increase in positive parenting skills (Arkan, Ustun, & Guvenir, 2013). The IY program also includes versions with teacher and child education components however; findings indicated that there was no difference in the reduction of child behavioural problems when these groups were compared to parent only versions of the program. This finding is of potential interest as it provides support for the notion that parent-based interventions may be helpful in providing support and treatment for youth mental health issues in families where the young person is not engaging with mental health services.

Research is also emerging within the area of parent-based treatments for autism spectrum disorders (ASDs). In general, parents are trained to be more responsive and observant of their child in order to capitalise on ‘in the moment learning opportunities’ and
develop communication skills (Pickles et al., 2015). Research into group-based parent interventions for ASDs has shown significant post-treatment improvements across a variety of outcomes such as improvements in restricted and repetitive behaviours, reducing aggressive behaviours, improving noncompliance, increasing socialising, and improving daily living skills (Grahame et al., 2015). A recent meta-analysis including 17 studies comprising of group- and non-group parent interventions for ASDs found that while there is a lack of consistency between studies making direct comparisons difficult, there was a statistically significant change in positive parent-child interactions, and evidence suggestive of improvements in child language comprehension and a reduction in the severity of autism characteristics (Oono, Honey, & McConachie, 2013). While the current literature suffers from a lack of consistency between studies in the ways in which outcomes are measured, the limited research to date suggests that parent-focussed interventions likely offer beneficial outcomes for this population.

There is also evidence that parent- and family-based interventions are effective in youth substance abuse. A group-based family treatment called the Strengthening Families Program (SFP) has been designed as a preventative treatment for young people with a substance-abusing parent. The program incorporates parent-, youth-, and family-skills training and draws upon family-systems- and cognitive-behavioural-based therapies. SFP has a well-established research history and has been shown to have a significantly positive influence on a range of causal factors for youth drug taking such as improved parenting skills, and youth factors such as reduced depression and aggression, and increased youth resilience and social skills (DeMarsh & Kumpfer, 1985; Kumpfer, Alvarado, & Whiteside, 2003). The program has also been shown to be effective across a range of child and adolescent age groups, and to significantly reduce the long-term occurrence of amphetamine use and mental health issues in youth participants (Kumpfer et al., 2010; Spoth, Clair, Shin, & Redmond, 2006).
Also within the area of youth substance abuse, a parent-focussed group intervention called the Behaviour Exchange Systems Training (BEST) program has been developed for families with a substance abusing young person, and the program has now also been adapted for young people with general mental health issues such as anxiety and depression (Bamberg, Toumbourou, Blyth, & Forer, 2001; Bertino et al., 2013). Descriptive evaluations of the pilot BEST program suggested that up to one-third of adolescents from families who completed the program ceased substance use, with a further third of families motivated to engage in further change strategies (Bamberg et al., 2001). The program also suggests benefits in reduced parental and sibling stress, in addition to improvements in family functioning (Bamberg, Toumbourou, & Marks, 2008). While data collected for the program are still limited, results are encouraging and provide support for the notion that family- and parent-based interventions can improve youth substance abuse, in addition to having several benefits for the family as a whole.

School programs designed to improve or prevent youth mental health issues have also incorporated parents. Toumbourou and Gregg (2002) ran a parent-focused intervention involving 28 schools based on research associating youth suicidal behaviour with family and individual risk factors. Parent groups were run delivering an Australian parent education program focussing on adolescent development, listening, assertiveness, conflict resolution, authoritative parenting, substance use, and adoption of attitudes of optimism and hope. The program was delivered to approximately 3000 parents across 28 school campuses and parents and adolescents completed surveys measuring family functioning, and adolescent delinquent behaviour, depression, substance use, and suicidal behaviours. Outcomes indicated that the parent-focused intervention had benefits in relation to a number of youth suicide risk factors, such as decreases in adolescent substance (adjusted odds ratio [AOR] of .5 to .6), delinquency (AOR of .2), and familial conflict (AOR .5), in addition to improvements in
maternal care (AOR 1.9). Interestingly, these effects were found to also extend to families who were not directly involved in the program, as similar benefits were observed in youths who were either best friends of a youth whose parents participated in the program, or had parents who were friends with parents participating in the program (Toumbourou & Gregg, 2002).

Another study trialled a school-based preventative program for adolescent depression and anxiety including a parent intervention component in a sample of 44 families, with half the families allocated to a comparison control group not receiving the treatment (Gillham et al., 2006). Using a CBT approach, parents were taught the same skills as their children in order to better cope with adversity in their lives. The goals of the parent component were to help parents challenge their pessimistic cognitions and improve parental anxiety and depression, which may then result in those parents modelling more adaptive interpretations and coping styles for their children. Adolescent depressive symptoms were shown to reduce more than controls at post-treatment, however the difference was non-significant. The difference was found to be significant at 6- (ES = -.38) and 12-month (ES = -.32) follow-up time points. The same pattern was observed in anxiety symptom changes, with post-treatment differences non-significant, while 6- (ES = -.42) and 12-month (ES = -.52) follow-up levels were significantly lower in the treatment group. No control condition was included removing the parent component so it was not possible to assess the relative contribution the parent intervention made to these outcomes.

Research into the efficacy of family- and parent-based interventions for youth mental health issues is very limited; however the studies completed to date provide evidence that these approaches can have significant benefits for youth mental health issues, in addition to providing a range of benefits to parents and families. Specifically, preliminary data suggests that FPEIs can have positive benefits in young people diagnosed with bi-polar disorder and
depression. In addition, family therapy based family- and parent-interventions have been shown to be effective in reducing child externalising behaviours, youth substance abuse, autistic symptoms, and help prevent youth anxiety and depression. Further research is needed to address weaknesses in the current literature such as limited sample sizes and a lack of appropriate controls, and to assess the efficacy of these approaches in treating other conditions such as depression and anxiety. While more research will help better understand the benefits and potential limitations of these approaches, the promising results to date in addition to the clear need for alternatives in addressing the current gaps in treating youth mental health provide compelling support for family-based approaches.

This chapter provided a discussion in relation to the association between certain family factors and youth mental health issues, in addition to the role of families in the treatment of youth mental health issues. In addition, the potential benefits of family and parent-focussed interventions in treating youth mental health issues were explored. The theoretical basis of family and parent-focussed interventions was then outlined and discussed, before the literature examining the efficacy of these interventions in treating youth mental health issues was reviewed and critiqued. The following chapter focuses upon research examining the role of alliance within parent-focussed interventions. Initially, the relationship between parent alliance and youth alliance is discussed, in addition to the relationship between parent alliance and youth retention in therapy. Following this, the research investigating parent alliance and its association with primary youth treatment outcomes is reviewed and critiqued. Specifically, parent alliance is examined within the context of parent-focussed interventions working with families individually, and then parent alliance is examined within the context of parent-focussed interventions working with parents in a group therapy context.
CHAPTER NINE

Parent Therapeutic Alliance in Youth Mental Health Treatment and Parent-Focussed Interventions

While research into the efficacy of family- and parent-based treatments for youth mental health issues is very limited, even less research has been conducted investigating the role parent alliance may play in these approaches. Research suggests that the therapist-youth relationship is important in mental health outcomes; however, support for the predictive relationship between the therapist-parent alliance and youth outcomes is mixed and inconclusive. As evidenced by Karver et al.’s (2006) analysis, there are few studies examining this relationship and those completed to date vary widely, with some studies showing a moderate to high effect size and others showing little relationship. However, the rationale for further investigations into this relationship, in addition to other possible parent-dependent mediating effects on various aspects of youth treatment and engagement is compelling. For example, the vast majority of therapists see parents when treating youths, and within this family context of engagement parents may have an impact upon youth compliance, support and engagement with treatment (Kazdin, Whitley, & Marciano, 2006). Furthermore, as parents play a significant role in their child’s life, parent engagement in the therapeutic process may play an important role in implementing and supporting changes not only at an individual youth-focused level, but also within overall family structures and behaviours that may be dysfunctional.

The little research conducted to date into the role of parents in youth mental health has indicated that parents involved in youth therapy can have a beneficial impact upon a number of important youth therapeutic processes. Studies have shown that the quality of the therapist-parent alliance is associated with the development of the alliance between therapist and youth (Alexander & Dore, 1999; Henry & Strupp, 1994). One study found that while
therapist-parent relations did not predict youth treatment outcomes, they did predict therapist-
youth alliance ratings at early, mid, and late phases of therapy, and these youth alliance
ratings were predictive of youth treatment outcome (Lawson & Brossart, 2003).

Some studies indicate that youth and parent alliance may be related to youth retention
in treatment programs, however results and the specific effects are inconsistent between
studies (Hawke, Hennen, & Gallione, 2005; Robbins, Turner, Alexander, & Perez, 2003;
Shelef, Diamond, Diamond, & Liddle, 2005). One study examined parent and adolescent
alliance ratings in a sample of 65 substance-abusing adolescents receiving multidimensional
family therapy. Observer ratings of the parent alliance were found to predict adolescent
premature termination ($r = .30$) from the program. In addition, observer ratings but not
adolescent ratings of the adolescent alliance were found to predict days of cannabis use ($r = -.26$) and dependency symptoms ($r = -.31$) at post-treatment. Observer rated parent alliance
was also found to moderate the relationship between observer rated adolescent alliance and
post-treatment cannabis use. The sample size for these comparisons was limited to only 55
cases however, due to dropout and incomplete data (Shelef et al., 2005). In another study
examining the relationship between youth- and parent-therapist alliance and youth retention
in a sample of 34 adolescents with behaviour problems receiving functional family therapy
(Robbins et al., 2003), observer rated parent or adolescent alliances were not predictive of
youth retention in therapy, but discrepancies between the strength of the parent and youth
alliances were predictive of adolescent dropout. One point of difference between the studies
by Shelef et al. (2005) and Robbins et al. (2003) that may have contributed to these
inconsistent findings relates to the therapists used in each study. The study by Shelef et al.
used only three experienced clinicians with masters or doctoral level qualifications, and each
clinician had a minimum of five years post-graduation clinical experience. Comparatively,
the Robbins et al. study used 34 graduate student trainees. As such, alliance development
may have been significantly impacted by factors such as therapist experience, training, and individual differences between therapists. Robbins et al. (2006) conducted a subsequent study in a sample of 30 adolescent drug-abusers being treated using multidimensional family therapy. Mother and adolescent alliance was rated in sessions one and two by observers, and results indicated that a significant reduction in alliance from session one to two for both mothers and adolescents was associated with early treatment termination (Mothers’ ES = 2.19, adolescents’ ES = 1.55) found that both mother- and adolescent-therapist alliances predicted youth dropout in the study (Robbins et al., 2006). While the sample size for this study was quite small, the large effect sizes obtained suggest a real effect was detected. Further research is needed to more clearly establish the relationship between parent alliance and youth treatment termination, but the limited studies to date suggest parent participation likely plays an important role in keeping youths engaged in treatment.

Research into the relationship between the therapist-parent alliance and the therapist-youth alliance and mental health outcomes suggests that therapist, parent and youth ratings of these relationships are associated with treatment outcomes (Alexander & Dore, 1999; Hawley & Garland, 2008; Kazdin, Marciano, & Whitley, 2005; Kazdin & Whitley, 2006; Kazdin et al., 2006; Lerner, Mikami, & McLeod, 2011; Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014). One group of researchers has conducted several studies investigating the role of parent alliance in individual parent management training (PMT) for children with externalising behaviours. The first study was conducted with 185 children presenting with oppositional, aggressive, and antisocial behaviours receiving PMT. Therapist-, parent-, and child-ratings of alliance were taken at sessions four and eight (12 sessions in total) and assessed in relation to several outcomes (Kazdin et al., 2005). The alliance scores were summed for each rater as there were no significant differences between the alliance session scores or their effects. Hierarchical linear regressions showed that child and parent ratings of
alliance were the best predictors of child behavioural improvements, with both raters alliance scores significantly predicting child- (child $r = .41$, parent $r = .09$), parent- (child $r = .09$, parent $r = .07$), and therapist-ratings (child $r = .07$, parent $r = .07$) of child behaviour improvements. Overall, the therapist ratings of the parent and child alliance were less predictive. Therapist ratings of the therapist-child alliance predicted child- ($r = .08$) and therapist-ratings ($r = .34$) of child behaviour changes, but not parent ratings. In addition, therapist ratings of the therapist-parent alliance were only predictive of therapist ratings ($r = .09$) of child behaviour changes (Kazdin et al., 2005). The second study by the same group also assessed PMT for child behavioural problems, but the main outcome assessed was changes in parenting practices. Using a sample of 218 children, parents and therapists rated alliance in sessions four and eight, and alliance scores were summed across the sessions. Multiple regressions showed that parent rated alliance predicted both parent- ($r = .10$) and therapist-ratings ($r = .03$) of positive changes in parenting practices, and therapist ratings of alliance also predicted parent- ($r = .03$) and therapist-ratings ($r = .16$) in these outcomes. The third study combined the designs of the previous two studies in a sample of 77 children, in which child, parent and therapist ratings of alliance in sessions four and eight were summed and both child outcomes and changes in parenting practices were assessed (Kazdin et al., 2006). The study replicated the findings of the first study, showing that facilitator ratings of the therapist-parent alliance only predicted therapist ($r = .28$) ratings of child outcomes, but not parent- and child-rated outcomes, while parent ratings of the therapist-parent alliance predicted therapist- ($r = .25$), parent- ($r = .31$), and child-ratings ($r = .26$) of child improvements. Also in agreement with their first study was the finding that therapist-ratings of the therapist-child alliance predicted therapist- ($r = .58$) and child-ratings ($r = .38$) of child improvements, but not parent-ratings. Child-ratings of the therapist-child alliance were once again associated with therapist- ($r = .36$), parent- ($r = .24$) and child-ratings ($r = .65$) of child
improvement. In relation to parent outcomes, therapist ratings of the therapist-parent alliance was only associated with therapists’ \( r = .37 \) evaluations of parenting practices, whereas parent-ratings of this relationship was associated with both therapist- \( r = .37 \) and parent-ratings \( r = .41 \) of positive parent changes. The studies by Kazdin et al. were conducted with good sample sizes and the replication of results provides further confidence in the findings of these studies. Overall, the results of these studies indicate that parent and child ratings of alliance are better predictors of child and parent therapeutic outcomes in this clinical population. While therapist ratings of the therapist-child alliance were good predictors of child- and therapist-rated child outcomes, therapist-ratings of the therapist-parent alliance generally only predicted therapist ratings of child and parent outcomes.

Another study assessed youth-, parent- and therapist-rated alliance among 78 cases of community-based treatments for youth mental health issues across two clinics (Hawley & Garland, 2008). The treatments consisted of a mix of individual youth psychotherapy, parent skills training, and family therapy. Hierarchical linear modelling was employed to examine the relationships between youth, parent and therapist ratings of alliance at six-month-follow-up and a number of outcomes. Overall, youth rated alliance was found to be the best predictor of outcomes and was significantly associated with several youth and parent reported outcomes such as decreased externalising and internalising symptoms, youth and parent reported improved family functioning, youth reported increased self-esteem, and youth and parent reported higher levels of perceived social support and satisfaction with therapy. Parent rated alliance was the next best predictor associated with fewer outcomes and generally were within rater outcomes, such that parent alliance predicted parent rated decreases in total child symptoms, and greater perceived social support and parent satisfaction with therapy. Overall, therapist rated alliance was found to be the least predictive and was only significantly associated with the therapist rated outcomes of youth global functioning and youth
satisfaction in therapy, and marginally associated with decreases in youth externalising symptoms for both youth- and parent-reported symptoms. The study was part of a larger practice-based study of usual clinical care treatment outcomes, and the measures were obtained from individual youth psychotherapy, parent skills training and family therapy and no comparisons were made between these approaches. As such, the results reported may not represent relationships specific to parent-focussed interventions.

The only study identified assessing parent alliance in a youth sample with an internalising disorder involved a manual-based family treatment for child anxiety disorders (Marker, Comer, Abramova, & Kendall, 2013). The study investigated the efficacy of this 16-week treatment on a sample of 86 children who had a diagnosis of either separation anxiety disorder, generalised anxiety disorder, and/or social phobia. Therapist-, parent-, and child-ratings of the therapist-child alliance were collected in each session, in addition to child-ratings of anxiety symptoms. Bivariate latent difference score (LDS) models were used to assess whether changes in alliance predicted later changes in child anxiety symptoms. Results indicated that greater increases in therapist ratings of alliance were significantly associated with greater reductions in child anxiety symptoms (ES = -.32), while child ratings of alliance were not. In addition, greater increases in maternal ratings of alliance were significantly associated with greater reductions in child symptoms (ES = -.28), while paternal ratings of alliance were found to be not significantly associated.

Overall, the studies discussed examining parent-focussed treatments in non-group-based contexts suggests that youth and parent ratings may be more robust predictors of treatment outcomes than therapist ratings of alliance. The majority of these studies were restricted to samples of children with externalising behaviours, and as such it is unclear whether this pattern extends to other clinical populations, such as depressed youths. In addition, these studies used one or two alliance time points in their comparisons, and overall
patterns of alliance may have different predictive properties in relation to therapist, parent and youth ratings of alliance and outcomes. The one study examining the relationship between alliance and treatment outcomes in a sample of children with an internalising disorder found that therapist-ratings of alliance were a good predictor of child treatment outcomes (Marker et al., 2013). This suggests that the predictive properties of different raters of alliance may change in relation to factors such as the disorder being treated.

Only three studies could be found examining the role of parent alliance within a group therapy context, and the results are mixed. The first study, completed in 2011, assessed therapist-parent alliance in a group-based parent training intervention to improve social competency among a sample of 27 parents with children diagnosed with attention-deficit/hyperactivity disorder (ADHD) (Lerner et al., 2011). The study used observer ratings of the therapist-parent alliance taken across sessions three to eight of treatment, and comparisons were made using an ‘early alliance’ score (session three score) and a coefficient representing change in alliance across time (across the six sessions). Hierarchical linear modelling was used to assess these variables in relation to positive changes in parent practices and positive changes in child clinical outcomes. Early parent alliance was not associated with changes in parent behaviours, but changes in parent alliance across sessions significantly predicted the linear slope of change in parent facilitation (ES = 1.64) and parent onlooking with child observed in playgroups (ES = 1.39). In relation to child outcomes, early parent alliance positively predicted increases in child disobedience (ES = .17), while positive change in parent alliance predicted a reduction in child disobedience in parent-child interactions (ES = -.65). Further analysis suggested that the unexpected result indicating higher early parent alliance predicting increased child disobedience was accounted for by increases in parent criticism. Parent alliance was also not associated with changes in several child outcomes such as social behaviour, quality of play and social acceptance. This was a
preliminary study, and given the small sample size used in addition to the number of comparisons in the study (20), these results should be interpreted with caution due to limitations associated with the accuracy of these predictions.

Another study assessed a group parenting program for parents of children with externalising behaviours, and consisted of 117 families (Schmidt et al., 2014). Therapists and parents rated alliance at session two or three, depending on the group format, and alliance was assessed for its relationship to child and parent outcomes using hierarchical linear regressions. Total alliance was assessed, in addition to the working alliance inventory subscales of task, goal, and bond. PS – Parenting scale, PSOC – Parenting sense of competence, DASS – Depression, anxiety and stress scales, SDQ – strengths and difficulties questionnaire, TEI – treatment evaluation inventories.

Total alliance, as rated by the mothers, was found to be predictive of several parent outcomes accounting for between 3.6 to 9% of variance. This included improvements in parent-rated parent over reactivity, parents’ ratings of their sense of competence in parenting, and all scales on the parent and therapist versions of the Treatment Evaluation Inventories (TEI = therapist rated version, PEI = parent rated version), which measure the degree of parent improvement due to treatment. Therapist ratings of maternal alliance were found to be comparatively more weakly associated with outcomes. In relation to child outcomes, therapist ratings were associated with the conduct scale of the Strengths and Difficulties (SDQ) questionnaire (3% of variance), while in relation to parent outcomes therapist ratings were associated with the TEI improvement (11.8% of variance) and progress (19.8% of variance) scales.

When examining the Working Alliance Inventory (WAI) subscales in relation to the mothers’ ratings of alliance, the task subscale was found to be the most related to outcomes, explaining a range of 6.5 to 26.4% of variance across various measures. Specifically, the
strength of the task subscale was related to positive parenting changes on the TEI, and over-reactivity disciplining style. Maternal ratings of the task subscale were also the only parent alliance component found to be related with child outcomes, with higher maternal task ratings found to be positively associated with reductions in child conduct behaviour problems. This suggests that the task components of alliance may be important for both parent and child outcomes in parent-focussed interventions. In addition, the bond subscale was found to be positively associated with increases in the level of maternal parenting satisfaction. The associations of subscale components for therapist ratings of the maternal alliance with outcomes were found to be not significant.

The small sample size of fathers in the study limited the type of analysis possible using their alliance data, however results indicated that increased father ratings of alliance were positively associated with improvements in parent laxness, the fathers’ sense of competency, all the PEI subscales, and the TEI improvement subscale. The amount of variance explained ranged from 9.4% to 20.5%. Paternal ratings of alliance were found to be not associated with child outcomes. Therapist ratings of the paternal alliance were found to have limited associations with father outcomes and were not related to child outcomes. Specifically, only the fathers’ ratings of increased self-efficacy and the TEI scales were found to be associated with therapist ratings of paternal alliance.

Taken together, the results of the maternal and paternal alliance in this study suggest that parent alliance may be more associated with parent outcomes than child outcomes in parent-focussed group interventions, however the task subscale in particular may be related to child outcomes. In addition, therapist ratings of alliance were found to have limited associations with parent and child outcomes. However, aside from maternal ratings of the task subscale, therapist ratings of total maternal alliance was the only other alliance found to be associated with a child outcome. A large number of comparisons were made in this study
with no control for Type 1 errors, and as such the results obtained should be interpreted with caution.

Finally, another recent study compared an FPEI-based intervention with an alliance-based intervention on parents with a child with a serious mental illness (Levy-Frank, Hasson-Ohayon, Kravetz, & Roe, 2011). One of the primary aims of the study was to examine the degree to which more directive, skills- and knowledge-based interventions may contribute to positive youth outcomes when compared to alliance processes within a parent-focused intervention. Parents participated in either an FPEI-based group, which focused on techniques and information to support the recovery of their child, or an alliance-based group, which focused upon developing strong and healthy alliances within the group in an open and supportive framework. The results showed a statistically significant reduction in family burden in both groups, and both groups reported a significantly greater quality of life (QoL) and less psychiatric symptoms for their daughter and sons (Levy-Frank et al., 2011). No statistically significant differences in treatment outcome were identified between the approaches. While this may suggest that alliance effects are primarily responsible for youth and family outcomes within parent-focused approaches, other considerations must be taken into account. Both child QoL and child psychiatric symptoms were assessed by parents, and as such may not have been adequately accurate. In addition, while both these outcomes were significant they had low effect sizes (−0.05), and may have been influenced by task demand effects.

Taken together, these results suggest that parent ratings of the therapist-parent alliance are predictive of child outcomes. In addition, therapist ratings appear to have comparatively poorer associations with outcomes and are more associated with therapist rated outcomes than parent- or child-rated outcomes. In assessing these results it should be noted that all the studies involving therapist ratings only measured alliance at two time points, being early and
mid-treatment in the case of Kazdin et al., and baseline and 6 month follow-up in the case of Hawley and Garland. It is possible that the relative predictive associations between different raters and child outcomes may vary depending upon at what stage of treatment they are taken. As such, potentially important predictive associations between therapist ratings and outcomes may have been missed in the studies. In addition, many studies assess the overall trajectory of alliance across treatment for its association with outcomes; however, this was also not assessed in these studies. Furthermore, most of the studies completed to date have investigated interventions for children with externalising behaviours, and alliance processes may vary in relation to different disorders. Indeed, Hawley and Garland (2008) noted that parent alliance was particularly associated with child externalising behaviour decreases, and the relationship between different alliance ratings across treatment from different rater perspectives may vary across different clinical populations such as depressed youth. In addition, the one study that did assess therapist ratings of alliance in relation to child internalising disorders found that therapist ratings of alliance were most predictive of outcomes when compared to child and parent ratings (Marker et al., 2013). Finally, only one study assessed the function of therapist-rated therapist-parent alliance within a group therapy context, and as such more research is needed to establish the importance of these ratings in relation to child outcomes, particularly in light of several studies showing an association between therapist alliance ratings and clinical outcomes in general group therapy.

This chapter outlined and discussed the available literature examining the role of alliance within parent-focussed interventions. The following chapter presents Study 1, which was designed to evaluate the pattern of the therapist-parent alliance and its predictive relationship with treatment dependant changes in the young persons’ depression. In addition, early- and mid-treatment alliances for therapists and parents, and mid-treatment alliance for young people, were assessed for their associations with treatment dependant changes in the
young persons’ depression. Initially, the chapter provides a rationale for the study, followed by the aims and hypotheses of the study, the method, procedure, results, and discussion of the findings of the study and their implications for therapeutic alliance research and parent-focused interventions.
CHAPTER TEN

Study 1. Quantitative Analysis of the Relationship Between Ratings of Alliance and Changes In Youth Depression in Parent Focussed Interventions

Study Background and Rationale

The research conducted to date investigating therapeutic processes in youth and family therapy has generally been done in a context where the youth is actively engaged in the therapeutic process. More recently, research is starting to investigate the benefits of specifically targeting parents using the general principles utilised in family psychoeducation interventions (FPEI) and family therapy approaches. It is of particular interest then, to examine whether the findings in youth alliance research can be generalised to a parent-focused intervention. Alternatively, it may be that parent-therapist alliances plays a different role in youth outcomes and engagement when it is the parent and not the youth who is actively engaged in therapy.

Research is mixed regarding the predictive relationship between the therapist-parent alliance and youth treatment outcomes in traditional youth and family therapy, however there is a robust predictive relationship between therapist-adult alliances and adult outcomes, and therapist-youth alliance and youth outcomes. It may be that in parent-focused contexts the therapist-parent relationship is functionally analogous to therapist-adult alliances and adult outcomes, as the parent is the intervention target and therefore the primary agent of change within the family. Therefore, a more robust relationship between the parent-therapist alliance and youth outcomes would be expected than has been previously shown in individual youth research.

There is a paucity of research investigating the role of alliance within group therapy, and to a greater extent parent-focussed group therapy, and its relationship with treatment outcomes. Therefore, elucidating the degree to which alliance and its components (task, goal,
and bond) contributes to outcomes within these therapeutic settings may provide valuable insights with regard to designing more effective interventions. In addition, it may help inform therapists and group facilitators in relation to what aspects of alliance need particular attention to ensure families and young people benefit optimally from these treatments.

Several studies investigating various group-based therapies have shown that a more positive alliance is associated with greater beneficial therapeutic outcomes for a range of issues such as relationship problems, domestic violence, psychosis, anxiety disorders, complicated grief, and drug and alcohol problems (Bentall et al., 2008; Bourgeois et al., 1990; Brown & O’Leary, 2000; Gillaspy et al., 2002; Mortberg, 2014; Owen et al., 2011; Piper et al., 2005; Taft & Murphy, 2003). While most of these studies used only client ratings of alliance, the few studies using both facilitator and client alliance ratings showed mixed results, with half of the studies showing the facilitator rating to be more predictive of outcomes, while half of the studies showed the opposite. Further research is therefore needed to understand the predictive relationship between facilitator ratings of alliance and treatment outcomes in group therapy settings. The few studies investigating alliance in parent-focussed group therapy have generally been for treatments of young people with externalising disorders (Kazdin et al., 2005; Kazdin et al., 2006; Lerner et al., 2011; Schmidt et al., 2014). These studies showed that more positive alliance ratings were predictive of greater therapeutic gains, and that parent ratings of alliance were more strongly associated with these outcomes than facilitator ratings. In contrast, a study examining these relationships in a sample of children with internalising disorders found therapist ratings of alliance to be a good predictor of child outcomes (Marker et al., 2013). The present study sought to extend prior research into parent-focussed group interventions for youth internalising disorders by assessing alliance within a clinical trial comparing the efficacy of two parent-focussed interventions for parents with clinically depressed young people.
**Aims and Hypotheses**

The aim of the present study was to evaluate the relationship between the facilitator/parent alliance and its association with post-treatment changes in the young persons’ depression. This relationship was assessed in several ways. Specifically, the overall pattern of facilitator ratings of the facilitator/parent alliance was assessed for its predictive associations with post-treatment changes in the young person’s depressive symptoms. Previous research into patterns of alliance in a group therapy context have found a linear pattern to be most common (Piper & Ogrodniczuk, 2010). It was therefore predicted that a linear pattern would best describe the pattern of facilitator alliance ratings, and that a greater degree of linear slope would be more predictive of lower post-treatment depression scores in the young people.

In addition, both facilitator- and parent- ratings of early- (week 2) and mid-treatment (week 5) alliance scores were assessed for their associations with young person depression changes. Early alliance ratings have been shown to be more predictive of treatment outcomes in individual adult therapy, and early alliance ratings have been shown to be predictive of outcomes in parent-focussed interventions (Hovarth & Bedi, 2002; Schmidt et al., 2014). It was therefore predicted that early facilitator- and parent-ratings of alliance would be more strongly associated with young person depression changes than mid-treatment alliance ratings.

A secondary aim was to assess the association of the facilitators’ and young persons’ ratings of the facilitator/young person alliance at mid-therapy (week 5) for their associations with young person depression changes. Prior research has shown that the young person ratings of alliance is a better predictor of young person ratings of mental health issues in parent-focussed interventions, so it was therefore predicted that the young persons’ ratings of
alliance would be more strongly associated with post-treatment depression changes than the facilitators’ ratings.

Method

The findings presented in this work were obtained from data collected as part of the Family Options study, which was a multi-centered, double-blinded, randomized controlled trial comparing two group interventions: the BEST MOOD program and a treatment-as-usual supportive parenting program known as Parenting Adolescents Support Training (PAST). Both interventions are for families of youth who present with a unipolar mood disorder, here defined as major or minor adolescent depression or dysthymia. In both treatment conditions, the parent/s of the depressed young persons received eight sessions of treatment delivered over two hours per week. The trial was run across sites in both metropolitan Melbourne and the regional Victorian city of Geelong. At the completion of the interventions, face-to-face interviews were conducted to better understand the level of engagement of participants with the treatment following intake/assessment.

Participants

Participants were defined as parents who have a youth aged between 12 to 18 years of age, with identified clinical or sub-clinical depression symptoms. Youth depression symptoms were assessed using the Structured Clinical Interview for DSM-IV Disorders (SCID-IV) Families were recruited primarily from the intake service of a large government run child and youth mental health service in the eastern region of Melbourne (Eastern Health’s Child and Youth Mental Health Service; CYMHS), in addition to community referrals accepted from schools and community based health and mental health services, and via promotion of the study at community forums. Sixty-four families were randomly allocated to the BEST and PAST treatment conditions, with 31 families allocated to BEST and 33 families allocated to PAST. Due to dropouts, withdrawals prior to groups starting, and
families lost to follow-up, 26 families completed PAST treatment and completed all study measures, and 25 families completed BEST treatment and completed all study measures. Out of the 25 participating families, forty-two youth participants completed pre-, post-, and follow-up measures and were therefore eligible for inclusion in the study. The youth participants ranged in age from 12 to 19 years, \((M = 14.90, SD = 1.41)\) (BEST) and \((M = 15.42, SD = 1.83)\) (PAST), which did not differ statistically significantly between groups. The total number of males was four (19%) and the total number of females was 17 (81%) in the BEST group, and five males (23.8%) and 16 (76.2%) females in the PAST group. Sixty-seven parents participated in the groups, with 35 parents allocated to BEST and 32 parents allocated to PAST. The 67 parents participating in the study ranged in age from 19 to 65 years, \((M = 48.58, SD = 7.87)\) (BEST) and \((M = 47.07, SD = 4.59)\) (PAST), which did not differ statistically significantly between groups. The total number of mothers was 20 (57.1%) and the total number of fathers was 15 (42.9%) in the BEST group, and 22 mothers (68.8%) and 10 fathers (31.2%) in the PAST group. Groups were composed of both mothers and fathers and the specific composition of each group varied as a result of random allocation. Overall, the groups consisted of sixteen parent couples (father and mother), and 51 individual parents.

Twenty facilitators participated in the study ranged in age from 22 to 62 years, \((M = 34.85, SD = 12.00)\). The total number of males was five (25%) and the total number of females was 15 (75%). Lead facilitators in the PAST groups were comprised of either psychology masters or doctoral students, and co-facilitators in PAST groups were comprised of psychology masters, doctoral, or post-graduate students. Lead and co-facilitators in the BEST groups were comprised of either fully qualified psychologists or social workers with several years of clinical experience working in their respective fields.
Measures

The Working Alliance Inventory. Parent, facilitator, and young person alliance was measured using the Working Alliance Inventory Short Form (WAI-S), with facilitators completing the therapist version (WAI-St), and parent’s and young people completing the client version (WAI-Sc). The WAI-S was developed from the Working Alliance Inventory Long Form (WAI-L), which is a self-report measure designed to measure Bordin’s (1979) bond, task and goal dimensions. The WAI-L was created in order to provide a measure to assess the working alliance independent of a therapist’s theoretical orientation, in addition to providing a clearly defined description of the functional components of a working alliance and how the alliance functions to promote therapeutic change (Bordin, 1979). As part of the WAI’s development, items were created representing Bordin’s task, goal, and bond were rated by psychologists from different theoretical backgrounds. In addition, experts on alliance reviewed and rated each item for accuracy and relevance. The top 12 items within each alliance dimension (task, goal, and bond) were selected to form the 36-item WAI-L. The WAI is the most extensively researched alliance measure, with well over 100 published studies and several analytic reviews (Hovarth, 1994; Hovarth & Symonds, 1991; Martin et al., 2000). There has been good empirical support for the validity of the WAI-L measure and its subscales (Stevens, Muran, Safran, Gorman, & Winston, 2007).

Tracy and Kokotovic (1989) used hierarchical modelling to examine the factor structure of the WAI-L, and found that the measure meaningfully assesses both the individual aspects of the alliance represented by the subscales, in addition to the overall alliance dimension (total alliance score). Based upon their findings, they developed the WAI-S by selecting the four items that best defined each of the three alliance dimensions. The 12 items are rated on a 7-point Likert scale ranging from 1 = ‘never’ to 7 = ‘always’. The WAI-S is now the most widely used alliance measure with the largest support base within the literature.
(Busseri & Tyler, 2003; Hovarth & Greenberg, 1989; Samstag et al., 1998). The WAI-S has been shown to have as good a predictive, convergent and discriminant validity as the WAI-L (Busseri & Tyler, 2003). As such, the WAI-S was selected as the shorter completion time compared to the WAI-L provides an excellent alternative in cases where a high number of alliance ratings need to be conducted, such as the present study.

The lead facilitator completed the WAI-St for each parent participant in each of the eight sessions. Parent participants completed the WAI-Sc in relation to their relationship with the lead facilitator, and the young people completed the WAI-Sc for the facilitator who was facilitating the young person groups.

*The Short Moods and Feelings Questionnaire.* Pre-, post-, and follow-up-levels of the young persons’ depressive symptoms were measured by the Short Moods and Feelings questionnaire (SMFQ), which were completed by the depressed young people. The SMFQ is a 13-item scale, which was developed in order to provide brief, easy to administer, self-report measure of childhood and adolescent depression in children between the ages of 8 – 18 years, based upon DSM-III-R criteria (Angold, Costello, & Messer, 1995). (Angold, 1989; Costello & Angold, 1988). The SMFQ has been found to have high predictive and criterion validity, and has been shown to perform favourably compared to other well-established depression inventories such as the Beck’s Depression Inventory, The Child Behaviour Checklist’s Anxious/Depressed Scale and the Children’s Depressive Rating Scale (Daviss et al., 2006). As prior studies associated with the present study have encountered issues in questionnaire completion, the SMFQ was selected due to its established performance and minimal burden upon participants.

**Procedure**

Ethics approval for the study was obtained from the Deakin University Research Ethics Committee (Appendix A). Recruitment of participating families in the study was achieved
primarily by referrals received from the intake service of a large government run mental health service in the eastern region of Melbourne (Eastern Health’s Child and Youth Mental Health Service; CYMHS). In addition, a small number of families were recruited via community referrals received as a result of Family Options promotional and information materials, which were available at select local schools and community based health and mental health services, and also via promotion of the study at community forums.

Families with a young person aged 12 to 18 years who were currently presenting with a depressive order were eligible to participate in the study. The identified young people from all participating families were assessed for the presence of a depressive disorder (major, minor, or dysthymia) according to a structured clinical assessment. The assessment utilized modules from the Structured Clinical Interview for DSM–IV Childhood Diagnoses KID-SCID (Matzner, Silva, Silvan, Chowdhury, & Nastasi, 1997). Exclusion criteria for the study were those youths presenting with either mania, hypomania, a bipolar disorder, psychosis or psychotic disorders, an intellectual disability, a pervasive developmental disorder, drug dependence other than alcohol, nicotine or cannabis use, or any severe mental illness currently requiring inpatient treatment.

Enrolment in the study involved an intake worker conducting an initial telephone assessment with the parent or caregiver of the young person. This assessment included the gathering of family demographic information, a genogram, a screen for inclusion and exclusion criteria, and the KID-SCID Mood Episodes Module B as reported by parents. In addition, details were collected in relation to the young person’s and parent/s current mental health status, engagement with support services, current psychotropic medications, recent alcohol or drug use and violence within the family. Risk assessments were also conducted in relation to suicide and self-harm risk. When the intake worker deemed a family was eligible to participate in the study, the worker then confirmed eligibility by administering selected
modules of the KID-SCID to the identified young person. These modules were those for Major Depressive Disorder, Minor Depressive Disorder, and Dysthymic Disorder (Matzner et al., 1997). If the young person met the inclusion criteria, the family was then allocated to a treatment condition (BEST or PAST) using the randomised allocation sequence. Figure 1 provides a CONSORT (Consolidated Standards of Reporting Trials) flow chart of the enrolment, allocation, post-treatment and follow-up data collection, and analysis phases of the Family Options trial.

All treatment groups consisted of a lead facilitator, a co-facilitator, and an observer. The lead facilitator was responsible for the majority of the facilitation duties, while the co-facilitator functioned in a supportive role in addition to facilitating groups with young people when they attended treatment. The observer was responsible for conducting an audio recording all group discussion, in addition to taking notes pertinent to the therapeutic content of the groups. These recording and notes were obtained for subsequent studies and analyses.

**Behaviour Exchange and Systems Therapy – MOOD**

The Behavior Exchange Systems Therapy – Mood (BEST MOOD) program is a fully manualised, evidence-based program designed to improve parent mental health symptoms, reduce family stresses, and to reduce adolescent depressive symptoms. The original BEST program was developed by Dr John Bamberg, Prof John Toumbourou and Ms Anne Blythe, as a professionally led, multifamily group education program for parents, with content focussed on Alcohol and Drug (AOD) use by adolescents. The BEST program consists of eight weekly group sessions run by two facilitators. The BEST intervention has been shown to reduce parental symptoms, such as stress and depression, and family stresses (Blyth, Bamberg, & Toumbourou, 2000; Toumbourou, Blyth, Bamberg, Bowes, & Douvos, 1997).
The BEST-Plus program was then developed, which included siblings aged 12 years and over in the treatment in order to increase the efficacy of the program. Evaluations of the BEST-Plus program indicated additional positive changes within the family system, specifically associated with stress symptoms, family cohesion, and increases in the young person’s behaviour to address their substance abuse (Bamberg, Toumbourou, & Marks, 2001).

*Figure 1.* Flow chart of enrolment, allocation, post-treatment, follow-up and analysis phase of the Family Options trial.
2007). Based upon the author’s observations that many AOD abusing young people entering the program were also presenting with co-morbid internalising issues such as depression and anxiety, the BEST-MOOD program was developed. While the BEST-MOOD program is somewhat tailored to support young people with AOD issues and/or depression, it also contains content that be applied to behavioural and anxiety issues. The BEST MOOD program differs to the earlier BEST programs in that it includes the whole family in the treatment process, with both siblings and the ‘identified’ young person invited to attend the final four group sessions of the program in parallel with the parent sessions. Another major rationale for the BEST-MOOD program development was based upon data indicating that a very small proportion of youth with diagnosable mental health issues actually seek or receive professional support (Brent et al., 1993; Dudley, Hadzi-Pavlovic, Andrews, & Perich, 2008). As such, programs such as BEST-MOOD and other family- and parent-based interventions may provide an avenue through which youth who are initially reluctant to acknowledge problems or engage with mental health services can be gradually engaged.

The BEST-MOOD program has a facilitator’s manual, which includes all relevant background information into the programs development, implementation notes, learning outcomes, group activities, and resources required to run each session. The program consists of 8 weekly two-hour public casework sessions for parents, with siblings and the identified young person invited to attend the final four sessions. The active components of the BEST MOOD program include mental health literacy; clarification of roles within the family; clarification of family goals to reinforce parental vision and leadership; skills in family communication, positive reinforcement and boundary setting; encouraging parent/guardian self-care; stress reduction techniques; encouragement of family connectedness; and family homework tasks related to these treatment components. The parent/s initially receive four, two-hour sessions of weekly intervention, after which the adolescent (12 to 18) and siblings
(aged 12 years of age and over) are invited to also attend with their parents and complete four additional, two-hour sessions of a multi-family weekly intervention. These last four sessions consist of whole group activities, and also activities in smaller groups of parents and adolescents separately. The groups were led by trained fully qualified psychologists and social workers. Non-participant observers made written records at every session, and an audiotape was made of the sessions, which was later transcribed. Each week of the program there is a set topic, and in the majority of sessions there is a ‘guiding metaphor’ used for that session. The sessions commenced with an introduction to that week’s topic, and a review from the previous week/s (aside from session 1). A description of the eight-sessions in the BEST-MOOD program follows.

**Session 1: Family unity - how to get ‘all aboard’**. Facilitators and observers introduced themselves and gave a description of their respective roles in the group, and briefly indicated their training and previous relevant experience. Group rules including confidentiality were discussed and established, and a review of the location’s amenities, group breaks, and security and parking arrangements were discussed.

A brief description of BEST-MOOD was then provided outlining that the program aims to promote family strengths and increase parental confidence, resolve difficulties families are experiencing, promote enduring and secure connections between family members, and engage the identified young person they are concerned about by inviting them to attend the groups from session five onwards. The group then engaged in an ‘ice breaker’ exercise to help facilitate group members getting to know one another and start bonding.

The remainder of the session was spent engaging in group discussions around the impacts of their child’s issues on the family as a whole the importance of engaging the young person fully in family life. Finally, parents were given an exercise where they were asked to
write a letter of invitation to their young person expressing their commitment to making positive change in the family and inviting them to attend the group later on.

*Session 2: The family life cycle – going back in order to move forward.* The session aimed to build the parents’ empathy for their young person and understand the key factors in the transition from adolescence to adulthood. Parents also explored their own parenting and adolescent histories in order to learn from the past not repeat poor parenting practices.

Psychoeducation was provided in relation to the family life cycle with the aim of establishing parenting as a developmental process. Parents were given the handout ‘Family Life Cycle’ (Appendix B) indicating a ‘typical’ family life cycle. Discussion was then held around the families’ experiences of their life cycle and how they viewed their roles within the family, in addition to discussion on the parents’ own experiences of growing up and the transition to adulthood. The session ended with an exercise based on a metaphor called the ‘river of life’, where parents learn to support their children whilst their children maintain their independence.

*Session 3: Parents taking care – taking stress out of the ball game.* There is substantial evidence indicating that stressful life events and stressful environments are major contributors to depression in young people. This session therefore aimed to help parents reduce common stressors within the family environment by making parents aware of this relationship, in addition to helping parents to develop more effective parenting strategies.

Specifically, the session focused upon parent self-care, encouraging parents to work together, and encouraging the adoption of parenting styles that balance warmth and firmness. Parents were given the handout ‘Parenting Styles’ outlining different parenting styles and their main features (Appendix B). Parents were also given a homework task in which they were asked to reflect on their own parenting style and watch the typical patterns of behaviours and interactions within their household. The session ended with a discussion around a metaphor
Session 4: Families staying on track – asking your adolescent to join the party. The first part of this session involved psychoeducation in relation to internalising disorders and how they affect adolescent behaviours, in addition to information and discussions around bullying. The biological, psychological, and social factors associated with internalising disorders were presented and discussed. In addition, parents were given information on the nature of bullying and some strategies for how parents can manage and respond if their child experiences bullying.

The second part of the session focussed upon enhancing parent-adolescent communication, with an emphasis on the parents listening to and validating their child. The session also discussed common co-morbidities associated with depression, such as anxiety, irritability and moody behaviour, and substance use. Parents were given the handout ‘Communication & Praise – Depressed Youth’ (Appendix B) with information and strategies on how to best support their young person when presenting with these symptoms. Parents were also given some homework to practice their new communication skills and praise with their young person, in addition to setting appropriate limits. The session ended with a discussion around a metaphor called ‘a true story about the power of praise’.

Session 5: Joining together and applying what we have learnt. Session five included all the parents, in addition to those identified young people and their siblings who decided to accept the invitation to attend sessions five to eight. After welcoming all the new group members, the facilitators briefly reviewed confidentiality and group rules. The young people were then asked to reflect on whether they had noticed any changes at home over the last four
weeks whilst their parents had been attending group sessions. The parents and adolescents were then split into separate groups.

The adolescents completed an activity in which they brainstormed some suggestions for improving their family life. The parent group discussed the adolescent group’s activity and what they thought their child may want to change. Topics including how to best support their child, the importance of communication, challenges associated with changes in how the family operates, and negotiating around new family rules were also discussed.

The parents and adolescents were then brought together, with the adolescents presenting the six things they each want to start, stop and keep doing in the family. The group was then broken up into family groups/dyads and the parents responded to their child and negotiated any family changes utilising previously learnt principles. The families then reconvened into one group and discussed any progress, compromises or agreements, in addition to reflecting upon the process. Families were set homework on adhering to any new arrangements within the family and to finish any incomplete negotiations during the week. The session finished with a discussion around the ‘river of life’ metaphor used in a previous session that the adolescents could reflect on as well.

Session 6: A bump in the road and how to get past it. The aim of this session was to elicit difficult past experiences within the families that may be causing enduring problems within the family system. In addition, the session aimed to set the expectation that these issues can be overcome. Importantly, it provided a space where the young people can see that their parents are prepared to work on these issues, even though it is unrealistic to expect that they be resolved in a single session. Parents and adolescents were given support and strategies on how to cope with difficult issues from the past.

Families were asked to construct a family timeline, represented by a road. Parents and adolescents were then split into separate groups. The parent group focussed upon
acknowledging and talking about distressing events in the past with their children. This part
of the session aimed to support parents in identifying helpful and not helpful ways of talking
about potentially challenging family events with their children, in addition to the potential
impact these events can have on adolescents. The adolescent group focussed on eliciting
emotions and developing coping strategies to manage difficult emotions by drawing upon
common CBT and relaxation techniques. This was done with the aim of helping the young
people to not only more openly express emotions, but to build skills around managing
distressing emotions.

The parents and young people then came together in one group and discussed what the
young people had discussed and learnt, and completed the ‘family road map’ started earlier
by adding in the emotions related to difficult events along the road. The aim of this portion of
the session was to encourage parents to support their child to acknowledge and cope with
difficult emotions. Homework was given to both the young people (practice breathing
technique) and the parents (practice supporting their child to talk and cope with managing
distress), in addition to committing to doing one special thing as a family together. The
session closed with a group discussion using ‘the bump in the road’ metaphor.

**Session 7: Lets leave the past in the past – and get on with the future.** The aim of this
session was to build upon the previous session in terms of parents and young people
addressing the emotion around difficult life events. This was achieved by helping both
parents and young people talk about these issues together and manage the emotions that arise
from reflecting on these past events. Parents and young people were put into separate groups.

The parent group focussed upon developing skills in putting the parents back into
‘steering’ the family in a positive direction. Parents were encouraged to resume a role of
leadership within the family by making important decisions and raising issues by setting the
agenda rather than being dictatorial. The adolescent group focussed upon CBT techniques
such as behavioural activation as a means of helping them recommence pleasurable activities. Parents and adolescents then came back to form one group again and the adolescents talked about the activities they decided to do in the coming week to improve their mood. The parents then discussed their plans for the future.

**Session 8: Moving forward.** The aim for this session was to close the group with a review and reflection on what has been achieved; encouragement to continue to use the skills taught in the group; and encouragement to get more help if needed. Parents and adolescents split into separate groups. The parent group focused upon moving forward by keeping the momentum going for change, continuing to apply the skills learnt throughout the sessions, seeking further support if needed, and maintaining self-care. The adolescent group focused upon moving forwards, developing plans, discussing any changes and things that have helped in the last few weeks, and continuing to apply learnt skills and seeking support if needed. Finally, the parent and adolescents formed one group and discussed the important points from the sessions and provided feedback on their experiences. Families were given the handout ‘Further support for families following BEST-MOOD’ (Appendix B), which provided information on a range of local mental health and family support services.

**Six month follow-up session: Reunion.** This session was an informal gathering where all families are invited and asked to reflect on the past six months in relation to changes since the group, major life changes, and how the identified young person has been going. Families were also asked to give feedback about the group as a whole.

**Parenting Adolescents Support Training (PAST)**

The PAST intervention functioned as the treatment-as-usual control condition in the trial. Parents attended a parenting group, facilitated by provisionally registered psychologists. PAST is a non-directive approach that uses supportive counselling techniques to facilitate discussions between parents. The PAST intervention ran for eight, weekly two-hour sessions.
Youth and siblings (aged 12 and over) were invited to attend the session in the fifth week. This intervention has been manualised for the purpose of this study. The content of PAST has been designed to equate with standard practices in currently available services in Australia, where if any service is offered, it is likely to consist of a parent support group. The development of this intervention was guided by the current protocols for the family mental health support services in Victoria, Australia. The PAST intervention offers: (a) supportive counselling to assist parents to articulate and identify concerns and (b) psycho-education to increase parents’ knowledge about youth mental health problems. The main content of the PAST group is support and the opportunity to share experiences and ideas as well as receiving contact with a mental health professional. As with BEST MOOD, non-participant observers attended all PAST sessions and made written records, and an audiotape was made of the sessions, which was later transcribed. A description of the eight session of the PAST program follows.

Session 1: Group introduction and orientation. Facilitators and observers introduced themselves and gave a description of their respective roles in the group, and briefly indicated their training and previous relevant experience. Group rules including confidentiality were discussed and established, and a review of the location’s amenities, group breaks, and security and parking arrangements were discussed. The group then engaged in an ‘ice breaker’ exercise to help facilitate group members getting to know one another and start bonding. Some time was then spent discussing what each member wanted to get out of the group sessions, and the therapy approach and rationale was explained. The group was informed that the focus of the group is on the group members sharing their experiences and ideas. The facilitator’s role was outlined as being one of clarifying and summarising, without providing all the answers. It was emphasised to the parents that it was their responsibility to bring their concerns to the group sessions and to try to talk about them as freely and honestly
as possible. It was explained that the PAST approach was about parents identifying and sharing common issues (including feelings and actions), in addition to giving and receiving support from one another. The remainder of the session was spent discussing a common theme from the ‘ice breaker’ exercise. The facilitators ended the session by summing up the groups content (this was done at the conclusion of all sessions), and the parents were asked to reflect on things between sessions and to bring topics for discussion each week. Parents were also handed a session overview with crisis contacts, and a psycho-educational information pack (Appendix C).

**Sessions 2-7: Support group.** The general structure of sessions two to seven for the parents was the same. This involved the facilitator asking the parents for someone to volunteer to begin the session’s discussion by describing something that happened during the week with their young person. Facilitators helped parents elaborate using supportive counselling techniques, such as probing for specific feelings and actions, reflecting patterns of behaviour, and using reflective listening and interpretations. Other parents were included into the discussion by asking their impressions or relating the content. This general process was followed for each parent member each week.

**Week 5: Young people attend.** Parents invited their identified child and any siblings to attend the fifth session of the PAST program. Facilitators and observers introduced themselves to the adolescents and outlined their role and the structure and aims of the group program, as per session one. Parents then introduced themselves and their young person/s to the new group members. An ‘ice breaker’ exercise was then conducted, similar to that undertaken in session one. After sharing a small meal of pizza, parents and adolescents were split into two groups. Parents continued their normal session structure, as outlined for session one to seven. The adolescents participated in a psycho-educational activity in which they were given *beyondblue* mental health handouts. The adolescents were then given time to read
through the materials, after which a quiz was given on the content. The young people were asked if they had learnt anything new and were given out further resources to take home. The parents and adolescents then re-convened into one group, and the young people talked about what they had done in their session before finishing the session.

**Session 8: Final reflections and moving forward.** Parents were asked to reflect on their experiences within the group, and to reflect upon how they might utilise and build upon those experiences for the future. Parents were then given a ‘Further support for families following PAST’ pack containing local mental health and family services information.

**Six month follow-up session: Reunion.** This session was an informal gathering where all families are invited and asked to reflect on the past six months in relation to changes since the group, major life changes, and how the identified young person has been going. Families were also asked to give feedback about the group as a whole.

**Analysis Plan**

The WAI is not a measure with published standardised norms. This is due to the considerable variability in factors influencing alliance scores in any one setting such as the nature of the client’s problems, the demographic characteristics of the sample tested, the intervention used and the setting in which it is conducted, and the experience and skill of the therapist (Munder, Wilmers, Leonhart, Linster, & Barth, 2010). As such, there are no established clinical interpretations of alliance scores generated from the WAI, and comparisons and interpretations are generally limited to the individual sample tested. Higher scores indicate a stronger relative alliance within the sample tested.

While initial studies of the WAI showed its subscales to be highly correlated, more recent factor analysis studies have shown the WAI to exhibit a structure consisting of two independent factors (Andrusyna et al., 2001; Hatcher & Barends, 1996b). These studies indicated the task and goals components loaded onto one factor, while the bond component
loaded onto the other factor. In addition, recent research has shown the task subscale to be comparatively more associated with outcomes than the other alliance subscales in a parent-focussed intervention (Schmidt et al., 2014). Given these findings the WAI alliance goal, task, and bond subscales were included in the analyses in addition to total alliance ratings.

Group facilitators completed the WAI-short-form-therapist-version (WAI-St) for each parent group member at the end of every group session, resulting in eight WAI-St alliance scores for each parent. These alliance scores were then used in subsequent regression analyses to assess the relationship between parent alliance scores and measures of the young person’s depressive symptoms post group treatment using the Short Moods and Feelings Questionnaire (SMFQ). The parents also completed the WAI-short-form-client-version (WAI-Sc) in weeks 2 and 5 for the facilitator-parent relationship, and the facilitators and young people assessed the facilitator-young-person relationship by completing the WAI-St and WAI-Sc in week 5, respectively. Scores from parent and young person completed WAIs were tested using Pearson correlations for their associations with the alliance scores of their respective facilitators and the young persons’ post-treatment scores on the SMFQ.

The overall pattern of facilitator ratings of the facilitator/parent relationship across the 8 sessions of treatment was also assessed for its predictive relationship to post-treatment SMFQ scores. Firstly, growth curve modelling was employed using each parent’s individual growth parameters (e.g., slope) and tested for linear, curvilinear (quadratic), and cubic models of growth. The linear term was first entered into the regression, followed by the curvilinear term, and then the cubic term to evaluate whether the curvilinear or cubic terms explained additional variance beyond that explained by the simple linear model. A linear growth model was found to best describe the sample and was therefore used in the subsequent analyses. Thus, all parents in the sample were assumed to have the same general form of linear trend; however, individual parents would have comparatively different slope parameters indicating
different degrees of positive and negative slope. The parents’ alliance slope variable was then used in a subsequent logistic regression analysis, along with the parents’ intercept variable as a measure of baseline alliance score, to assess its predictive associations with post-treatment depression changes in the young people.

*Preparation of Data*

No missing data was present in the individual WAIs completed each week in the group sessions or the SMFQ completed by young people, as any missing items were followed up with the participant and completed. Missing WAI data was limited to sessions in which parent group members failed to attend the session, and any missing SMFQ data was limited to young people who refused to complete pre-, post-, or follow-up-questionnaires. The WAI and SMFQ data were subjected to Little’s missing completely at random (MCAR) test, which indicated that missing data was missing completely at random. As such, missing data did not bias the datasets and all subsequent analyses were conducted without further modification of the data.

Both independent (WAI) and dependent variable data (SMFQ) were tested for normality using Kolmogorov-Smirnov and the Shapiro-Wilk tests. Results were non-significant, indicating the distribution of scores for the measures conformed to a normal distribution. Visual inspection of WAI and SMFQ histograms was also conducted to confirm these results.

**Results**

*Group Differences in Working Alliance Inventory Measures*

Initially, total alliance scores were assessed in order to determine if there was a difference between the intervention group (BEST) and the treatment as usual group (PAST) on facilitator alliance scores. Analysis of Variance (ANOVA) showed that there was not a significant difference in facilitator alliance scores (total, goal, task and bond) between the BEST and PAST interventions across treatment weeks. As such, all subsequent analyses
pooled the BEST and PAST alliance scores together. Summary ANOVA statistics for total alliance in weeks two and five are presented in Table 1.

**Table 1**

*Summary of One-way Analysis of Variance of Total Alliance by Intervention Received (BEST and PAST)*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
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<tbody>
<tr>
<td><strong>Week 2</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Between groups</td>
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<td>Within groups</td>
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<td>25.40</td>
<td>.48</td>
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<td>Total</td>
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<td><strong>Week 5</strong></td>
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<td></td>
</tr>
<tr>
<td>Between groups</td>
<td>1</td>
<td>.88</td>
<td>.88</td>
<td>1.90</td>
<td>.17</td>
</tr>
<tr>
<td>Within groups</td>
<td>48</td>
<td>22.33</td>
<td>.47</td>
<td></td>
<td></td>
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<tr>
<td>Total</td>
<td>49</td>
<td>23.22</td>
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</tbody>
</table>

*df = Degrees of freedom, SS = Sum of squares, MS = Mean square between groups, F = F test statistic, p = p value.*

**Alliance Between Facilitators and Parents**

The descriptive statistics present the results from curve estimation modelling of individual facilitator alliance ratings for each parent across the eight weeks of treatment. Facilitator WAI scores are then presented aggregated across weeks, followed by presentation of week trends of alliance scores across treatment. Finally, Pearson correlations between facilitator alliance and parent alliance ratings are presented for weeks 2 and 5, along with effect sizes (proportion of pooled standard deviation) for differences between facilitator and parent alliance scores.
Facilitator alliance scores across the eight weeks of treatment were submitted to a curve estimation modelling in order to identify the best curve model to represent the alliance data. Total alliance and the goal-, task-, and bond-subscales were subjected to curve estimation and tested for goodness of fit for linear, quadratic and cubic models. Results indicated a linear model to be most parsimonious for all the scales tested. Figure 1 presents the results of the curve estimations, which show linearly increasing alliance scores for total alliance and the task-, goal- and bond-subscales.

Descriptive statistics for facilitator completed total alliance, and the goal-, task-, and bond-subscales aggregated for each of the facilitator completed WAI scales across all of the weeks, are presented in Table 2. The means indicated that the facilitator’s alliance tended to score at the upper end of the distributions, suggesting they had a generally positive alliance with the parents.
Figure 2. Curve estimations for facilitator total-, task-, goal-, and bond-ratings of parent alliance for sessions one to eight of treatment.
Table 2

Descriptive Statistics for Facilitator Alliance Aggregated From All Weeks of Treatment

<table>
<thead>
<tr>
<th>WAI Scales</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
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</thead>
<tbody>
<tr>
<td>Total alliance</td>
<td>56</td>
<td>5.00</td>
<td>.80</td>
<td>2.75</td>
<td>6.92</td>
</tr>
<tr>
<td>Task</td>
<td>56</td>
<td>4.85</td>
<td>.90</td>
<td>2.50</td>
<td>7.0</td>
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<tr>
<td>Goal</td>
<td>56</td>
<td>4.64</td>
<td>1.24</td>
<td>1.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Bond</td>
<td>56</td>
<td>5.35</td>
<td>.84</td>
<td>1.0</td>
<td>7.0</td>
</tr>
</tbody>
</table>

n = Number of participants, M = Mean, SD = Standard deviation.

Means for facilitator alliance across each week of the group treatments are presented in Figure 3. These show a trend for facilitator total alliance scores to increase from Week 1 to Week 8. Task, Goal, and Bond scores also revealed a trend to increase.

![Bar charts showing average facilitator ratings](image)

Figure 3. Average facilitator total-, task-, goal-, and bond-ratings of parent alliance for weeks one to eight of treatment.
Parents completed the WAI-Sc in weeks two and five of treatment. Table 3 and Table 4 presents means, standard deviations, effect sizes for differences between alliance scores, and Pearson’s correlations between parent and facilitator alliance scores for week two and week five, respectively. Similar to facilitator alliance, the parent alliance also tended to score at the upper end of the distributions, indicating that parents felt that they had a generally positive alliance with the facilitators. T-tests were conducted where the effect size for differences between facilitator and parent alliance scores was large ($d > x$). This analysis revealed a significant difference between week two total facilitator alliance ($M=4.70$, $SD=0.69$) and total parent alliance ($M=5.24$, $SD=0.79$); $t(48)=-4.05$, $p < .001$. In addition, a significant difference was also detected between week two facilitator goal ($M=4.35$, $SD=1.08$) and parent goal ($M=5.27$, $SD=0.99$); $t(49)=-4.50$, $p < .001$. These results indicate that parents were somewhat more optimistic regarding their alliance with the facilitators compared to the facilitator’s view of the alliance with the parents. However, by week five the facilitator’s view of the alliance had improved to the same level as the parents. While parent and facilitator alliance scores were generally not significantly different, they were also not significantly correlated aside from week five bond scores.
Table 3

Means, Standard Deviations, Effect Sizes for Differences Between Alliance Scores, and Correlations Between Parent and Facilitator Alliance Scores in Week 2

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>ES</th>
<th>r</th>
</tr>
</thead>
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<td><strong>Total Alliance</strong></td>
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</tr>
<tr>
<td>Parent</td>
<td>5.24</td>
<td>.79</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Facilitator</td>
<td>4.70</td>
<td>.69</td>
<td>-.78</td>
<td>.09</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>4.94</td>
<td>1.08</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Facilitator</td>
<td>4.60</td>
<td>.88</td>
<td>-.32</td>
<td>.05</td>
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<tr>
<td><strong>Goal</strong></td>
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</tr>
<tr>
<td>Parent</td>
<td>5.27</td>
<td>.99</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Facilitator</td>
<td>4.35</td>
<td>1.08</td>
<td>-.90</td>
<td>-.01</td>
</tr>
<tr>
<td><strong>Bond</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>5.17</td>
<td>1.10</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Facilitator</td>
<td>5.14</td>
<td>.61</td>
<td>-.04</td>
<td>.08</td>
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</tbody>
</table>

Note. ES: Effect sizes (proportion of pooled standard deviation) for differences between facilitator and parent alliance scores; no significant differences were detected. M = Mean, SD = Standard deviation, ES = Effect size, r = Pearson Correlation for parent and facilitator; no significant correlations were detected.
Table 4

*Means, Standard Deviations, Effect Sizes for Differences Between Alliance Scores, and Correlations for Parent and Facilitator Alliance Scores in Week 5*

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
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<tr>
<td><strong>Total Alliance</strong></td>
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<tr>
<td>Parent</td>
<td>5.25</td>
<td>.94</td>
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<td>-</td>
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<td>Facilitator</td>
<td>5.10</td>
<td>.69</td>
<td>-.25</td>
<td>.07</td>
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<td>Parent</td>
<td>5.10</td>
<td>1.04</td>
<td>-</td>
<td>-</td>
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<td>Facilitator</td>
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<td>.18</td>
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<td><strong>Goal</strong></td>
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<tr>
<td>Parent</td>
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<tr>
<td>Facilitator</td>
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<td>1.28</td>
<td>-.37</td>
<td>-.01</td>
</tr>
<tr>
<td><strong>Bond</strong></td>
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<tr>
<td>Parent</td>
<td>5.21</td>
<td>1.28</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Facilitator</td>
<td>5.22</td>
<td>1.29</td>
<td>.01</td>
<td>.99</td>
</tr>
</tbody>
</table>

Note. ES: Effect sizes (proportion of pooled standard deviation) for differences between facilitator and parent alliance scores; values greater than absolute value |.99| are significant at the p < .01 level. M = Mean, SD = Standard deviation, ES = Effect size, r = Pearson Correlation for parent and facilitator; values above |.90| are significant at p < .05.
Alliance Between Facilitators and Young People

Results of comparisons of alliance ratings by young people and facilitators collected at week five of treatment, are presented in Table 5. Both young people and facilitators produced alliance scores that were on the upper end of the distributions, indicating that the young people and facilitators viewed the alliance optimistically. Effect sizes for differences between young person and facilitator alliance scores across all alliance scales were small, indicating that these scores were not significantly different. As with the correlation analysis conducted between facilitator and parent alliance scores, facilitator and young person alliance scores were also generally not significantly correlated, aside from the task subscale ($r = .44, p < .05$).

Treatment Effects On Young Person Depressive Symptoms

Young people completed the Short Moods and Feelings questionnaire (SMFQ) at pre-treatment, post-treatment, and at three-month follow-up time points. Table 6 presents a one-way ANOVA, which indicates that there was no significant difference in the treatment effects between the BEST and PAST interventions. As such, the BEST and PAST SMFQ scores were pooled for subsequent analyses. Descriptive statistics for SMFQ scores at pre-, post-, and follow-up-time-points are presented in Table 7. Effect sizes were large between overall mean pre-SMFQ scores and both post- and follow-up-SMFQ scores. T-tests showed that the treatment effects were significant for the difference between pre-SMFQ scores (M=19.56, SD=4.64) and post-SMFQ scores (M=13.61, SD=7.22); t (35)=5.30, p=.000, in addition to the difference between pre-SMFQ scores and three month follow-up scores (M=15.79, SD=7.22); t(37)=3.86, p=.000.
Table 5

Means, Standard Deviations, Effect Sizes for Differences Between Alliance Scores, and Correlations for Young Person and Facilitator Alliance Scores in Week 5

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
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<td>Total Alliance</td>
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<td>Young Person</td>
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<td></td>
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<tr>
<td>Young Person</td>
<td>4.54</td>
<td>.98</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Facilitator</td>
<td>4.43</td>
<td>.90</td>
<td>.09</td>
<td>.44</td>
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<td>Goal</td>
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<tr>
<td>Young Person</td>
<td>4.91</td>
<td>.78</td>
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<td>-</td>
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<tr>
<td>Facilitator</td>
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<td>Young Person</td>
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</tr>
</tbody>
</table>

Note. ES: Effect sizes (proportion of pooled standard deviation) for differences between facilitator and parent alliance scores; no significant differences were detected. M = Mean, SD = Standard deviation, ES = Effect size, r = Pearson Correlation for parent and facilitator; values above |.40| are significant at p < .05.
Table 6

One-way Analysis of Variance of Pre-, Post-, and Follow-up-SMFQ scores by Intervention Received (BEST and PAST)

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>SS</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-SMFQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between groups</td>
<td>2</td>
<td>32.83</td>
<td>16.42</td>
<td>.75</td>
<td>.48</td>
</tr>
<tr>
<td>Within groups</td>
<td>39</td>
<td>849.57</td>
<td>21.78</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>882.41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-SMFQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between groups</td>
<td>2</td>
<td>67.02</td>
<td>33.53</td>
<td>.63</td>
<td>.54</td>
</tr>
<tr>
<td>Within groups</td>
<td>33</td>
<td>1755.49</td>
<td>53.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>35</td>
<td>1822.56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fu-SMFQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between groups</td>
<td>2</td>
<td>120.90</td>
<td>60.45</td>
<td>1.36</td>
<td>.27</td>
</tr>
<tr>
<td>Within groups</td>
<td>35</td>
<td>1559.42</td>
<td>44.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>1680.32</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$df =$ Degrees of freedom, $SS =$ Sum of squares, $MS =$ Mean square between groups, $F =$ F test statistic, $p =$ p value.
Table 7

*Means, Standard Deviations, and Effect Sizes for Differences Between Pre-, Post- and Follow-up-SMFQ Measures*

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>ES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-SMFQ</td>
<td>42</td>
<td>19.56</td>
<td>4.64</td>
<td>-</td>
</tr>
<tr>
<td>Post-SMFQ</td>
<td>36</td>
<td>13.61</td>
<td>7.22</td>
<td>1.00</td>
</tr>
<tr>
<td>Fu-SMFQ</td>
<td>38</td>
<td>15.79</td>
<td>6.74</td>
<td>.66</td>
</tr>
</tbody>
</table>

Note. Effect sizes are significant at p=0.01 level, two-tailed. n’s range from 36 to 42 due to occasional missing data. Fu = Follow-up, n = Number of participants, M = Mean, SD = Standard deviation, ES = Effect size.

**Relationship Between Alliance and Changes in Young Person Depressive Symptoms**

Given the limited sample size a power analysis was conducted to assess the degree of change on the SMFQ measures that could be detected in the study. Results indicated at power .8 and alpha .05 it was possible to detect score changes of five or more points on the SMFQ measures, within the available sample size. This was used as the basis of detecting ‘measurable change’ in the young person’s depressive symptoms. The SMFQ scores were split into two groups based upon whether the young person’s post SMFQ score resulted in a reduction (decrease in depressive symptoms) of five points or more when compared to their pre-treatment SMFQ score, or resulted in an increase in SMFQ score (increase in depressive symptoms) or a reduction of under four points. Thus, a depression change variable (DCV) was created to represent those young people who had undergone a measurable reduction in depressive symptoms (scored 0), versus those who either experienced an increase in depressive symptoms post-treatment or no measurable change (1).

Facilitator, parent and young person alliance scores were assessed for their association with changes in the young person’s depressive symptoms. Table 8 and Table 9 present the
Pearson correlations between facilitator and parent alliance scores, and the DCV in week two and week five, respectively. Table 10 presents the Pearson correlations between facilitator and young person alliance scores, and the DCV in week five of treatment. Week two parent task scores were shown to significantly negatively correlate with changes in the young person’s depressive symptoms, so that those parents who had higher task scores in week two tended to have young people who showed significantly lower depressive symptoms post treatment. No other significant associations between parent or facilitator week 2 alliance scores and changes in the young person’s depressive symptoms were detected.

A negative association between week 5 facilitator total alliance and changes in young person depressive symptoms was found to approach significance. In addition, week 5 facilitator ratings of the goal subscale were significantly negatively associated with the DCV, indicating that the parents with whom facilitators rated a higher agreement on therapeutic goals, also tended to have young people with a reduction in depressive symptoms post treatment. No other facilitator or parent alliance scores were significantly associated with changes in the young person’s depressive symptoms. Assessment of the alliance between the facilitators and young people revealed that neither the facilitators nor the young people’s alliance scores were significantly associated with changes in the young person’s depressive symptoms. Standard SMFQ change scores based upon pre- to post-SMFQ score changes were also tested for their associations with alliance scores; however, they were found to be more weakly associated with all alliance scores when compared to the DCV. Hence, the DCV was selected as the more sensitive variable to be used in the present analyses.

To test the main hypothesis that a linear increase in alliance scores would predict changes in the young person’s scores on depression (or depressive symptoms) post treatment, individual linear regressions were conducted for each parent’s facilitator completed alliance score across the eight weeks of treatment. The regressions were conducted with the goal
subscale, as the previous correlation analyses presented indicated that this alliance scale was most closely related to young person depression changes. The regressions produced a goal slope variable, in addition to a goal intercept variable, which was also included to assess whether baseline alliance ratings were related to depression outcomes. Goal slope was found to significantly correlate with goal intercept, however, subsequent testing showed this interaction to be non-significant. These variables were used as predictors in a logistic regression, where the DCV was the dependent variable.

A further predictor variable was also included in the logistic regression based upon a post-hoc analysis of the depression change grouping the DCV was based upon. Figure 3 presents the two parent groups’ average total alliance scores across the eight weeks of treatment. As discussed earlier, these groups were created based upon the power analysis conducted, and parents were grouped depending on whether their young person achieved a reduction of five points or more on their post-SMFQ measure (measurable change), or reported an increase in depressive symptoms or no measurable change. Figure 4 indicates that those parents whose child achieved a reduction in depressive symptoms had higher average total alliance scores beyond standard error from week four of treatment onwards. Based upon this data, a new variable was created that sought to maximise this difference and was included in the logistic regression. As the variance between the two parent group’s total alliance
## Table 8.

**Pearson Correlations Between Week 2 Facilitator Alliance with Parents, Parent Alliance, and Young Person Depressive Symptom Changes**

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Facilitator TA</td>
<td></td>
<td>-.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Parent TA</td>
<td></td>
<td></td>
<td>-.13</td>
<td>.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Facilitator Task</td>
<td></td>
<td></td>
<td></td>
<td>.21</td>
<td>.83</td>
<td>.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Parent Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.30</td>
<td>-.07</td>
<td>.85</td>
<td>.05</td>
</tr>
<tr>
<td>6 Facilitator Goal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.08</td>
<td>.79</td>
<td>-.14</td>
</tr>
<tr>
<td>7 Parent Goal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.09</td>
<td>.08</td>
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<tr>
<td>8 Facilitator Bond</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.06</td>
</tr>
<tr>
<td>9 Parent Bond</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. Correlations above |.29| are significant at p < 0.05, two-tailed test. Correlations above |.36| are significant at p < 0.01, two-tailed test. TA=Total alliance, DCV=Depression change variable.*
### Table 9.

*Pearson Correlations Between Week 5 Facilitator Alliance with Parents, Parent Alliance, and Young Person Depressive Symptom Changes*

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Facilitator TA</td>
<td>-.27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Parent TA</td>
<td>-.24</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Facilitator Task</td>
<td>-.18</td>
<td>.79</td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Parent Task</td>
<td>-.26</td>
<td>.07</td>
<td>.92</td>
<td>.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Facilitator Goal</td>
<td>-.30</td>
<td>.79</td>
<td>-.08</td>
<td>.30</td>
<td>-.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Parent Goal</td>
<td>-.15</td>
<td>.12</td>
<td>.92</td>
<td>.23</td>
<td>.81</td>
<td>-.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Facilitator Bond</td>
<td>.03</td>
<td>.04</td>
<td>.90</td>
<td>.06</td>
<td>.69</td>
<td>.02</td>
<td>.77</td>
<td></td>
</tr>
<tr>
<td>9 Parent Bond</td>
<td>.03</td>
<td>.05</td>
<td>.90</td>
<td>.05</td>
<td>.69</td>
<td>.04</td>
<td>.76</td>
<td>.99</td>
</tr>
</tbody>
</table>

Note. Correlations over .29 are significant at p=0.05 level, two-tailed test. Correlations over .68 are significant at p=0.01 level, two-tailed test. TA=Total alliance, DCV=Depression change variable.
Table 10.

*Intercorrelations Between Week 5 Facilitator Alliance with Young People, Young Person Alliance, and Young Person Depressive Symptom Changes*

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DCV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Facilitator TA</td>
<td>.12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Young person TA</td>
<td>-.01</td>
<td>.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Facilitator task</td>
<td>.18</td>
<td>.94</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Young person task</td>
<td>.01</td>
<td>.30</td>
<td>.87</td>
<td>.44</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Facilitator goal</td>
<td>.15</td>
<td>.94</td>
<td>.21</td>
<td>.82</td>
<td>.29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Young person goal</td>
<td>.11</td>
<td>.01</td>
<td>.86</td>
<td>.09</td>
<td>.72</td>
<td>.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Facilitator bond</td>
<td>-.03</td>
<td>.89</td>
<td>-.01</td>
<td>.72</td>
<td>-.00</td>
<td>.78</td>
<td>-.17</td>
<td></td>
</tr>
<tr>
<td>9 Young person bond</td>
<td>-.12</td>
<td>.09</td>
<td>.83</td>
<td>-.01</td>
<td>.51</td>
<td>.17</td>
<td>.55</td>
<td>.11</td>
</tr>
</tbody>
</table>

Note. Correlations over .44 are significant at p=0.05 level, two-tailed test. Correlations over .50 are significant at p=0.01 level, two-tailed test. TA=Total alliance, DCV=Depression change variable.
scores in weeks one through three was within standard error, these scores were averaged per group and subtracted from the average of parent scores from weeks four through eight in order to optimally capture the divergence in scores beyond standard error between the groups. This was then included as a ‘group difference’ variable in the logistic regression.

Table 11 presents the results of the logistic regression. Goal slope was found to trend towards significance in predicting young person depression changes, while goal intercept and group difference were not significant predictors. In addition, while the chi squared statistic describing the model’s predictive capacity in the regression equation was not significant, a trend towards significance was evident.
### Table 11.

*Logistic Regression Analysis of Alliance Measures on Young Person Depressive Symptom Changes*

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>b</th>
<th>se</th>
<th>z ratio</th>
<th>Prob.</th>
<th>Odds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Difference</td>
<td>-1.93</td>
<td>1.88</td>
<td>1.05</td>
<td>.31</td>
<td>.15</td>
</tr>
<tr>
<td>Linear Slope (Goal)</td>
<td>-14.11</td>
<td>7.73</td>
<td>1.33</td>
<td>.07</td>
<td>.00</td>
</tr>
<tr>
<td>Intercept (Goal)</td>
<td>-.67</td>
<td>.57</td>
<td>1.38</td>
<td>.24</td>
<td>.51</td>
</tr>
</tbody>
</table>

Model $\chi^2 = 6.97$  
Pseudo $R^2 = .27$

$n = 31$

Note. The dependent variable in this analysis is the depression change variable (DCV) coded so that 1 = reduction from pre- to post-treatment SMFQ score of 5 or more points and 2 = increase from pre- to post-treatment SMFQ score or no change.
Discussion

The aim of the present study was to assess whether a stronger therapeutic alliance between parents and therapists within parent-focussed interventions predicted post-treatment improvements in the target clients’ (young persons’) depressive symptoms. This putative relationship was assessed in several ways. Specifically, it was hypothesised that a greater degree of linear slope (improvement) in parent-reported alliance scores would predict lower post-treatment depressive symptoms in the target young person. Alliance scores for week 2 (facilitators and parents) and week 5 (facilitators, parents, and young people) were also investigated in order to assess the predictive effect of early- and mid-therapy alliance ratings from different sources on child depression outcomes. It was predicted that high ratings of alliance early in treatment by the facilitator and parent would be more predictive of post-treatment improvements in the young persons’ depressive symptoms than mid-treatment ratings of alliance.

Summary of Findings

The present study was part of a larger clinical trial assessing the efficacy of two parent-based interventions (BEST and PAST) in the treatment of youth depression. Results indicated that both interventions were associated with significant reductions in the depressive symptoms of the young people in the sample. The main aim of the present study was to investigate the relationship between the therapeutic alliance between the group facilitators and parent participants, and post-treatment changes in the young person’s depression. The main hypothesis of this study was that a greater degree of increase (positive linear slope) in facilitator/parent alliance scores would predict lower post-treatment depressive symptoms in the young people. While the findings did not reach significance to support this hypothesis, the relationship
approached significance and the association was in the direction predicted. As such, while the relationship marginally failed to meet statistical significance it remains possible that there is a small effect but the study sample was not large enough to detect it. Baseline facilitator ratings of the facilitator-parent alliance scores were also found to be not significantly predictive of changes in the young peoples’ depression scores. In addition, facilitator ratings of alliance with parents were also found to be non-significant predictors of children who were observed to have achieved measureable reductions in their post-treatment depressive symptoms.

The prediction that early alliance ratings would be more associated with child depression changes than mid-treatment alliance ratings was partially met. Baseline facilitator ratings of the facilitator-parent alliance were found to be not predictive of depression changes. In addition, early facilitator ratings of the facilitator-parent alliance (week 2) were not associated with depression changes, whereas mid-treatment facilitator ratings of the goal subscale were found to be significant predictors of reduced child depression. However, a different pattern was found with parent ratings of the facilitator-parent alliance whereby early parent ratings of the facilitator-parent task subscale were significant predictors of reduced child depression scores, whereas later parent ratings of the alliance were not significantly associated. Both early and mid-treatment ratings of the facilitator-young person alliance by both facilitators and young people were also not significantly associated with young person depression outcomes.

Finally, the relationships between different raters of the alliance were also assessed. Alliance ratings between facilitators and parents, and facilitators and young people, across all raters were found to be at the upper end of the distributions indicating positive alliances, and were not statistically different from one another.
However, facilitator ratings of alliance were poorly correlated to both the parents’ and young persons’ ratings of alliance.

*Pattern of Alliance Over Time*

Research into the relationships between trajectories of alliance scores and treatment outcomes is limited and the results are mixed. In individual therapy, different studies have found either linear or curvilinear trajectories to be most predictive of treatment outcomes (de Roten et al., 2004; Morral et al., 1997). However, several studies have also failed to find these patterns of alliance growth at all in their samples (Despland et al., 2009; Gaston, Piper, Debbane, Bienvenu, & Garant, 1994; Kramer et al., 2009; Sexton, Littauer, Sexton, & Tommeras, 1996). In the very few studies examining the growth of alliance within a group therapy context, a pattern of linear growth appears to be the most common pattern found (Lindgren, Barber, & Sandahl, 2008; Piper & Ogrodniczuk, 2010; Piper et al., 2005; Taft, Murphy, Musser, & Remington, 2004; Tasca, Balfour, Ritchie, & Bissada, 2007; Woody & Adessky, 2002).

Only Piper et al. (2005) and Woody and Adessky (2002) examined the predictive relationship between the linear pattern of alliance and treatment outcomes. Woody and Adessky’s analysis used growth curve modelling and found that overall, client-rated alliance grew in a linear fashion. Furthermore, the addition of a curvilinear term failed to account for any further significant variance. Treatment outcomes, however, were found to be not associated with the strength of linear change in alliance over time. Consistent with the previous study’s findings, Piper et al. employed Hierarchical Linear Modelling and found a linear model to significantly account for the growth of client-rated alliance, whereas a curvilinear model was not significant. Contrary to Woody and Adessky’s findings, however, Piper et al. found
that the strength of linear change in alliance was negatively associated with treatment outcomes, so that a greater increase in the strength of alliance over time predicted more favourable outcomes.

The only study that could be found assessing the linear properties of alliance patterns within a parent-focussed treatment was conducted by Lerner et al. (2011), who took parent alliance measures from weeks 3 to 8 in a group-based treatment for children with ADHD. Their analysis showed no significant linear change across time for parent alliance, with parent alliances having substantial individual differences in their trajectories across the treatment.

In agreement with the majority of prior research assessing alliance patterns in a group therapy context, the present study found that a linear pattern of alliance growth was the best fitting model describing alliance scores, with a curvilinear or cubic model accounting for very little variance. While research into the patterns of alliance in group therapy is very limited, the present study contributes to this area by providing further evidence that alliance processes within a group therapy context may most commonly accord with linear patterns of growth. Further research is needed in order to more clearly establish whether this observation is due to the limited data available, or is a common effect in group family therapy contexts.

In addition, the present findings do not agree with Lerner et al’s results, which is the only other study to assess linear patterns within a parent-focussed group therapy. More research is needed to identify whether patterns of alliance within a parent-focussed group context may have specific characteristics. For example, the primary target of treatment is the young person in parent-focussed treatments; however, it is expected that young people are indirectly impacted through changes in their parents and families that arise through the group-based therapeutic processes. As
such, compared to other group therapies where the target of the intervention is directly impacted by the group therapy, there may be less effect on the child through the alliance processes in parent-focussed group interventions. Parent motivation, commitment, and investment in therapy may be impacted by alliance but may confront barriers in translating to change in parenting behaviour and family environments and to more distal changes in child outcomes. This therapeutic context is likely to be more complex compared to those where an individual is directly engaging in therapy to treat their own mental health issues. Therefore, parents will likely have characteristically different ways of interacting with alliance constructs such as goal, bond and task and there are likely to be weaker impacts on child outcomes.

**Predictive Relationship Between Linear Pattern of Alliance and Depression Changes in Young People**

No prior study was found to assess the relationship between the overall pattern of alliance and child treatment outcomes in a parent-focussed group therapy. As previously discussed, Piper et al. (2010) found that the strength of linear slope was positively associated with favourable outcomes in a group-based treatment for adults with complicated grief. In addition, the strength of linear slope has been found to be predictive of outcomes in individual therapy (Kivlighan & Shaughnessy, 1995; Kramer et al., 2009). We predicted and found that the strength of positive linear slope (increase) in alliance approached significance in predicting lower post-treatment child depression scores. Given the limited sample size used in the present study and the degree of missing data, it is likely that a larger sample would have yielded a significant result. The power analysis conducted for our sample suggested the design was sufficiently powered to detect changes in the young persons’ depressive
symptoms as significant. As such, while the strength of positive linear change in parent alliance may have had some effect on the depression outcomes for the young people, this appears to be a small effect and is likely not clinically important.

Given the inconsistent research to date in relation to the predictive relationship between patterns of alliance and treatment outcomes in group therapy, it may be that overall trajectories of alliance are not as reliable as predictors compared to measures of alliance at specific points in therapy or the overall average level of alliance. The two studies that could be found that specifically examined alliance ratings at specific points within a parent-focussed group therapy both found significant associations between early parent alliance ratings and child outcomes. (Lerner et al., 2011; Schmidt et al., 2014). In addition, summed parent alliance scores from sessions 4 and 8 were predictive of child outcomes in a parent-focussed treatment for child externalising behaviours (Kazdin et al., 2005). However, it should be noted that these results have occurred in studies investigating child externalising disorders, and differential alliance relationships may exist in relation to internalising disorders such as depression.

Other factors may also have had an impact upon the present results. Generally, client ratings of alliance have been shown to be more associated with treatment outcomes than therapist ratings of alliance in individual adult therapy (Hovarth & Bedi, 2002). Due to this finding within individual adult therapy, most of the studies investigating alliance within a group therapy context have only used client ratings of alliance. However, as discussed earlier, of the limited studies that have included therapist ratings, half of those studies found the therapist ratings to be more predictive than client ratings. It is not presently clear then, if client ratings are more predictive in group therapy compared to therapist ratings and further comparative research is
needed to clarify this question. The few studies undertaken with parent-focussed interventions have generally found that parent ratings of alliance are more predictive of child outcomes than therapist ratings of alliance. However, the studies showing this pattern used alliance measures taken from one or two sessions throughout treatment and have generally focussed on treatments for externalising behaviours (Hawley & Garland, 2008; Kazdin et al., 2005; Kazdin et al., 2006; Schmidt et al., 2014). The one study identified assessing parent and therapist ratings of alliance in the treatment of youth internalising disorders (anxiety disorders) found a different pattern, with results indicating therapist ratings of alliance to be a stronger predictor of youth outcomes than parent ratings of alliance (Marker et al., 2013) The present study differed to prior research in this area in that it also included an assessment of the pattern of alliance in relation to treatment outcomes, and in addition this was assessed within a population of children with depression. Our findings indicated a weak association between the linear pattern of therapist ratings of parent alliance and changes in child depression, and as such are consistent with previous findings within parent-focussed interventions. Further research would benefit by assessing patterns of parent ratings of alliance in order to assess its association with child outcomes.

**The Association of Early- and Mid-treatment Alliance scores with Depression**

**Changes in the Young People**

The findings in relation to the association between early- and mid-treatment parent- or therapist-ratings of alliance and child outcomes partially align with previous findings. Parent ratings of total early- and mid-treatment alliance have been shown in prior studies to be associated with child outcomes. However, both early- and mid-treatment ratings of total alliance were not significant within the current sample of parents. Our results, however, showed a significant negative association such that
higher scores on the week 2 parent-rated task subscale predicted lower post treatment depression in the young person. Schmidt et al. (2014) is the only study to assess alliance subscales within a parent-focussed intervention, and they also took alliance measures at week 2 of treatment. Their results also indicated that parent-ratings of the task subscale were the best predictor of child outcomes. Task was significantly associated with 6 of the 11 outcomes Schmidt and colleagues assessed, while goal was only associated with one outcome, and bond was associated with two outcomes. As such, our findings are consistent with Schmidt et al. and support the notion that the task subscale may be a relatively more important indicator of positive child outcomes than the other alliance subscales. Furthermore, our results are also consistent with Schmidt et al’s findings that early parent ratings of alliance are more predictive of child outcomes than early facilitator ratings of alliance.

In considering the function of the alliance subscales within a parent-focussed intervention, there may be some basis as to why the task subscale is more associated with positive child outcomes. The task subscale specifically measures the degree to which the client agrees that the therapeutic processes and in-therapy activities are correct and necessary in order to achieve the therapeutic goals. In addition, it assesses the degree to which the client accepts responsibility to perform these acts (Hovarth, 1994). Parent-focussed interventions are different to most other therapeutic approaches in that the target of the intervention, the child, is often not directly involved in the therapeutic process or involved to a much lesser degree. As such, the parent is responsible for implementing behavioural and relational changes within the family system that are thought to ultimately have beneficial impacts on their child. It is not surprising then, that the degree to which the parent agrees with the mode of therapeutic change, in addition to the degree to which the parent actually follows
through with carrying out those changes would be potentially more associated with the child’s outcomes.

Bond is a component of the alliance that is limited to the relationship between the parent and therapist. While this aspect of the alliance may have therapeutic benefits in individual therapy where the target of the intervention directly forms a relationship with the therapist, it may be that it is less important in parent-focussed interventions as the child is not involved in this aspect. Goal measures the degree to which the parent and facilitator mutually endorse and value the aims of the intervention. It would seem unlikely that there would be significant variation within the parents with regard to this subscale as all the parents have committed to the program to help their child. Common issues in individual therapy such as ambivalence towards change and secondary gains that may impact upon a clients orientation towards therapeutic goals are likely not as relevant in the alliance with parents. In addition, parents may have positive alliances with regard to bond or goal however still fail to follow through and act upon the therapeutic components of the intervention. In such cases the intervention would likely result in little change to that parent’s family system. Therefore, the task subscale would appear to be the most relevant scale when considering the potential for each of the scales to predict a tangible therapeutic effect on the child.

A consistent finding in the few studies investigating parent ratings of alliance in parent-focussed interventions has been that parent total alliance is associated with child outcomes. However, our results for total parent rated alliance in both weeks 2 and 5 were not significant. The different results in the present study may be related to intervention, sample, and disorder specific effects, as prior studies have focussed on treatments for externalising behaviours. Clearly, more research is needed assessing
parent-focused interventions for a range of youth mental health issues, such as depression, in order to establish whether the nature of the child’s disorder is impacted in different ways by alliance processes and their relationships to treatments outcomes.

The results also showed that total facilitator rated alliance for early- and mid-treatment was not significantly associated with changes in the young persons’ depression, however the mid-treatment alliance ratings approached significance. This agrees with prior research showing that early- and mid-treatment facilitator total alliance is weakly associated with child outcomes (Hawley & Garland, 2008; Kazdin et al., 2005; Kazdin et al., 2006; Schmidt et al., 2014). However, also found in the current study was that facilitator ratings for goal at mid-treatment were significantly negatively associated with the young persons’ depression changes. Prior studies that included mid-therapy facilitator alliance ratings in parent-focused interventions only assessed total alliance and not the alliance subscales, and as such no comparison for the present finding can be made. While the present findings do not suggest that facilitator ratings of alliance are more predictively robust than other sources, future research may benefit by assessing the subscale components of facilitator alliance ratings in relation to child outcomes.

Finally, the results indicated that both facilitators’- and the young-persons’- ratings of early facilitator-young person alliance were not significantly associated with young person depression changes from pre to post-treatment. Prior research has found that both facilitator and child ratings of the alliance are associated with child outcomes, with child ratings a better predictor than facilitator ratings (Hawley & Garland, 2008; Kazdin et al., 2005; Kazdin et al., 2006). These studies, however, involved treatments in which the child was significantly involved in the therapeutic process, and attended 12 to 14 sessions of treatment. In addition, alliance scores were
taken after the children had attended several sessions of treatment. Comparatively, young people in the present study attended 1 (PAST) or 4 sessions (BEST), and the young people completed their alliance measure on their first session. In the present study, then, the parents were comparatively much more involved in the therapeutic process compared to the young people, whereas the young people and parents were equally involved in treatment in the prior studies. As such, it is not surprising that the parents’ alliance ratings were more predictive of the child’s treatment outcomes than the young person’s alliance ratings.

**Associations Between Different Raters of Alliance**

The results in Study 1 showed a generally poor relation between facilitator- and parent-ratings of the facilitator/parent alliance, aside from the week 5 bond subscale, which was highly correlated. The poor correlations between the therapist and parent alliance scores were maintained even in cases where the overall values between the two raters were not significantly different. Kazdin (2006) found small to moderate correlations ($r = .24 - .38$) between facilitator and parent alliance ratings, and Kazdin (2005) and Schmidt (2014) found small correlations between these raters ($r = .13 - .26$). While we also generally found small correlations between facilitator and parent alliance ratings, the correlations were also generally much smaller than the previous studies, with most correlations falling within the range of $r = .011 - .088$. The degree of ‘mismatch’ between the facilitators’ and parents’ view of their relationship in the present study is concerning, and may indicate a methodological issue with the completion of the alliance measures, such as the parents or facilitators not adequately understanding the items on the measure or not completing the measure correctly. If this is the case, it could account for not only the generally very low correlations
between facilitator and parent ratings of alliance, but also the weak association found between parent and facilitator alliance, and the young persons’ depression changes.

It may also be that facilitator ratings of alliance in parent-focused group interventions are inaccurate. The fact that prior studies have shown parent alliance to be a good predictor of child outcomes using the same alliance measure used in the present study, indicates that parents are able to accurately assess and rate their relationship with the facilitator using the measure. In addition, facilitator ratings of alliance have generally been a poor predictor of alliance in these prior studies. It is likely more difficult for a facilitator to be aware of the nuances of each relationship they have with every member in group therapy, when compared to just engaging with one relationship in an individual therapy context. Consequently, it may be that facilitators are not able to accurately assess all parent alliances to a sufficient degree within a group therapy context. Furthermore, in the present study, where the target of the treatment (young person) had minimal engagement in the therapeutic process, the relationship between alliance and child symptom changes may be weaker than in previous studies where the child participated more in the therapy.

**Final Comments, Limitations, and Further Considerations**

Overall, the present study found that the linear pattern of facilitator rated facilitator/parent alliance was weakly related to changes in the young persons’ depression. A limitation of the present study was that the small sample size obtained may have been underpowered to assess the predictive effect of the facilitator alliance score on the child outcomes. Identification of discrete groups of alliance patterns within the parent sample using techniques such as cluster analysis or latent class analysis would allow a more sophisticated assessment of the relationship between differing groups of alliance patterns and their relationship to the young persons’
outcomes. The present study suffered from a low rate of families being recruited into the study, and future studies of the program need to address this issue by expanding referral sources, increasing parent information sessions, and identifying parent perceived barriers to entering the program.

Parent ratings of task were significantly associated with lower post treatment depression scores in the young people, as were higher facilitator ratings of goal. As such, it may be beneficial for facilitators to monitor the parents’ orientation towards these aspects of the therapy and relationship throughout group sessions in the program, in order to ensure that any parent ambivalence or uncertainty can be resolved. Previous studies into group parent-focussed interventions have only used total alliance scores, aside from Schmidt et al. (2014), who also found the task subscale to be comparatively more associated with outcomes than the other alliance subscales. As such, future research would benefit by including these subscales in their analysis to assess their comparative associations with outcomes in this area.

Future studies of the program would also benefit from having parents complete the alliance measure across all 8 sessions, rather than just sessions 2 and 5. While this would increase the burden on parent participants, it would allow a direct comparison between facilitator and parent alliance patterns. This change would also make sense in light of previous studies showing a greater association between parent ratings of alliance compared to facilitator ratings. In addition, a formal protocol explaining the alliance measure to all parents and outlining how it is to be completed should be introduced to future studies in order to ensure its correct completion.
CHAPTER ELEVEN

Study 2. A Qualitative Analysis of the Parent’s Experience of the Therapeutic Alliance and it’s Relationship with Therapeutic Processes and Outcomes

Study 2 Aims

The findings from Study 1 in Chapter 10 demonstrated a generally weak association between facilitator, parent, and young person alliance, and the positive impact the Family Options program had upon the depressive symptoms of the young people involved. Study 2 was conducted in order to gather rich data in relation to the parents’ experience of the therapeutic alliance. Specifically, the study aimed to explore aspects of the parents’ experience of the therapeutic alliance that may not have been captured by the Working Alliance Inventory (WAI). Furthermore, another aim of the study was to gather understanding into the individual, relational, group-specific, historical, and familial factors that may play an important role in alliance processes both related and unrelated to the WAI’s underlying model of alliance (task, goal, and bond) in a parent-focused group therapy context.

Method

Participants

The participants were 12 parents who participated in the Family Options study and who also agreed to take part in a qualitative interview about their experiences. The pool of 12 parents consisted of six parent participants from the BEST groups and six parent participants from the PAST groups, and included nine females and three males. The average age of the parents was 47.17 years ($SD = 4.00$). All interviews were conducted by the author of this thesis.
**Materials**

**Interviews.** Semi-structured interviews were conducted to gather detailed information regarding each parent’s experience of their participation in the groups. An interview schedule was designed to specifically gather information regarding the parents’ perception the alliance-based factors shown to be important within the alliance literature, which were alliance formation processes, and the impact of alliance upon therapeutic processes, group bonding, and treatment outcomes (Safran & Muran, 2006; Schmidt et al., 2014; Sexton et al., 1996; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). In addition, questions were included to gather information regarding the parents’ perceptions of their child’s views on the treatment, and how this may have impacted upon parent participation and alliance within the group. The interview schedule was structured as follows:

**Characterising the therapeutic alliance**

1. How would you describe your relationship with the facilitator?
2. Was your relationship very different with each of the facilitators? Did this impact upon things for you?
3. How important was your relationship with the facilitator compared to your relationship with other group members?
4. Did you feel differently towards the facilitator over the course of the group?
5. What specifically about the facilitator did you find helpful or unhelpful?
6. Can you talk about whether your assumptions or preconceptions about the group or the facilitators impacted upon your attitude or relationship towards the facilitators?

**Therapeutic alliance and outcomes of group**
1. Do you feel as though you have gained anything through your participation in the group? Could you describe what?

2. Can you comment on whether your relationship with the facilitator impacted upon what you got out of the group? How?

3. How important do you feel your relationship with the facilitator was in relation to what you got out of the group?

Young person’s attitudes towards treatment

1. Can you describe your child’s attitude towards the group?

2. Did your child attend the group and how did they feel about going?

3. Did your child’s attitude towards the group or attending the group impact upon your feelings about the group?

4. Can you comment on whether your relationship with the facilitator impacted upon your child’s participation in the group or their attitude towards the group?

5. Is there anything else you would like to comment upon?

All interviews utilised the interview schedule as the basis of initial prompting questions for parents. The interviewer then asked further individual questions based upon the parents’ initial responses to the interview schedule questions in order to more fully explore responses and encourage further elaboration. Individual parent interviews were conducted by telephone at a convenient time identified by the parent. All interviews were recorded with parent permission and the length of the interviews varied from 15 to 32 minutes.

**Procedure**

Ethics approval for the study was obtained from the Deakin University Human Research Ethics Committee (Appendix A). The intake assessment for all participating
parents included a question asking the parent if they would be interested in participating in an interview relating to their experiences in the Family Options program after program completion. The 12 parents interviewed were randomly selected from the pool of parents who answered yes to this question during the intake process. Six parents were randomly selected from BEST groups and seven parents (due to dropout) were randomly selected from PAST groups. Selected parents were then contacted by telephone and asked if they would like to participate in the interviews. The consent rate was 100%; however, one participant dropped out of the study during the interview period. As such, 13 parents were contacted in total. The parent interviews were conducted within a six-month period upon completion of the Family Options clinical trial. Both the student and parents conducted the phone interviews within their respective homes.

**Data Analysis**

Thematic analysis was selected as an appropriate methodological approach to achieve the aims of the study, as it focuses on identifying patterns (themes) within the data that facilitates it being analysed in a variety of meaningful ways. The study sought to fully explore the parents’ experiences related to alliance processes within the group and the potential implications these experiences had in relation to the parents’ therapeutic engagement in the group and parent and family therapeutic benefits from the group. The study also aimed to explore the potential impacts of these parent experiences in relation to the engagement of their young people in the treatment. Specifically, thematic analysis offers an effective way of achieving these aims by employing a range of analytic approaches that not only involve coding and theme development as directed by the content of the data, but also the identification of themes based upon existing concepts or ideas, or latent themes based upon concepts
and assumptions underpinning the data (Braun & Clarke, 2006). The flexibility thematic analysis offers in these approaches and techniques allows the data to be thoroughly described, interrogated, interpreted on both explicit and implicit levels to not only produce a rich description of the entire data set, but also to provide a detailed and nuanced account of one particular theme, or group of themes, within the data. Thematic analysis was therefore selected as an appropriate method to address all the potentially meaningful factors relating to parent alliance that the study aimed to identify.

The interview for each parent was transcribed verbatim from the digital audio files by the student, and double-checked for accuracy. Sample size was determined based upon the point at which saturation was achieved in relation to the novelty of parent responses. Thematic analysis was conducted as outlined by Braun and Clarke (2006), which involved a six-phase process. Initially, the parent transcripts were read and re-read in order to become intimately familiar with their content. During this process, initial impressions and potential themes about the data were generated and recorded. The transcripts were then analysed, and potentially important features within the data were tagged and collated into conceptual groups. The next phase involved examining the tags and collated data for implicit themes, in addition to latent themes underlying the concepts and patterns identified. Next, candidate themes were reviewed against the dataset to ensure they were representative of the data and relevant to the study aims, and were further clarified and refined. Identified themes were then subjected to detailed analysis to ensure the ‘whole story’ of the themes was captured in rich detail. Finally, themes were written up and explored using analytic narrative and relevant data extracts.
The validity and reliability of qualitative research is commonly measured based on Lincoln and Guba’s (1985) concept of ‘trustworthiness’, which involves establishing the evaluative criteria of credibility, transferability, dependability, and confirmability.

Credibility was established by random sampling of the parent participants; iterative questions during the interview; the accuracy of the data were checked at different stages of the interview; holding regular debriefing sessions and reaching consensus among researchers; conducting interviews beyond the saturation of themes in order to ensure the reliability and relevance of established themes; and analysis of finding in relation to previously established research.

Transferability was established according to previously established standards within the literature (Cole & Gardner, 1979; Marchionini & Teague, 1987). This involved providing detailed descriptions of each stage of the research process including sufficient contextual detail in relation to factors such as locations, data collection methods, the number and length of data collections, the time period over which the data was collected, and the people involved in data collection.

Confirmability was established by the inclusion of open-ended questions to reduce bias, using multiple participants groups, and discussing themes and interpretations with a second researcher until final themes were established. In addition, the interviewer employed self-reflection and self-monitoring to ensure personal biases and subjectivities did not unduly influence the research. Pseudonyms were used for all parents used in the following results section.
Results

Thematic analysis of the parent interview transcripts resulted in the identification of three major themes, which are discussed below. These themes were; The Alliance and Opening Up, Intervention Matters, and Familial Historical Context.

The Alliance and Opening Up

All of the parents in the BEST group and half of those in the PAST group reported experiencing a positive relationship with the facilitators. These parents also universally stated that the relationship with the facilitators was fundamental to them being able to engage comfortably and openly in the group.

(Margaret) I was quite happy to ask what I wanted to ask and related to what they were saying.

(Interviewer) So you felt quite comfortable to talk openly?

(M) Absolutely, to say anything, I could have said any of the curliest things and you wouldn’t have felt out of place saying it.

Another parent Sue commented that she was “very comfortable” speaking in the group and when asked whether this was the case from the first session she qualified “I think things do take time but as each session grew we got more relaxed and comfortable and felt more easy and open to talk”.

A male parent, John, reported feeling dubious about the group before commencing the program, and wasn’t sure if he would continue to participate in the group. He also commented that he initially felt quite uncomfortable sitting in the group. However, he reflected that the facilitators were able to help him relax and feel
more comfortable in the group within the first few sessions, which led to him to opening up and being able to ultimately get a lot out of the group:

(John) Yeah, I was right out of my comfort zone for the first week, I was like a fish out of water, and I think they even said that to me the next week, that I was much better, yeah but they were um very good but I was half not wanting to be there, so the first week was a bit stand offish.

(Interviewer) So you were a bit apprehensive in going initially?

(J) I was, I knew we had to go and do stuff, but yeah it was not my scene at all, I’d never been to anything like that ever before.

(I) So coming in with that kind of feeling, did the facilitators help with that?

(J) Yeah, they did – mainly [the main facilitator], he could see that I was way out of my comfort zone and he was pretty good to put everyone at ease – I think the first week it seemed like everyone was a little bit stand offish, so he was pretty good at sort of easing everyone into it and getting everyone to know everybody, yeah I found he was very good at that.

Several parents also reported feeling more ‘connected’ or comfortable with one facilitator more than the other. However, these parents’ comments indicated that as long as they felt a positive alliance with at least one of the facilitators, then they were able to feel comfortable, engaged, and open to discuss their issues and feelings within the group. Upon being asked if her relationship was very different with each of the facilitators, group member Jackie responded:
(Jackie) Yes, one day I had a horrible day and I spoke to [co-facilitator B] about that, and you could have a chat to her on that level, but I found it quite difficult to converse with her in a bigger setting than that. I think that she just kinda stood back, and I can understand why, and let [co-facilitator A] do it. So then you kinda think ok, and then everyone automatically goes to [co-facilitator A].

(Interviewer) And do you think that impacted upon things in the group for you at all?

(J) I don’t think it did at all because I don’t think it matters, if you get along with one and not the other, as long as you get along with someone.

In response to the interviewer who asked a father participant, Brian, to describe his relationship with the facilitators, he responded:

(Brian) Good, particularly the men I think because we were all a bit older men [another male facilitator filled in for two sessions] and we all had a similar perspective on things – I found I could talk quite freely with them. The young lady who did it with them was very nice, but just a bit of a different place in life I suppose. You know, didn’t have children and was doing post graduate studies or something – she was certainly terrific but a bit harder to get that connection going.

(Interviewer) And having that difference between the facilitators, did that have any impact on anything for you do you think?

(B) Well, no, I think it seemed to work ok.
Both these parents found it somewhat difficult to engage with one of the facilitators in the group; however, they each reported connecting well with the other facilitator. Importantly, there didn’t appear to be any negative consequence from their perspectives, as long as the parent felt connected to at least one of the facilitators. The latter quote also highlights other factors that may have an impact upon the alliance, such as compatible life stages and experience between the facilitator and parent that may help the parent feel more comfortable and relaxed when engaging. This parent highlighted that he could “talk more freely” with those facilitators who were the same sex and a similar age and who he perceived to have a “similar perspective on things”. This suggests that facilitators present to the group with a range of personal characteristics that will likely have varying compatibilities with each parent participant, so that each parent will have a natural tendency or predisposition in relation to how comfortable, open and compatible they feel towards them. It should also be acknowledged that the facilitators would also have similar tendencies and predispositions that may also impact upon their engagement with each parent; however, the degree to which this plays a role may be different due to the professional training and role the facilitators are engaged in. For example, the general counselling skills and professional training psychologists receive prepare them to function in a professional helping role, where their natural personal feelings in relation to specific individuals is not as influential in their general engagement with that person.

In addition, the parents’ accounts indicated that the experience, knowledge and expertise they perceived the facilitator had impacted upon their engagement and willingness to ‘buy into’ what the facilitator said. For example, a facilitator with no children could have been viewed as ill equipped to work with a parent-group dealing with child depression. Similarly, a young post-graduate student may be viewed as not
having adequate knowledge and experience, which might weaken the parents’ alliance with them, as it might be “a bit harder to get that connection going”.

Most parents also felt that their relationship with the facilitators had a direct impact upon the benefits they received from being in the group, even when those benefits were associated with people other than the facilitator. A male participant from a BEST group recounted that he felt as though his relationship with the facilitators helped him to open up to his daughter as well as the other group members:

(Simon) I think it goes back to what I was saying before that sense of empathy and understanding which came through all of them [the facilitators], that helped to build an understanding, which was a positive. And just when you find someone when you talk about personal things and you come across that situation of empathy you start to relax a bit and open up more and receive more as well.

(Interviewer) Did opening up more enable you to get more out of the group?

(S) I think so yeah, you know there was one specific time at the beginning where we had to write a letter to our child, and I found that an opportunity to really open up, not to just your own child but also to the other people within the group. And I suppose I felt comfortable in doing such a thing, even though the stories are different we all have a similar situation.

Simon’s report indicates that the alliance with the facilitator helped create a set of relations within the group where he felt able to “really open up” to both his child and the other group members. Within a group context, then, the alliance
between the facilitator and the parent seems to be particularly important to not
only enable meaningful and therapeutic engagement between the parent and
facilitator, but to also enable this kind of engagement between the other parents
and potentially the parent and child. His relationship with the facilitators seemed
to assist in allowing him to alter his approach to “relax a bit and open up more”,
and in doing so was also able to “receive more as well”. This suggests the
development of a positive alliance may be important in facilitating a ‘two-way’
process in which the parent is not only able to open up more and express
personal content, but is also aligned to receive and take in more content from the
facilitator and other group members. Taken together, these parent reports suggest
that the alliance with the facilitator was a fundamental element that enabled
therapeutic processes to take place within the group. Importantly, developing a
comfortable, open and non-judgemental relationship with the facilitator not only
enabled meaningful engagement between the facilitator and parent, it also
enabled meaningful engagement to occur between the parents themselves. Thus,
in many ways the alliance between the parent and therapist acts as a ‘lubricant’
to help form connection and cohesion within the group as a whole, in addition to
orienting group members to both contribute openly and receive content and
support from the facilitators and other group members.

**Intervention Matters**

Another major theme evident in the data was the impact that the intervention
type [BEST or PAST] appeared to have upon the alliance between the parents and
facilitators. In addition, and perhaps surprisingly, there were indications that the
intervention type may have also had an impact upon the relationships between the
parents themselves. In particular, the expectations parents had in relation to what the
facilitators would offer them in the groups appeared to be an important factor in influencing the development of that therapeutic relationship. Parents were found to vary in the degree to which they expected the facilitators to directly guide, inform, and teach them specific strategies and skills in relation to their depressed children, and these expectations interacted differently with each intervention. The BEST group offered facilitator taught skills and strategies, in addition to the facilitators providing general supportive counselling, and all of the BEST parents interviewed reported positive alliances with the facilitators. In contrast, the PAST group is structured around the parents supporting one another and problem solving together, while the facilitator provides general supportive counselling and facilitates parent discussion. Those PAST parents who had clear skills- and strategy-based expectations of the facilitators generally reported poor alliances with the facilitators. However, this did not occur in all these cases, and the ways in which dissatisfied parents responded when their initial expectations were not met was also found to play an important role in how the alliance developed. While the majority of parents who were dissatisfied with the PAST group reported poor alliances with the facilitators and with the other parents, a smaller number of parents who also expressed initial dissatisfaction with the group model were able to successfully adapt and develop positive alliances with the facilitators in addition to gaining benefits from engaging with the other parents in the group.

As all of the BEST parents reported positive alliances with the facilitators, the following discussion primarily focuses on the PAST parents, as 50% of the PAST parents reported positive alliances with the facilitators and 50% of the PAST parents reported sub-optimal alliances with the facilitators. As such, the following accounts selected and analysed sought to understand the underlying factors that led to these
parents having significantly different experiences within the same intervention. Generally, the BEST intervention appeared to cater for a wider range of parent expectations and parent-specific situational factors, while the PAST intervention appeared to cater for only a subset of these.

The PAST model utilises a non-directive approach that encourages dialogue predominantly between group members to share their experiences, support one another, and develop coping strategies and solutions in relation to their familial issues. Consequently, the facilitators within the PAST groups focussed upon generating meaningful dialogue between the parents to achieve these aims rather than directly teaching parent skills or offering clear problem-solving guidance and direction. The dissatisfaction expressed by these participants in respect to their relationships with the facilitators appeared to be fundamentally associated with dissatisfaction with the PAST intervention method. When asked how she would describe her relationship with the facilitators, Jenny from a PAST group responded “distant”. When the interviewer probed about a possible bond with the facilitator, Jenny’s focus was on the process:

“No, its because he let us just do whatever we wanted so there was no bond there”.

PAST group member Pam also made clear links between her feelings of distance to the facilitator and the PAST approach:

“Because he [the facilitator] didn’t want to have any sides or any input because our group was just helping each other basically, so he always stepped away and let us do whatever we talked. I think I would have liked
more leadership from him, but he probably couldn’t have done it because that was the experience [the group format], that people help each other, yes but for me that was not what I expected…I don’t feel as though the relationship with the facilitator was very important.”

Pam also expressed a similar sense of distance with the facilitator to that expressed by Jenny:

“… but by the end when I look at my involvement, we don’t feel that we are much closer [relationship with facilitator] if you put it that way, so the relationship with the facilitator is quite distant”.

Pam also stated that she felt disappointment in the facilitators due to her expectations that they would “endorse or guide us in a certain way”, and that she “started to learn that he [the facilitator] is not in a role to help me”.

Another PAST parent, Sue, also described negative feelings when speaking of her relationship with the facilitators that were related to the PAST approach:

“At points I got annoyed, because obviously we were in a group where they [the facilitators] weren’t really doing anything for us. I mean they were giving us information and that was good, but they weren’t really that helpful, and I guess that’s what they were meant to be doing, so yeah, occasionally you’d go “raaw” [makes aggravated sound]”.
Jenny, Pam, and Sue all expressed feelings of disappointment and frustration that were clearly related to their expectations of what the facilitators and group would offer before the group commenced. Interestingly, these parents also acknowledged that these issues were associated with the therapeutic approach employed in the PAST model rather than shortcomings associated with the facilitators themselves, regardless that they were unaware that there was another group with a different method. Nevertheless, these issues appeared to have an important impact upon the relationships these parents had with the facilitators. While this is perhaps initially surprising, the facilitators are the primary contact the parents have with the Family Options program and therefore any feelings of dissatisfaction and frustration the parents may have with the program itself may be projected onto the facilitators. Furthermore, while the issue of parent frustration or disappointment in relation to the group’s therapeutic model is related to the program’s overarching design and research aims rather than its facilitators, it is the individual facilitators who are enacting these program elements within the context of the parent/facilitator relationships in the groups. As such, negative emotional responses from parents are likely ascribed to the facilitator, as the therapeutic model itself is embedded within the relational interactions between the parents and facilitators.

The accounts from dissatisfied parents also suggested that they may have actively withdrawn or disengaged from their relationship with the facilitators as a consequence of not being able to get what they wanted or expected from the relationship. For example, Pam reflected that she came to realise that the facilitators were “not in a role to help” her after she directly asked one of the facilitators a question about her son’s situation. Upon finding the facilitators response not particularly “helpful or resourceful”, Pam commented that she didn’t “impose” on the
facilitator after that by refraining from asking them further questions. Similarly, Sue commented that early on in the group she came to a point “where you just stop asking, you know you stop asking them for help, you just come to an understanding of what they’re [the facilitators] willing to do and what they aren’t”. For these parents then, the facilitator was no longer viewed as a source of support or benefit, which not only impacted how the parent actively sought their support, but also impacted, and even negated, a range of parent/facilitator interactions of potential therapeutic benefit. This may be an important factor in the dissatisfied parents’ observations that their relationships with the facilitators failed to develop and remained distant.

In contrast, several points of difference were apparent in the accounts of those PAST parents who reported a positive alliance with the facilitators. A pervasive theme amongst those dissatisfied parents was ‘expectations not being met’. In contrast, this was not a theme amongst those parents who viewed the parent/facilitator relationship optimistically, which appeared to largely be due to them not having preconceived ideas of what to expect from the intervention. For example, parents Tina and Sandra reflected that they entered the group with no expectations at all, with parent Tina reflecting “I can honestly say I had no idea what I was going to be in for, I went in with an open mind in unknown territory and just see what happens”, while parent Sandra commented “I had no idea what I was walking in to, I went in with no idea and trying not to sort of jump to conclusions”. It is apparent that those parents entering a group with no expectations have a much lower chance of being disappointed, in addition to being more likely to be open to exploring what the group may have to offer. As discussed above, the dissatisfied parents reported distant relationships with the facilitators that failed to develop over the course of the sessions. In contrast Tina and Sandra both reported positive relationships with the facilitators that they felt
developed over time, with Tina commenting “I definitely felt more comfortable with them as time went on, but they made us feel comfortable at the beginning as well, so it just deepened the relationship”, and parent Sandra saying “The longer the group went on the more you got to know them [the facilitators] and relaxed and chat with, and you did feel more comfortable and at ease as time went on as with any relationship”. These parent accounts are consistent with and support the notion that the dissatisfied parents’ expectations leading into the groups had a significant impact upon their alliance with the facilitators.

Of note was an account from another PAST parent Lucy, who was similar to the other dissatisfied PAST parents in that she initially had some different expectations regarding the approach of the PAST group prior to commencing. However, she appeared to be able to adapt more successfully than the other dissatisfied parents and had a very different response to these expectations not being met:

“I believe that all of us in the group felt that it would be more prescriptive; and it was more of a support group, that’s how it sort of played out. It was explained to us fairly early on that that’s the format it would take, but none of us realised that before we went into it, and that was fine, you know that was ok, and it didn’t change our relationship with them at all”.

Being able to move past her initial expectations of what the group would offer allowed Lucy to continue without it affecting her investment in the group, and more specifically without it negatively impacting upon her relationships with the facilitators and other parents. In addition, as with Tina and Sandra, Lucy also reported that her alliance with the facilitators was very positive and deepened as the group progressed.
In trying to understand why Lucy was still able to have a positive experience regardless that she had similar expectations to the other dissatisfied parents that were also not met, another theme that appeared to help explain this became apparent. This theme was consistent among those dissatisfied parents and involved their assumptions regarding what the other parents in the group could offer them. Both parent Pam and Jenny expressed reservations about the likelihood of obtaining anything useful or beneficial from the other parents in the group. Pam reflected that “I think we were all at a dead end so we couldn’t really help each other very much, you would have expected someone there who knows more about these things”. Jenny also expressed concerns over employing strategies or advice from other parents in the group, stating “But there’s no certainty about whether that information [from other parents] is accurate or whether what they do is applicable to my own situation”. Jenny stated that she didn’t feel comfortable utilising the parents as a resource as it was not from a professional source and was therefore of questionable value. Similarly, Sue felt that “the other couples’ issues were different to ours” and as such felt as though they could not offer any support or advice that would be relevant to them. For these parents then, not only were they not getting what they expected from the facilitators, they also felt as though they weren’t able get anything of use from the other parents in the group. Conversely, Lucy expressed that she benefitted from sharing her experiences with the other parents, in addition to hearing the other parents’ stories and getting support from them, commenting that “it made me feel like I wasn’t the only one if that makes sense”.

Of interest is the question of whether the quality of the alliance between the parents and the facilitators may have had an impact upon the dissatisfied parents’ pessimistic viewpoint of what the other parents in their groups could offer. When
asked which relationships were more important, their relationship with the facilitators or with the other parents in the group, a clear difference was apparent between dissatisfied and satisfied parents in the PAST groups. The former rated their parent relationships as more important than those with the facilitators; however, this was generally framed as being due to the facilitator relationships not being important, rather than the parent relationships as being more important. While this difference may be subtle, it indicates disapproval towards the facilitators rather than an endorsement of the parent relationships. This is also consistent with the prior discussion indicating that the dissatisfied parents appeared to actively disengage from the facilitators, and therefore the parent relationships would be expected to be more important by default. Perhaps most revealing was that all of the dissatisfied parents reported not gaining anything from their engagement with the other parents, while the satisfied parents all identified their engagement with the other parents as the primary source of benefit from the group.

Comparatively, all of the satisfied PAST parents rated their relationships with the facilitators and other parent group members as equal. This is perhaps the most ideal scenario within a group therapy context, in which all members are equally connected and bonded. When asked if they got anything from their participation in the group a common theme emerged among the satisfied PAST parents that involved a normalisation of their experiences and a sense of not being alone in their struggles. Tina commented that “It was the knowledge that you weren’t on your own, that there were other people out there going through the same sort of issues, and you know it was helpful to know that you weren’t alone through the difficulties that you were experiencing”. Similarly, Sandra reflected that “I think that by knowing what I feel sometimes and my frustrations, all that sort of stuff – that its normal, and being able to
say some of the things out loud that I hadn’t allowed myself to think sometimes even though I know its there, yeah that helped”. For these parents, then, both opening up and expressing their experiences, in addition to being open to engaging with the other parents and receiving their experiences and viewpoints was of therapeutic value.

While their engagement and relationships with other parents was the primary source of benefit from the group for the satisfied parents, they still felt as though their relationship with the facilitator was just as important. All of the satisfied parents felt as though their experience and relationship with the facilitators was important in engendering a meaningful engagement with the other parents. Tina commented “I think if the facilitators weren’t engaging and friendly that you wouldn’t be willing to open up and share in the group, it would give a ‘tone’ over the group, I think they were good”. Similarly, Lucy reflected “I think if I didn’t feel comfortable with them [the facilitators] I wouldn’t have talked about what was going on and how it made me feel and all that, and I probably wouldn’t be better off if that were the case”. These comments are consistent with the theme identified earlier, in which a positive relationship between the parent and facilitator enables connections and cohesion between that parent and other group members, in addition to helping that parent be more open to expressing themselves and receive things from other group members.

Taken together, these observations and parent accounts support the notion that the lack of a positive alliance with the facilitators experienced by the dissatisfied PAST parents may have then impacted upon their subsequent engagement with the other parents in the group. The theme consistent with the dissatisfied parents that the other parent members in the group had nothing to offer may be partly a consequence of those parents not openly expressing their issues and experiences to the group, and not being oriented to receive meaningful engagement from the other group members.
Indeed, both Jenny and Pam indicated that they were somewhat quieter in the group compared to other parents, with Pam stating that she often sat back because she had a “tired attitude”. It is revealing that within the PAST group the only parents who rated their relationship with the facilitators as positive were also the only parents to describe their engagement with the other parents as beneficial.

Another potentially important area of difference between the satisfied and dissatisfied parents that may have impacted upon the dissatisfied parents’ alliances with the facilitators was certain rigid beliefs they appeared to hold that informed their expectations coming into the group. All the dissatisfied parents appeared to hold a belief that the group should be skills focussed and that the facilitator should be responsible for guiding the parents in developing these skills. These rigidly held beliefs appeared to be important differentiators between the dissatisfied parents (Jenny, Pam, and Sue) and Lucy, who also entered the group with beliefs in relation to skills but was still able to engage meaningfully once she saw this was not the case. As such, the degree to which parents held on to their beliefs about how the groups should be structured may have been an important factor in creating a barrier to the dissatisfied parents being able to meaningfully engage.

When analysing the parent accounts three general groups of parents became apparent that have distinct qualities and potential ramifications for the facilitator/parent alliance and the parents’ alliance with other group members. These groups are:

1. Expectations not met (Rigid): These parents were skills focussed with clear expectations that the facilitator should be solely responsible for guiding the parents in developing these skills. Implicit in this expectation is that the parents
were not there to open up and express themselves, or to share their experiences with other parents. In addition, this group of parents appeared to hold a belief that only skilled professionals such as the facilitator have valuable information, and as such information, guidance or support from the other parents should be rejected or treated dubiously. This group of parents failed to develop a positive alliance with the facilitators and actively disengaged from the relationship. In addition they were less communicative with other parent members, did not openly express their issues and were not aligned to receive support, guidance or experience from other group members. These parents reported not gaining any therapeutic benefit from the group.

2. Expectations not met (Flexible): This parent had expectations that the group would/should involve direction from the facilitators in relation to skills but was also open to seeing what the group could offer if this were not the case. The parent also viewed the other parents in the group as valuable resources with whom they could share experiences with and mutually learn from. The parent developed a positive alliance with facilitators and engaged meaningfully with the other parents. The parent was able to openly express personal experiences and struggles within the group and receive support, guidance and experience from other parents. The parent also reported gaining therapeutic benefit from the group.

3. No expectations (Open): These parents entered the group with no preconceived ideas or expectations of how the group should be and were open to experiencing whatever the group had to offer. These parents developed positive
alliances with the facilitators and viewed other parents as a valuable resource. They were able to openly express personal experiences and struggles within the group and receive support, guidance and experience from other parents. These parents also reported gaining therapeutic benefit from the group.

Each of these categories is potentially important when considering how parents may engage with a specific therapeutic approach. In the analysis presented here, there is evidence suggesting that the rigid group of parents may have problems when participating in non-directive support-type groups such as PAST, due to their inflexible requirement to receive facilitator led skills training. However, groups two and three are able to meaningfully engage with these types of groups, develop positive alliances and gain therapeutic benefit. In directive groups such as BEST, parents are able to not only learn specific strategies and psycho-education, but they also receive the benefits of non-directive groups such as PAST as parents still engage in sharing, bonding and gaining support from other parents. Consequently, BEST caters for all of these parent categories, and the parent accounts support this notion.

As discussed previously, all the parents interviewed from the BEST groups described positive alliances with the facilitators; however, there were some differences in the types of benefits parents received through their participation. Four of the six BEST parents interviewed identified skills-based changes in their parenting as being the primary benefit they achieved from their participation in the group; two parents identified benefits similar to those parents from the PAST groups. One BEST parent commented that her main benefit from the group was that it “made me feel I wasn’t so alone I suppose, that other people knew and understood”, while another parent identified being able to open up and share his experiences as being the most valuable
aspect of the group for him. The latter parent also commented that he had preconceived ideas of how the group should be before participating, and that by the second session he was satisfied that the group would meet those expectations. It is possible that if these parents had been allocated to the PAST groups they may not have had these initial expectations met, and consequently may not have developed positive alliances with the facilitators. This may have placed these parents in category one, then, in which the parents were not able to engage meaningfully and would not have obtained the benefits they were able to gain from the BEST group, even though those benefits were achieved by PAST parent participants in category two and three. While this is speculation, it highlights a potential limitation this analysis identifies associated with non-directive support-based groups.

**Familial Historical Context**

Another theme identified from the parent accounts was the ways in which the specific historical contexts of each family can influence not only alliance processes but also potential therapeutic outcomes for the families. A complex picture emerged where a range of factors such as the specific relational characteristics within the family and the family’s specific historical context in relation to mental health issues and treatment may interact with or independently of group processes to influence an individual family’s therapeutic outcome. One historical factor that appeared to be pertinent was the extent to which a family had previously engaged with mental health services. One of the dissatisfied PAST parents worked within the community mental health services and had prior experiences with treatment groups. She commented that she had found the PAST group “quite different to most of the focus groups” she had previously participated in, which had more of an emphasis on facilitator led skill and strategy development. As such, this parent likely had significantly more knowledge and
experience in relation to mental health issues and treatment groups compared to most other participating parents. This prior experience not only establishes expectations around how groups should be structured and run, her knowledge of mental health issues could potentially influence her role within the group and openness to other parents. Indeed, this parent reflected that:

“I feel that the group are almost limited to their capacity, you know that’s all they have, they cannot learn more apart from the [other] parents, so if I’m the parent with most of the resources I didn’t gain much from it”.

Consequently, this parent felt as though she could not benefit much from engaging with the other parents as she had more knowledge and experience in relation to mental health issues, and her prior experience oriented her to view the parents as being valuable only as a source of practical advice or information rather than people with whom she could express and share her struggles and experiences with.

Comparatively, one of the satisfied parents entered the PAST group with very different prior experience commenting that for her family, participation in the group “was very early sort of in our journey of his [her son’s] mental health issues and we hadn’t had a lot of help and support at that point”. While this parent commented that she gained a lot through sharing with other parents and not feeling alone in her struggles, she also commented that her husband, who had limited understanding and exposure to mental health problems throughout his life and was struggling with his son’s depression, benefitted greatly from his participation in the group. She reflected that:
“The group helped give him a much better understanding (of depression) through the sharing of other experiences - he ended hearing other people in the group who had similar experiences and how they handled things, which gave him a much better scope for how to deal with what was going on”.

This family had limited knowledge of mental health issues and had little support from mental health services previously. As such, their historical context was one in which they were open to gaining whatever they could from the group without prior knowledge or expectations influencing their engagement. These conditions allowed this family to achieve therapeutic gains for both the parents and their young person, while the previous parent’s family failed to achieve any therapeutic outcomes. Of note is the fact that both interventions resulted in overall significant reductions in post-treatment levels of youth depression, with no significant difference in the degree of reduction between interventions. As such, the parents from the previous family may have actually been able to achieve their goal of helping reduce their child’s depression if they had been able to engage more effectively in their group. This may indicate that the degree to which the parents successfully engaged within their group was of as much therapeutic value as the specific intervention their group employed.

Another factor that may play a role in the parents’ engagement with the group is the severity of the child’s current issues. While most of the young people in the PAST group reported varying degrees of passive suicidal ideation and there had been instances of past overdoses and trauma in the satisfied PAST parent’s young people’s lives, they were not current or recent events. Comparatively, two of the dissatisfied parents’ children were exhibiting more acute symptoms characteristic of a current
crisis period that would have likely been placing their parents under significantly more stress. One child had been displaying aggressive behaviours at home smashing items and threatening violence. This led to the parents recently calling the police out of safety concerns. The other child was reporting current suicidal ideation and had engaged in recent self-harm behaviours involving deep cutting. Parents in these circumstances are often overwhelmed and desperate to seek support that can provide immediate help for their children. It is therefore not surprising that these parents may have felt as though a non-directed group focused on other parents being the primary source of support and help would not sufficiently meet their needs. It is also not surprising that these parents may have feelings of frustration and disappointment in relation to the facilitator when they are viewed as ‘not helping’ in what the parents likely feel is a desperate situation. Furthermore, many of the parents participating in the Family Options program were referred by a child and youth mental health service in the region, which had very limited places and significant community demand. Consequently, many of the parents participating in the Family Options program may have already been frustrated due to feeling not supported by mental health professionals.

While most of the parents interviewed felt as though their relationship with the facilitators had a direct impact upon what they gained through their participation in the program, analysis of the parents’ responses indicated that relationship factors within the family can have beneficial effects independent of the parents’ alliance or the content in the group. For example, one of the PAST parents who was dissatisfied, reported poor alliance with the facilitators and felt as though she didn’t personally get anything out of the group, nevertheless she identified that her relationship with her
daughter had changed significantly in a positive way due to her participation in the group. She commented that:

“Our son realised we were trying to help him, I think from our point of view he appreciated us a bit more for doing that - he seemed to be more open to trying things after that. I just think he relaxed a bit more, I think for him he was less adversarial towards us, it was more like ‘they are trying to help me’ rather than ‘what are they doing to me’”.

Similarly, another satisfied PAST parent noticed a similar sort of change commenting:

“The only thing that [her daughter] got from it, was knowing that her father and I were prepared to do something to try and help her, and we found that that made a difference, especially having her dad go along because he doesn’t do that sort of thing, and for him to take time out of his day and make that attempt to go, it really had a big impact on her”.

These insights are potentially important as they show how parent-focussed interventions can have beneficial impacts upon disengaged depressed young people, even when those parents do not seem to be engaging meaningfully within the group. It also highlights the complex ways in which the specific conditions of familial relationships can interact with mental health services to engender beneficial change.

The analysis presented here informed by the parent interviews suggests that the formation of a positive alliance between the parent and facilitator plays an important
role in enabling that parent to meaningfully engage within the group in a number of therapeutically beneficial ways. The parent accounts revealed the alliance between the parent and facilitator as an important factor in being able to open up and share with the group; to connect with the facilitator and other parents in addition to their young person; and to orient the parent to be in a position to receive therapeutically beneficial information and interactions from the group generally. Revealingly, those parents who did not form positive alliances with the facilitators also found it difficult to meaningfully engage with the other parents in the group and generally reported benefitting little from their participation. In addition, the intervention used appeared to have an important impact upon the ways in which the parents engaged with the facilitators, and consequently a direct impact upon the formation of their alliance. A number of contextual factors are also likely to have an impact upon alliance processes in addition to therapeutic outcomes independent of the parent’s engagement with the group.

Discussion

In this study, parents from both the BEST and PAST interventions were interviewed in order to build upon the insights gained via the alliance data collected using the Working Alliance Inventory (WAI) in study one. Specifically, study two was aimed at extending our understanding into parent alliance by further exploring alliance processes that may not have been captured by the WAI, in addition to identifying and understanding other factors that may impact upon alliance processes, from the parent’s point of view. As very little qualitative research has been conducted into parent alliance, it was expected that the present study would provide rich data in relation to how alliance processes may differ within a parent-focussed intervention compared to other group- or individual-based treatments.
Consistent with previous qualitative research into client perspectives on alliance within individual therapy, the parents unanimously identified facilitator behaviours, such as being non-judgemental, supportive, and understanding as being fundamental to them being able to feel comfortable in opening up and discussing personal issues and experiences (Bachelor, 1995; Bedi, 2006b; Bedi & Duff, 2014; MacFarlane et al., 2015). These results also indicate that parents felt they could engage openly and meaningfully within the group as long as they felt as though they had a positive alliance with one of the facilitators, even if their alliance with the other facilitator was sub-optimal. As such, treatment clinics and mental health services that have the resources to provide more than one clinician in group-based treatments may benefit from doing so, as this will increase the likelihood that positive alliance formation can occur. In addition, if mental health providers identify diversity within a group of clients in relation to factors such as age, gender, and ethnicity, providing clinicians that may collectively reflect a greater proportion of this diversity may ensure a greater number of participants form positive alliances. For example, in therapeutic groups where participants range from young- to older adults, the mental health service may allocate both a younger and older group facilitator to run the group.

Another finding was that positive alliance formation with the facilitator appeared to be an important factor in facilitating subsequent therapeutic processes within the treatment, such as participants being able to more effectively complete group exercises, explore personal experiences and issues, and more effectively receive therapeutically important content from both facilitators and other group members. This finding is consistent with Fitzpatrick, Janzen, Chamodraka, and Park’s (2006) qualitative research in individual therapy indicating a “spiral effect”, in which therapist-based behaviours or “critical incidents” gave rise to greater client openness
and positive orientation towards the therapist, thereby positioning the client to engage in further therapeutically important processes and further building a positive alliance. The present findings suggest a similar process may occur in parent group settings, however further research is needed to establish the generalisability of this process.

The study also found that the formation of a positive alliance between the parent and facilitator was perceived by the parents as being an important factor in orienting them to form beneficial relationships with other parent group members. Parents who reported positive alliances with the facilitators also reported having beneficial relationships with the other parent group members, while in contrast; those parents who reported sub-optimal alliances with the facilitators also reported not having beneficial relationships with the other parent group members. While it may be that factors underlying relationship processes with the facilitator and other group members function independently, there were indications in the present study that this may not be the case. Parent accounts suggested that their relationship with the facilitators directly contributed to them being able to more openly and effectively engage with the other group members, in addition to orienting them to be open to receive content from other group members. As such, the facilitator/parent alliance may play a mediating role in helping parents develop more effective and therapeutically beneficial relationships with other group members.

These results suggest, then, that the parent/facilitator alliance has important consequences for both successful therapeutic and group bonding processes. It is revealing that those parents who reported poor alliances with the facilitators also reported that their relationships with the other parent group members were not beneficial, in addition to reporting that they did not benefit overall from the group. In contrast, those parents who reported having positive facilitator alliances also reported
the opposite trend. As such, the results presented here suggest that ensuring a positive client/facilitator alliance in a parent group settings is likely of primary importance before subsequent group bonding and therapeutic work can occur. This observation also supports the notion that alliance processes, and particularly the alliance with the facilitator, are as important, and potentially more important in the early stages of treatment, when compared to group cohesion factors. While these results provide insight into individuals’ experiences within a parent-focussed group setting, they are representative of a small sample of parents, and further research is needed to establish whether these observations are robust enough to be significant across different populations, interventions and settings using quantitative methods of investigation.

The study also identified that parent expectancies in relation to the treatment they received had an important impact upon alliance development. As families participating in this study were part of a clinical trial and were randomly allocated to either the BEST or PAST interventions, they were only given very general information regarding the groups and did not have access to details such as whether a group was skills-based or non-directive. As such, this scenario was somewhat artificial as most mental health services would provide detailed information to prospective group participants, and it is likely that one or more of the parents with discrepant treatment expectancies would not have chosen to attend the PAST group. However, it is also likely that many families face similar scenarios within general mental health care systems, as proximity to and availability of services and treatments may often dictate what treatments parents and families participate in. In addition, the pre-conceived ideas many mental health care consumers have regarding treatment specifics may be quite different to what they actually experience once they enter treatment. Research indicates that parent and family treatment programs have dropout rates as high as 60%,
with families from low socio-economic backgrounds and families with limited resources particularly at risk (Coard, Wallace, Stevenson, & Brotman, 2004; Fox & Holtz, 2009; Mendez, Carpenter, LaForett, & Cohen, 2009). Identifying whether client treatment expectancies play an important role in treatment drop-out and outcomes may help benefit the development of future therapies.

Three parents reported having discrepancies between their expectations of their treatment and the PAST model their group employed. Specifically, these parents held expectations that the group would be fundamentally skills-based, and that the facilitator would play a directive role in teaching the parents these skills. Two of these parents went on to develop sub-optimal alliances with the group facilitators, and their accounts revealed that their treatment expectancies were directly related to how they viewed their relationship with the facilitators. In addition, their expectancies appeared to have negative impacts upon bond formation (feeling distant to the facilitators) and their willingness to engage in and initiate discussions, even though they recognised their primary issues were with the therapeutic model and not the facilitators. In contrast, the remaining parent who also had discrepant expectancies went on to develop a positive alliance with the facilitators. In analysing the differences between these cases it became apparent that the parent who formed a positive alliance also held an expectation that she could benefit from her relationship with the facilitators and the other parents in the group, whereas the other two parents viewed both the facilitators and other parents in the group as not useful to them. The other three PAST parents interviewed all reported having positive alliances with the facilitators and all stated that they entered the group not knowing what to expect and were open to getting what they could out of the experience. The results presented here suggest that parent
expectations around treatment have a direct and important impact upon alliance development, which in turn has important impacts upon therapeutic engagement.

Research examining the relationship between client pre-treatment expectancies and treatment outcomes has been somewhat neglected within the field of psychological research. Initial interest in this area led to seven published studies between 1956 and 1963; however only eight further studies in the area were published up until 1989 (Greenberg, Constantino, & Bruce, 2006). There has been a renewed interest in examining client expectancy since 1990 that has resulted in several published studies. Overall, the findings have been mixed in regard to the relationship between client pre-treatment expectancies and treatment outcomes. Arnkoff, Glass and Shapiro (2002) reviewed 24 studies published up until 2000 and found that a significant positive association was found between client expectancies and treatment outcomes in 12 studies, while 7 studies had mixed findings and 7 studies found no association. Results have been relatively more consistent in the last 15 years with studies showing a positive association between client expectancies and outcomes in the treatment of a range of mental health issues, such as substance abuse, anxiety disorders, and depression (Fromm, 2001; Joyce, Ogrodniczuk, Piper, & McCallum, 2003; Price & Anderson, 2012; Price, Anderson, & Henrich, 2008; Rayfu & Kaur, 2012). Overall, research suggests that there is a relationship between client expectancy and treatment outcomes in individual therapy; however, further research is needed to establish the consistency of this relationship and what factors may influence or mediate its effects.

Very few studies have examined youth and parent treatment expectancies and treatment outcomes. Some studies have shown that discrepancies between parent expectancies and the focus and structure of treatment predict premature termination
from treatment (Furey & Basili, 1988; Nock, Phil, & Kazdin, 2001; Plunket, 1984).

Parent expectancies have also been found to uniquely predict barriers to treatment including perceptions that treatment is not relevant, missed sessions, and treatment dropout after controlling for other known predictors such as family socio-economic disadvantage, parental stress and depression, and severity of child dysfunction (Nock et al., 2001). Within the sample interviewed in the present study, two of the three parents with treatment expectancy discrepancies chose to prematurely terminate their treatment, and these decisions appeared to be directly related to expectations that led to believing the treatment was not appropriate or relevant. In addition, prior research has concluded that parent stress and mental health impacts upon their outcome expectations for their youth’s mental health treatment (Nock et al., 2001; Shuman & Shapiro, 2002). These studies showed that those parents with lower expectations also reported higher levels of stress and depression compared to parents who had higher treatment expectancies. These results may help explain the finding in the present study that those parents with children who had more acute symptoms and recent crisis behaviours had the lowest treatment expectancies. It is highly likely, given these parents’ recent family contexts, that they were experiencing comparatively more stress and emotional issues than the other parents reporting less severe recent issues who also reported an ‘openness’ to getting what they can from the groups. As such, the findings of the present study are consistent with prior research into the factors helping shape parent treatment expectancies, in addition providing further support that discrepancies between parent expectancies and treatment present a serious barrier to beneficial therapeutic outcomes for these families.

The observation in the present study that parent treatment expectancy appeared to significantly impact upon the alliance, while the alliance in turn appeared to
significantly impact upon therapeutic processes and ultimately treatment outcomes, may indicate that the alliance mediates client expectancy effects on treatment outcomes. Research into the possible relationship between client expectancy and the alliance has remained largely absent throughout expectancy research; however, since the late 1990’s a number of studies have begun to investigate this possibility.

Several studies have shown that client expectancies are positively associated with the alliance. Joyce and Piper (1998) examined the relationship between client expectancy, alliance, and treatment outcome in a sample of 64 adults receiving short-term psychotherapy for a range of affective and anxiety issues. The study identified three strongly associated expectancy-alliance relationships. Firstly, the client’s expectancy of treatment usefulness was directly associated with the client’s ratings of alliance. Second, the therapist’s expectancy of treatment usefulness was directly associated with the therapist’s ratings of alliance. Third, the therapist’s expectancy of session comfort (how smoothly the session would run) was directly related to the therapist’s ratings of the alliance. Measures of expectancy were found to account for 18 to 40% of the variation in alliance ratings. While expectancy was found to be directly and strongly related to alliance, it was found to be weakly and indirectly related to treatment outcomes. Constantino, Arnow, Blasey, and Agras (2005) examined the relationship between clients pre-treatment expectancies and the alliance when receiving either supportive-expressive-therapy (SE) or cognitive therapy (CT). Results indicated that expectancy was positively associated with client-rated early alliance in SE, in addition to client-rated mid-treatment alliance in both SE and CT.

In light of these results, researchers have begun to examine the possibility that the alliance mediates the positive relationship between client expectancies and treatment outcomes. Meyer et al. (2002) analysed data from the Treatment of
Depression Collaborative Research Program and found that the previously reported positive correlations between patient expectancies and outcomes (Sotsky et al., 1991) were mediated by the patient’s contribution to the alliance. Joyce and colleagues analysed data from two prior studies showing a positive association between client expectancy and treatment outcomes and found in both cases that the alliance mediated the expectancy/outcome relationship (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004; Joyce et al., 2003). More recently, a study examined this relationship and found that all three expectations factors used were associated with the alliance; however only one of these factors was associated with treatment outcome and the alliance was not found to mediate this effect (C. L. Patterson, Anderson, & Wei, 2014). Finally, McClintock, Anderson, and Petrarce (2015) provided evidence for a three-path mediation model, in which the effect of client expectations on treatment outcome is mediated by alliance, which in turn is mediated by client positivity leading to improvements in client symptoms and functioning.

Overall, the limited studies to date indicate that the alliance may play a mediating role in the relationship between client expectancies and treatment outcomes. The results of the present study are consistent with this model based upon the following findings. Firstly, overall those parents who reported discrepancies between their treatment expectations and their treatment also reported no benefits from their participation in their group. Second, these parents also reported poor alliances with the group facilitators that appeared to be directly related to these expectations. Third, parent accounts suggested that the alliance was fundamentally important to them being able to engage therapeutically with both the facilitators and other group members. In the one instance where a parent had initial discrepancies between her treatment expectations and the group model but went on to gain therapeutically from the group,
this seemed to be based upon additional expectancies that she could benefit from her relationships with both the facilitators and other group members. As such, the overall relationship between expectations and alliance likely involves the sum of expectancy factors in relation to a range of treatment, facilitator, and group member variables. This suggests a process in which client expectations can play a key role in alliance formation, thereby significantly impacting upon the alliance-based potential for that client to therapeutically function within therapy, and ultimately impacting upon treatment outcome. Furthermore, previous mediation studies have involved individual therapy, and the present study suggests that this relationship may extend to group-based scenarios.

The current study also identified specific familial contextual factors that may have impacted upon alliances processes. Dissatisfied parents from the PAST group had children with comparatively more severe recent symptoms than other interviewed parents, which had resulted in recent crisis events such as self-harm or aggressive behaviours. These parents were clearly distressed by their child’s behaviours and the impact it was having upon their family as a whole. Prior research has shown that group members with more acute problems tend to project to a greater degree onto the facilitator, and that these projections also involve that member’s needs, fears, and interpersonal style (Kivlighan, Marsh-Angelone, & Angelone, 1994).

The dissatisfied parents in the present study likely had feelings of frustration, disappointment, and potentially anger associated with their previous attempts to help their child. It may be that these parents’ disappointment in the facilitators and distant relationship they reported to have with them may have involved a projection of these feelings once they were viewed as ‘not being able to help’. It is also worth noting that these parents acknowledged that the facilitators clearly outlined the theoretical basis of
the group model, and were informed that the group used an evidence-based approach shown to be effective. Even so, these parents still rejected the group and facilitators based on their expectations that the facilitators should have been more directive in teaching them skills and strategies, as they viewed them as the ‘professionals’ who could help. The fact that these parents rejected an evidence-based intervention based upon a perceived failure of individuals within the group (the facilitators) is consistent with the proposition that these parents may have been projecting feelings such as personal frustration, failure, inadequacy or helplessness onto the facilitators. Projection processes may have also contributed to these parents’ tendency to view other parents in the group as not having the resources, knowledge, or expertise to offer them anything of benefit as they may have viewed themselves in this way. Study 1 showed that BEST and PAST were equally effective in significantly reducing the young people’s level of depression, and therefore the issues discussed above present potentially serious barriers to treatments associated with non-directive interventions such as PAST, where these potential client-based barriers to treatment may be more likely to occur.

**Final Comments, Limitations, and Further Considerations**

The present study had limitations common to those of other qualitative studies using small sample sizes. While interviews were conducted to a point where saturation appeared to occur regarding the themes that were present in the data collected, the extent to which these findings can be generalised beyond the specific group of individuals involved in these interviews is limited. In addition, while the interviews provided rich data from the perspective of the parents, conducting interviews with the facilitators attending the groups with these parents would have provided a potentially valuable comparison. Study 1 showed a generally poor correlation between facilitator
and parent ratings of alliance, suggesting that there might be significant differences between the facilitator and parent perspectives of the same relationship. Therefore, capturing data from both perspectives may have provided valuable insights into how the parent and facilitator experiences and perspectives of the alliance tended to differ.

Overall, the findings of Study 2 were consistent with previous research indicating that the alliance plays an important role in achieving positive therapeutic outcomes. The present study also identified several areas of potential interest for future studies investigating parent-focused interventions. Parent treatment expectations were identified as a potentially important factor impacting upon alliance development and overall parent treatment outcomes. Therefore, gaining a greater understanding into these processes and how to mitigate negative expectation-dependent effects may inform more effective intervention development. The study also identified several family contextual factors that may warrant further research. Future studies into parent-based interventions may benefit from assessing factors such as the severity and duration of their child’s issues, the parents’ views of themselves as parents, and the levels of family stress and functioning in relation to the alliance and treatment outcomes. In addition, it may be of benefit for facilitators, particularly in non-directive treatments, to specifically discuss any doubts parents may have in relation to the structure and therapeutic approach of the group, so that issues such as projection, discrepant expectations, or other barriers to treatment can be openly addressed and resolved.
CHAPTER TWELVE

General Discussion

Chapter Summary

The overall aim of this thesis was to examine the relationship between parent alliance with the facilitator in a parent-focussed group intervention for youth depression, and treatment dependent changes in youth depression. Initially, a brief rationale for the aims of this thesis and a description of the Family Options program will be outlined. Following this, the general aims of Study 1 and Study 2 will be outlined followed by a discussion of their respective findings and their implications in relation to previous research and future development of parent-focussed interventions. The limitations of the study will then be outlined and discussed in relation to how these limitations may be addressed in future studies. Finally, the thesis will be concluded summarising the major outcomes of this thesis and suggestions for future research directions.

Summary of Findings and Overview of Results

The therapeutic alliance has been shown to have a robust moderate effect on therapeutic outcomes in individual therapy (Hovarth & Bedi, 2002; Hovarth & Symonds, 1991; Martin et al., 2000), and the comparatively limited amount of literature examining alliance in youth therapy suggests it impacts outcomes to a similar degree (Karver et al., 2006; McLeod, 2011; Shirk & Karver, 2003). However, due to the lack of a clearly defined model of youth and parent alliance, much of the alliance research contains studies using poorly defined concepts of alliance, and there is a lack of consistency in measures used to capture alliance processes across studies. The most recent meta analysis conducted (McLeod, 2011) only included studies that
used alliance measures compatible with Bordin’s (1979) well established model of alliance. The analysis included the most studies of any meta analysis of alliance in youth therapy to date (38 studies) and found the relationship between both youth and parent alliance, and treatment outcomes to be small. As such, it is currently unclear if alliance processes in youth therapy play as significant a role in therapeutic outcomes when compared to individual adult therapy.

The focus of this thesis was examining the relationship between the facilitator-parent alliance and treatment dependent changes in youth depression in the Family Options program. The Family Options program was a randomised controlled trial assessing the efficacy of two parent-focused interventions in the treatment of youth depression, which were The Behaviour Exchange and Systems Therapy – MOOD (BEST MOOD) program and the Parent and Adolescent Support Training (PAST) program. The MOOD (BEST MOOD) program was designed to address mental health issues in youth, with an emphasis on youth depression, in addition to providing support and benefits for the parents and siblings of depressed youths. The program’s development was based upon the significant challenges mental health services face in engaging and retaining young people in treatment programs such as BEST MOOD potentially offer an alternative treatment pathway for families in which a young person is refusing mental health support. The PAST intervention provided a ‘treatment as usual’ condition in the trial representing standard practices currently available in Australian mental health services, where if any parent service is offered, it is likely to consist of a parent support group.

Study 1 of this thesis, which was discussed in chapter 10, was designed to examine the relationship between the alliance across time and any changes evident in the young person’s post-treatment depression. This was achieved by assessing the
degree of linear slope of facilitator alliance ratings for each parent in relation to whether their young person had undergone a reduction of ‘measurable change’ in their post Small Moods and Feelings questionnaire (SMFQ). In addition, early and mid-treatment facilitator, parent, and young person (just mid-treatment alliance was assessed) alliance scores were also examined for their associations with post-treatment depression changes.

The findings demonstrated that the degree of linear slope of facilitator alliance for each parent was not a significant predictor of post-treatment depression changes within this sample of youth. While the association approached significance, indicating that there may be a real relationship between these two factors, the results obtained suggest it is unlikely to be clinically significant. The small sample size obtained in the study, however, placed limitations on how the alliance over time could be assessed. While the power analysis conducted for Study 1 suggested adequate power to detect measurable change on the SMFQ, the limited sample size means the results obtained in these analyses should be interpreted with caution. A larger sample size would have provided greater power, thereby providing the conditions for a more sensitive measurement of changes in depressive symptoms that may have yielded a significant result in the logistic regression analysis.

A larger sample size would have also allowed a more sophisticated approach in assessing the various patterns of alliance across time, in which discrete groups of differing alliance trajectories within the parent sample could each be assessed for their relationship with depression outcomes. As such, while the current study suggests that the degree of linear change across time is not a significant predictor of outcome in this study, it may be that specific patterns (which may or may not be linear in nature) have a stronger relationship to changes in depressive symptoms.
Another limitation of this study was that the nesting of clients in groups was not addressed. Therapy was delivered by particular facilitators to particular groups of participants in a number of different locations. The nesting of clients within these groups may have had associated location-, facilitator-, and client-specific effects that impacted upon alliance development and alliance dependant processes. Statistical approaches, such as multilevel modelling, are ideally suited to assess these kinds of nesting effects; however, unfortunately the sample size obtained in the present study provided insufficient power to conduct these types of analyses.

In addition, study 1 also showed a limited association between both parent- and facilitator-rated early and mid-treatment alliance ratings and post-treatment youth depression changes. Only the week two parent task and week five facilitator goal subscales of the Working Alliance Inventory were found to significantly associate with changes in depressive symptoms, suggesting that most of the components of the alliance construct were not important contributors to the main therapeutic outcome in this study. Research has shown that early alliance ratings within individual adult therapy predict therapeutic outcomes, while late alliance ratings are more predictive of outcomes in youth therapy (Karver et al., 2006). It may be that parent alliance at various stages of treatment also has different predictive associations with outcomes, and as such future research would benefit from assessing alliance ratings from other treatment points, such as pre- and late-stage ratings. Alternatively, it may be that parent alliance is simply not an important factor in parent-focussed interventions for youth depression.

Previous studies demonstrating a predictive relationship between parent alliance and treatment outcomes have focussed upon externalising disorders (Kazdin et al., 2005; Kazdin et al., 2006; Schmidt et al., 2014). It may be that parents are more able
to have a direct impact upon overt, behaviour-based issues such as their child’s aggression and hyperactivity when compared to child internalising issues such as depression. Furthermore, these impacts are likely highly dependent upon the development of clearly defined changes in parent management strategies, which are relatively straightforward skills-based therapeutic goals. As such, the process of positive alliance facilitating greater therapeutic engagement and consequently greater parent management changes may be more directly related to treatment outcomes than the relationship between alliance and youth depression changes.

The fact that both the BEST MOOD and PAST interventions significantly reduced the young people’s depression to a similar degree suggests that this process was not significantly skills-based, as the PAST approach does not involve formal skill development. If the therapeutically beneficial factors associated with these interventions are not skills-based, it may be that they involve other therapeutic factors that are not as directly dependent upon the specific strength of the alliance. As such, just having a ‘good enough’ alliance to be able to participate adequately in the group may be sufficient for these factors to exert their influence. For example, one parent may have a very strong alliance with the facilitator, while another parent has an average alliance. However, these conditions are both sufficient for these parents to bond and share experiences with the other parents in the group, which can result in a therapeutic reduction in parent stress, more open exploration of personal and family issues and a consequent positive change in the way these parents engage with their young person at home.

In addition, the findings from study 2 identified factors independent of the therapy that appeared to have a positive impact upon the relationship between the young person and other family members. This was evidenced by multiple accounts by
parents expressing that the act of them simply committing to the program in order to help their child affected their relationship with their child. These parents reported that this act of caring and ‘good will’ meant a lot to their children, and resulted in changes in their child’s attitudes and relational interactions, which the parents believed led to improvements in family relationships and functioning. Potential therapeutic benefits such as these are not dependent upon factors associated with the intervention itself nor the quality of the parents’ alliance or engagement in the group, as the parent simply attending the program is all that is required. It may be that these kinds of ‘peripheral’ therapeutic effects are more likely to occur in cases where the young person suffers from an internalising disorder, such as depression or anxiety. In cases such as these, the young person may be more likely to perceive the basis of their parent’s participation in the treatment as being due to them wanting to help and support their child, as the presentations associated with these issues do not necessarily result in struggles for control or conflict between the parents and young person. In contrast, young people with externalising disorders may be more likely to view their parent’s participation in a similar program as being an attempt to control or stop them from misbehaving rather than an act of love and support.

Study 2 provided further evidence that general therapist-based counselling techniques, such as empathic and reflective listening, being non-judgemental, exhibiting unconditional positive regard towards clients, and providing space and support for group members to explore and express their feelings and experiences are important skills in creating the necessary conditions in which therapeutic change can occur (Bachelor, 1995; Bedi et al., 2005; Fitzpatrick et al., 2006).

Parent treatment expectancies also emerged as an important factor that had negative impacts upon alliance development, subsequent group bonding and
therapeutic engagement, and treatment outcomes. Given these substantial treatment consequences, it may be beneficial to explicitly discuss parent treatment expectancies in parent-focussed interventions and their potential to sabotage beneficial treatment outcomes. This is likely to be more pertinent to non-directive interventions, such as the PAST approach used in the present study, where parents may be more likely to struggle to see a clear link between their participation in the group and therapeutic benefits for their child’s mental health issues.

Overall, study 1 indicated that alliance was not a particularly significant factor in treatment outcomes, while study 2 suggested that alliance was an essential factor in the parents’ ability to therapeutically engage and benefit from the group. Taken at face value, these results may appear to be contradictory, yet this is not necessarily the case. As alluded to previously, it may be that just having a relatively positive alliance was sufficient for parents to be able to therapeutically engage in the groups, and a comparatively stronger alliance did not necessarily have a direct impact upon greater therapeutic gains. Consequently, once parents passed this ‘threshold’ of minimum alliance strength required, further increases in alliance weren’t therapeutically important. As such, it may be that the overall level of alliance is a more important factor than the degree of linear change over time or specific alliance ratings at different stages of treatment; however, further studies are required to test this latter possibility.

Another possibility explaining the results between the findings of studies 1 and 2 may be due to specific factors associated with parent-focussed interventions. Due to the nature of parent-focussed interventions where the target of the therapy (the young person) is not directly involved in alliance processes, it may be that the therapeutic actions of the alliance components are largely negated with regard to the young
person. The established relationship between the alliance and treatment outcomes in individual adult and youth therapy are based on scenarios in which the identified client actively forms an alliance with the therapist. As such, the client can benefit from any intrinsically therapeutic alliance-based processes as they are directly involved in these relational exchanges. From a psychodynamic perspective, the therapeutic relationship itself is thought to have therapeutic and healing properties that are inherent to the relational exchanges between the therapist and client (Manetta, Gentile, & Gillig, 2011). The maladaptive issues of the client are thought to manifest within these relational exchanges and as such the relationship itself becomes an object of scrutiny and a vehicle of change (Holmes, 1999). The target young people in parent-focussed interventions are largely removed from these relationship-based therapeutic processes, and as such are therefore not directly subject to their therapeutic effects. It may be, then, that parents are in a position to benefit from these alliance-based processes, however these benefits may not have a direct relationship to changes in the young person’s depression. The goal subscale within the Working Alliance Inventory (WAI), for example, measures the degree to which the client and therapist agree in regard to what the goals of the therapy should be. This makes sense in individual therapy, as the work and commitment necessary for personal change would be unlikely to occur if the client was not invested in achieving the goals of the therapy or goals stated by the therapist. However, this relationship does not exist within a parent-focussed intervention, as regardless of how much the parent agrees with the therapeutic goals, the target young person may or may not be interested in changing anything and is not involved in this exchange.

This is not to say that the therapeutic strategies and goals of the therapy are not appropriate, indeed the results of this study indicate that both interventions tested
were effective. It may be that the effects of the alliance constructs tested are only directly related to participants actively involved in those alliance processes, and as such are not directly related to outcomes in a parent-focussed intervention.

It is possible that another factor could mediate parent alliance-based effects in relation to treatment outcomes such as changes in the young person’s depression. For example, greater parent alliance may predict greater change in positive parenting styles, which may then predict greater reductions in youth depression changes. As such, future studies of the Family Options program and other parent-focussed interventions may benefit from including alliance mediation studies assessing potential family- and young-person-based mediation targets.

**Study Limitations and Further Considerations**

The studies presented here are not without limitations, which will be discussed in this section. The measure used to assess youth depression changes in the sample consisted of a self-report measure completed by the young people, and research indicates that levels of youth depression are inconsistent across different informants (child, parent, teacher, or peers) (Kazdin, 2013). In addition, it has been suggested that children’s self-reports of anxiety and depression symptoms tend to decline with repeated measures (Michael & Merrell, 1998). As such, it is possible that the pre- and post-treatment measures of depression used in study 1 were not sufficiently accurate; however, this issue only relates to depression changes rather than the presence of depression, as all young people were also independently assessed for the presence of clinical levels of depression based upon DSM-III criteria by trained assessors.

As previously discussed, another limitation of the study was the limited sample size. This placed limitations on the nature of the analysis possible in study 1. Whilst the results of study 1 indicated that the alliance plays a relatively small role in youth
depression changes, a larger sample size may have provided a more significant result. The Family Options Study aimed to recruit a minimum of 160 families into the study, which would have provided the power to detect small or moderate alliance effects, in addition to providing a sufficient sample size to conduct more sophisticated analyses of groups of alliance trajectories and their relationship to depression changes.

A total of 247 families were referred to the Family Options program, the vast majority of whom were referred by a major regional child and youth mental health service (CYMHS). Of these 247 referred families, only 51 families completed treatment. In addition, the 247 referred families represented a very small proportion of parents (less than 10%) who agreed to be contacted by Family Options after being offered the referral by CYMHS. Fifty-seven-per cent of parents who agreed to be contacted by Family Options then declined to participate in the study. Of these parents, 17 parents cited logistical reasons while 124 parents cited personal reasons.

The significant challenge the Family Options program experienced in recruiting adequate numbers for the study is of obvious concern. In particular, one of the primary aims of the program was to develop a treatment pathway for disengaged depressed youth by primarily working with the depressed youth’s parents, in addition to inviting any siblings and the depressed youth to participate in the program. The program sought to address serious issues associated with the current treatment model for youth mental health treatment, in which figures estimate up to 75% of children and adolescents fail to follow-up on referrals or complete treatment, while within Australia less than 20% of youths with a diagnosable mental health issue actually receive treatment (2011; Robbins et al., 2006).

One of the more obvious potential barriers predicted in relation to recruiting parents into the study was the logistical challenge many families may face in
coordinating their normal family routines whilst one or both parents attend a two hour Family Options session one week night per week for two months. Surprisingly only 17 parents cited logistical reasons as the basis for their decision to not participate in the study, while 124 parents cited personal reasons. These parents had already contacted CYMHS in order to seek support for their young person, and CYMHS only offered appropriate families a referral to the Family Options program upon being placed onto their waiting list. As such, these parents were already motivated to seek professional help as they had already initiated contact with CYMHS, and were in a position where their depressed young person could not be treated by CYMHS for approximately three months or more (average CYMHS wait list time). It seems likely then, that the majority of parents declined to participate in the Family Options program based upon the parent-focussed model being offered, as this was the primary difference between the services CYMHS and Family Options offered. It is of particular importance then, to understand what specific barriers were associated with the parent-focussed model that resulted in such a poor consent and participation rate.

Future studies involving the Family Options program would benefit by collecting and collating detailed information in relation to the nature of the ‘personal reasons’ predominantly given by parents declining the Family Options program. This information could then be used to design more effective processes during the initial engagement phases with interested families to help reduce low consent rates. During the studies presented here, the Family Options intake team reported some potential barriers associated with the parents’ perceptions of the program that future studies may need to address. One common issue reported was that some parents appeared to view the program as primarily helping parents rather than helping their depressed child. Indeed, the BEST MOOD and PAST interventions were designed to also help
improve parent stress and mental health, and this was included as an aim in the basic information conveyed to prospective parents. As such, some parents may have viewed the Family Options program as primarily a ‘parent support’ program, rather than a program that potentially offers mental health changes for their young person. For parents who feel they are in a desperate situation with regard to their child needing treatment, parents viewing the program in this way may view the service being offered as not appropriate. Future research into the Family Options program may benefit from placing a greater emphasis on the depressed child as being the main therapeutic target, as this aspect of the treatment is what parents are invested in most.

It is also likely challenging for some parents to understand how working with them could have a significant impact upon their child’s depression, particularly if they view their child’s depression as ‘not their issue’ and that it is the child that needs to deal with the issue. Most parent-focussed approaches to date have focussed on treating child externalising disorders, and it may be easier for parents to see how their actions could help in changing their child’s overt behaviours. It is probably less intuitively clear for many parents how they may significantly influence the internal states of their child. Future Family Options studies, and other parent-focussed interventions designed to treat youth internalising disorders, may have to more clearly communicate that the intervention is designed to improve their child’s depression and outline the basic principles as to why parents can influence this.

Another factor that may have been a barrier to parents participating in the Family Options program is the higher rates of poorer family functioning and parent mental health issues associated with families who have a young person with depression. A recent nationwide survey assessing the mental health of children and adolescents released by the Australian government showed that the incidence of youth
mental health issues increases dramatically as the level of family functioning decreases (Lawrence et al., 2015). The survey revealed that over 10% of families with ‘very good’ functioning had young people with a mental health issue, while over 35% of families with ‘poor’ functioning had a young person with a mental health issue. In addition, the prevalence of youth mental health issues has been reported to be between 30 – 50% in families where a parent also has a mental health issue (Nicholson, Biebel, Hinden, Henry, & Stier, 2001). As such, many of the families being contacted in relation to potentially participating in the Family Options study likely had low levels of family functioning and higher levels of parent mental health issues and parental stress. These factors represent significant barriers in relation to parents having the personal coping and organisational resources required to commit to and participate in the demands of a two-month program such as Family Options when compared to their child receiving direct support from a child and youth mental health service.

Another potential barrier that may have impacted upon parents entering into the Family Options program was anxiety related to their views of themselves and their parenting competency. Research shows that parents’ sense of parenting competency is negatively associated with the degree of severity of their child’s mental health issues (Preyde et al., 2015). The prospect of a parent entering a parent-focussed program such as Family Options may be quite confronting for parents with perceived low levels of parenting competency, who may feel as though they will be blamed or be ‘exposed’ as being a ‘terrible parent’. It may be important to pay particular attention to how programs such as Family Options are being described to prospective parents, so that potential negative reactions based upon parenting insecurities can be minimised and addressed. Identifying and addressing the barriers that resulted in the low recruitment rate into the program is of vital importance moving forward, not only
in relation to the Family Options program, but for designing effective parent-focused treatments in circumstances where the young person is refusing to engage with mental health services.

In considering alliance research more broadly, the present study reflects the potentially significant variation alliance effects may have in different treatment contexts. The present study found minimal evidence supporting the notion that greater facilitator/parent alliance results in better therapeutic outcomes for young people, which is inconsistent with some studies assessing alliance in parent-focused interventions. However, the present study differed to these studies in that prior research has been conducted on youths with externalising disorders, while the present study assessed youths with depression. Thus, differences in factors such as clinical population, therapeutic modality and treatment setting may impact upon the importance and function of alliance processes, and further research is needed to assess how these factors may influence the relationship between alliance and treatment outcomes. In addition, other factors such as family relational patterns, client and parent attachment styles, and levels of parent and family functioning may have moderating effects on alliance and associated outcomes.

Given the complex nature of these potentially important research questions, youth alliance research, and alliance research generally, would benefit from a more consistent approach in relation to its theoretical underpinnings and psychometric measurement. Alliance research generally, has suffered from a lack of consistency in the measures used across studies, in addition to the lack of a unified model of alliance underpinning these measures. These issues are even more apparent within the field of youth alliance research, where measures based upon adult alliance are predominantly
used. It is presently unclear, however, as to whether alliance processes are as important for positive therapeutic outcomes in youth therapy.

The recent development of therapeutic approaches utilising delivery via technology are also raising important questions about the role of alliance processes in treatment outcomes. Treatments utilising email, chat technology, video conferencing, or purely internet-based treatments are now being developed. Many of these types of treatments have now been shown to be effective where there may be no therapist, or the therapist has very limited contact with the client (Sucala et al., 2012). These approaches are calling into question the commonly held belief within the psychological field that the therapeutic alliance is an essential component of therapeutic change. Models of alliance, and the measures constructed to assess the quality of alliance, were conceived within an historical period in which the relationship between the therapist and client was a central feature of the therapy itself, such as in psychodynamic therapy and client-centred therapy. It is not surprising, then, that alliance models and alliance measures reflected this, and in ‘relationship-based’ therapeutic approaches such as these alliance processes likely play an important role in relation to beneficial outcomes. However, it may be that therapeutic approaches in which the therapist/client relationship plays a minimal role may still be effective, and alliance processes within these therapeutic contexts are not as important for positive outcomes. As such, the use of technology in developing new models of therapeutic interventions may fundamentally challenge the current paradigm placing alliance as a central feature of therapeutic change. Rather than being a central feature of therapeutic change generally, alliance may come to be viewed as an essential feature of ‘alliance-based’ treatment modalities.
Conclusion

Parent-based interventions offer an important alternative treatment pathway for families who have a young person with mental health issues who is also refusing to engage with mental health services. The aim of the Family Options study was to help reduce adolescent depression, in addition to helping relieve parental and family stress, and improve family functioning. The work presented here aimed to assess the relationship between the therapeutic alliance between the parents and facilitators in relation to its associations with post-treatment depressive outcomes for the young people and within the broader context of the parents’ experiences within the groups.

Overall, the research and discussions presented in this thesis indicate that parent-focussed interventions can be effective in reducing youth depression. In addition, while the Family Options program was effective in reducing adolescent depression, parent alliance was likely a clinically insignificant factor in this process. The results presented in this thesis support previous research findings in group therapies indicating that facilitator-client alliance tends to conform to a linearly increasing pattern over time. In addition, the findings provide further evidence that early-treatment ratings of parent alliance are more associated with young person outcomes than later-treatment ratings of alliance. Further, parent ratings of the task subscale of the Working Alliance Inventory parent were found to be more associated with young person outcomes than the goal and bond subscales.

The development of a positive facilitator-parent alliance was also found to be an important factor in parents being able to therapeutically engage within the groups and bond with other group members. It may be that parent alliance effects are mediated by other factors that may have a more direct relationship with the young person’s depression outcomes, such as changes in parenting styles, and future research is
needed in order to assess these possibilities. The findings also identified other factors, such as parent treatment expectancies, that appear to have important consequences for alliance development. Further research in these areas may inform the development of more effective parent-focussed treatments.

Finally, the results presented here suggest that parent-focussed interventions offer a potentially effective alternative treatment pathway for families with a disengaged depressed young person. However, understanding the potential barriers discouraging parents from participating in these types of interventions is an area that needs particular attention in future research in order to achieve greater viability of these approaches.
References


use of meta-analyses. *Psychol Methods, 17*(1), 120-128. doi: 10.1037/a0024445


Appendix A – Ethics Approval Letter For Family Options Study

Memorandum

To: A/Prof Andrew Lewis
School of Psychology

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 22 June, 2012

Subject: 2012-178
Engaging Youth with high prevalence mental health problems using family based interventions

Please quote this project number in all future communications

Approval granted by Eastern Health HREC for this project will be noted at the DUHREC meeting to be held on 6 August 2012.

It will be noted that approval has been granted for A/Prof Andrew Lewis, School of Psychology, to undertake this project as stipulated in Eastern Health HREC approval documentation.

The approval noted by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the memo. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
## FAMILY LIFE CYCLE
### Developmental Tasks

<table>
<thead>
<tr>
<th>Parents’ Role</th>
<th>Childs’ role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life as a couple before children – Select a suitable mate, commitment</td>
<td>N/A</td>
</tr>
<tr>
<td>First pregnancy - preparation for parenting, coping with new stressors on the couple</td>
<td>N/A</td>
</tr>
<tr>
<td>Infants – Intensive caring role and bonding</td>
<td>Get needs met – physical and emotional</td>
</tr>
<tr>
<td>Toddlers – disciplining children, dealing with challenging behaviour</td>
<td>Explore the world, test boundaries, from a secure base</td>
</tr>
<tr>
<td>Kids enter school – encouraging child autonomy and responsibility - through friendships, play dates, connecting with the school, and interacting with school and other parents</td>
<td>Increasing autonomy, adapt to school environment – classroom and playground, understanding relationships, developing social skills, education</td>
</tr>
<tr>
<td>Kids enter Adolescence – A lot happens! A period of rebellion – giving increasing responsibilities while balancing consequences and boundaries – communication changes, finding new ways to interact with them *** Biggest change at this stage since birth in the way that you as a parent have to interact with them – all parents find this a challenge!!***</td>
<td>Becoming an adult, hormonal changes, physical and sexual maturity, form new relationships, try out new identities and select a peer group, test boundaries, rebel, take on greater responsibilities</td>
</tr>
<tr>
<td>Youth enter early adulthood, Parent’s own parents aging or death, dealing with the grief and loss, continued support of young adult children (may still be living at home)</td>
<td>Orienting to the workplace, career decisions, and their increasingly adult-to-adult relationships</td>
</tr>
<tr>
<td>Becoming grandparents, supporting role</td>
<td>Maintain work, find a partner – Life as a couple before children – as above</td>
</tr>
<tr>
<td>Older adulthood - retirement, planning for the end, looking back</td>
<td>First pregnancy – as above</td>
</tr>
<tr>
<td>Infants – as above</td>
<td>Toddlers – as above</td>
</tr>
<tr>
<td>Kids enter school – as above</td>
<td>Kids enter Adolescence – as above</td>
</tr>
</tbody>
</table>
PARENTING STYLES
These have been derived from 40 years of research - looking at relational patterns in hundreds of different families

4 typical styles of parenting

**Authoritarian = cold + firm**
Authoritarian parenting lacks the closeness and involvement of the other parenting styles. There is no room for negotiations. Give-and-take with the child is discouraged. Punishment is used if young people do not obey.

**Permissive = warm + lack boundaries**
Tendency to acquiesce with your young person’s requests, trying to be their friend. A style of parenting in which parents are very involved with their children but place few demands or controls on them. Lenient, avoid confrontation. Some may act conditionally – treat child as mini-adult, give everything they want provided they comply with certain parental demands e.g. do well in school.

**Inconsistent = oscillate between authoritarian and permissive**
Unpredictable pattern

**Authoritative or “Positive Parenting” = warm + firm**
Set clear expectations, monitor the limits that have been set, and allow encourage them to develop autonomy. Expect and encourage mature and age-appropriate behavior, with consistent consequences for misbehavior and rewards for good behavior.

WHAT WE ARE AIMING FOR!

Note: ‘Firm’ means having clear boundaries and expectations, and clear consequences which are given in advance. Firm also means having consistent routines where there are expected behaviors.

‘Warm’ means listening to your adolescent, being interested in them and validating them (this doesn’t necessarily mean agreeing with their point of view or always acquiescing). Also it suggests a willingness to negotiate around increasing responsibility.
SELF-CARE ACTIVITY

Q: Remember what happens during an emergency on a plane?  
A: The oxygen masks drop down – you must fit your own mask and help yourself before you have the strength and ability to help others!

If you can’t be happy until your child is well, you are actually placing further burden on your child – they will believe that they are causing you to be unhappy!  

By first looking after your own happiness and health, it can actually really help them in at least two ways:

• First, it helps to remove some of the pressure from them. It reduces in them the feeling of being a burden
• Second, by showing them that you can be happy and enjoy life, you will be providing them with a good role model - so that they can see all of the rich possibilities available in adult life, and have hope for the future.

Self-Care Homework Activity

1. Think about your favorite past times. The things that you used to enjoy that have dropped away, or perhaps something you’ve wanted to do or try but never seem to get around to. Whatever it is, make sure it’s something that you enjoy, that feels a little indulgent, and special.

Some examples might include:

• A long hot bubble bath
• Going out for dinner / brunch / coffee
• A day spa visit
• Going to a movie
• Spending an afternoon in a sunny spot with a hot drink and a good book
• A long leisurely walk on the beach

2. Schedule and set aside some uninterrupted time for this

3. Make sure you do it!

4. Repeat – the same activity or something else – at least once a week! Do not give up your self-care time – even just an hour to your-self can do the trick!

Remember – what’s good for you is good for your family! It is very important to take time out to recharge.
# COMMUNICATION & PRAISE - DEPRESSED YOUTH

<table>
<thead>
<tr>
<th>How to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Look for opportunities to highlight effort, achievements, responsible choices, mature behaviours, and more</td>
</tr>
<tr>
<td>• Note that we need to be more subtle in delivering praise with adolescents than with young children</td>
</tr>
</tbody>
</table>
| • Give lots of encouragement when they do something challenging and positive in the context of their depression or anxiety  
  e.g. pleasant activity, social activity, achievement activity, say something good about themselves |
| • Remember: depressed youth tend to attribute the cause of positive events to external, transient & specific factors, but negative events to internal global & stable factors.  
  • So look out for opportunities to provide the opposite in your communication & help them see the world differently  
  (i.e. attribute the cause of positive events and occurrences to stable, internal traits of the young person; and help them to assign the cause of negative events to external and passing factors). |

<table>
<thead>
<tr>
<th>What you should expect in return:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• They may not act like they like, accept or appreciate it! (but trust that they do, deep down!)</td>
</tr>
<tr>
<td>• Although you may not see it, in subtle ways trust that this will increase their self-esteem, and also the positive connection between you both, over time.</td>
</tr>
</tbody>
</table>
Further support for families following BEST-MOOD

Your group or some members may wish to continue meeting / swap details e.g. emails – we can’t facilitate this but you are welcome to organize with each other

Other services

Crisis

<table>
<thead>
<tr>
<th>Crisis contacts</th>
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</thead>
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<tr>
<td>Emergency: Dial 000 or go to local Emergency Department</td>
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<tr>
<td>Crisis assessments:</td>
</tr>
<tr>
<td>Melbourne Eastern Region = Phone 1300 721 927</td>
</tr>
<tr>
<td>Maroondah, Knox, Yarra Ranges, Manningham, Whitehorse and Monash (except southwest corner)</td>
</tr>
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</tr>
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</tr>
<tr>
<td>Whittlesea, Nillumbik, Darebin, Banyule, Yarra and Boroondara</td>
</tr>
<tr>
<td>For other areas and adult services see</td>
</tr>
<tr>
<td>Lifeline: 13 11 14</td>
</tr>
</tbody>
</table>

Support for carers

There is an organisation called ARAFEMI who have support groups, online groups, and a helpline. “ARAFEMI is a community based service that seeks to improve the lives and well being of all people effected by mental illness.”

- http://www.arafemi.org.au
- Carer helpline: 1300 550 265

Beyondblue has some great resources for carer’s of depressed family members, via this link

beyondblue help line – phone 1300 22 4636. They also have an email service - infoline@beyondblue.org.au

Carers Australia also list lots of organisations and may be able to link you with something locally - Phone 1800 242 636

Medicare - Mental Health Care Plans for mental illness (youth or parents) – organize through your GP
Other local agencies and supports, clubs:
Appendix C – Session Handouts for PAST Intervention

Further support for families following FAMILY OPTIONS: EASTERN AND SOUTH EASTERN AREAS

Your group or some members may wish to continue meeting / swap details e.g. emails – we can’t facilitate this but you are welcome to organise with each other

Other services

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<td>Whittlesea, Nillumbik, Darebin, Banyule, Yarra and Boroondara</td>
</tr>
<tr>
<td>Geelong Barwon area= Phone BH (03) 5260 3700 or 1300 094 187. Emergency contact (24hrs): 5226 7410</td>
</tr>
<tr>
<td>Chilwell, Drumcondra, Fyansford, Geelong City, Geelong South, Geelong West, Geelong North, Hamlyn Heights, Herne Hill, Highton, Manifold Heights, Newtown, Rippleside, Wandana Heights</td>
</tr>
<tr>
<td>For other areas and adult services see</td>
</tr>
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<td>Lifeline: 13 11 14</td>
</tr>
<tr>
<td>Lifeline (Geelong Barwon Region): 03 5222 2255</td>
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• Support for carers:

ARAFEMI - There is an organisation called ARAFEMI who have support groups, online groups, and a helpline. “ARAFEMI is a community based service that seeks to improve the lives and well being of all people effected by mental illness.”

Carer helpline: 1300 550 265

Beyondblue help line – phone 1300 22 4636. They also have an email service - infoline@beyondblue.org.au

Carers Australia also list lots of organisations and may be able to link you with something locally - Phone 1800 242 636
The telephone HelpLine provides support, information and referral to mental health care providers, people with anxiety disorders and their families and carers.

**GROW BETTER TOGETHER PROGRAM** “Grow-Better Together”, a peer support service for caregivers of people experiencing mental illness, delivers aspects of the Grown Program through structured, twice monthly meetings. It deals with the day by day needs of its members, encouraging them to use their own resources and the GROW Program to change for the better their thinking, their talk and their ways. The outcomes include improved family resilience and interpersonal relationships. [http://www.grow.net.au/index.php/grow-in-your-state/grow-better-together](http://www.grow.net.au/index.php/grow-in-your-state/grow-better-together)

GROW Better Together - Carer Support Group
Grown Dandenong
1st and 3rd Tues / For carers of
month, 12.30- people with a
2.30pm mental illness

It is essential that all new members ring the GROW Office to confirm meeting details before attending group meetings, as meeting times and locations may change. Please Phone (03) 9528 2977 OR 1800 558 268.

**MENTAL ILLNESS FELLOWSHIP - RUNS A PROGRAM CALLED WELLWAYS**

Wellways, which is an education and information based program for both carers and people that have been diagnosed with a mental illness. There are two relevant types of Wellways- the snapshot program, which is a one day session for carers and involves information about the impacts of mental illness and the importance of self-care. The second type is Wellways 'building a future' which includes 12-sessions and focuses on the causes and impacts of mental illness as well as involving assisting carers with a supportive basis.

Wellways- South Regions (Dandenong). Contact Southern Specialist Family Support Worker Frankston on 9784 6809 or 9784 6800 or email wellwaysouth@mifellowship.org

Wellways- Eastern Regions (Ringwood East), Contact MIFV East on 03 8873 2500 or wellwayseast@mifellowship.org

**ARCVIC Anxiety Recovery Centre Victoria:** ARCVIC run support groups for carers of people living with anxiety disorders and carers. **Office Number:** 03 9830 0566 **Location:** 292 Canterbury Road Surrey Hills Vic 3127 Melway Map 46 F11, **Postal Address:** PO Box 367 Canterbury

ARCVIC- OCD & Dandenong Anxiety Disorders Support Group 2nd Wed/ month, 1.30- 3.00pm The Anxiety Recovery Centre Victoria run this ongoing open Support Group for carers of people living with anxiety disorders and carers.
SHINE: Anxiety and/or depression

Shine is a group program for young women aged 14-17 years who are experiencing symptoms of anxiety and/or depression that are having an impact on their self-esteem and relationships. The program will cover topics such as body image, identity, coping skills, friendships, relationships and respect.

All young women referred to the program will meet with the facilitators prior to the program beginning to ensure the program will best meet their needs.

For further details or to make a referral, please contact Rhianna Perkin or the Youth and Family Intake on 9871 1802 or youthandfamilyvic@each.com.au

Where: EACH 14 Silver Grove Nunawading, 3131
When: Tuesdays 13th May – 17th June, 2014
Time: 9:30am-12pm
Cost: FREE

• Mental health treatment and support- NATIONAL SERVICES

Anxiety Recovery Centre Victoria (ARCVic) is a state-wide, specialist mental health organisation, providing support, recovery and educational services to people and families living with anxiety disorders. ARCVic aims to support and equip people with knowledge and skills that will build resilience and recovery and reduce the impact of anxiety disorders. ARCVic has some great resources for carers, family members and individuals with an anxiety disorder, via this link http://www.arcvic.org.au/

ARCVic also has an OCD and Anxiety Helpline (1300 269 438 or 03 9830 0533) that operates Monday to Friday 10.00am - 4.00pm and face-to-face support groups for both people living with anxiety disorders and family members and carers (see following pages).

The Australian Drug Foundation develops and distributes free and quality assured information on alcohol, other drugs and harm prevention through a range of programs, websites and services available through their website: www.adf.org.au/

Eating disorders Victoria (EDV) provides a comprehensive support and information service on all aspects of eating disorders. EDV has some terrific
resources for people living with an ED and for carers and family members including an online carer’s support forum (http://www.eatingdisorders.org.au/carers/online-carers-forum), a recovery support service and a family recovery service. More information is available via this link http://www.eatingdisorders.org.au/

EDV also has a Helpline (1300 550 236) that provides information, guidance and support to anyone whose life is affected by an eating disorder, body image issues or disordered eating. The Eating Disorders Helpline is often the first point of contact with support, guidance, information and referrals for thousands of people with an eating disorder and their families, partners and friends. It operates Monday to Friday 9.30am – 5.00pm. Moreover, EDV offers face-to-face support groups for both people living with an eating disorder and family members and carers (see following pages).

- **National Drug Helplines**

**Family Drug Help** (http://www.familydrughelp.com.au/) = 1300 660 068 9am–9pm, Monday to Friday
Support, information, education, inspiration and the encouragement for family members of people who use drugs.

**Family Drug Support** (http://www.fds.org.au/)
1300 368 186
24 hours a day, 7 days a week
Support for families faced with problematic drug use.

**DirectLine**
If you or someone you care about has an alcohol or drug problem, you can call DirectLine on 1800 888 236. DirectLine provides 24-hour, 7-day counselling, information and referral.
At DirectLine, you can talk to professional counsellors who are experienced in alcohol and drug-related matters. DirectLine is free, anonymous and confidential.

- **Mental health treatment and support– LOCAL SERVICES (Eastern & 5th Eastern agencies/groups)**

**General Mental Health:**
**Medicare** - Mental Health Care Plans for mental illness (youth or parents) – organize through your GP for private psychologist rebates
**Headspace Knox** - Headspace has been set up to assist young people aged 12-25 and their families deal with different problems and access help with experts in a range of areas. If a young person is feeling ill, depressed or anxious they can see a doctor/counsellor. Headspace Knox can also give you advice about education, finding work or accommodation. Headspace Knox is currently seeing people aged 12 to 25. Suite 3027, 2 Capital City Boulevard, Westfield Knox Ozone, Wantirna South VIC 3152, Phone 9801 6088. For more information visit the Headspace Knox website at http://www.headspace.org.au/headspace-centres/headspace-knox or phone (03) 9801 6088
**Eating disorders:**
Butterfly Eating Disorders Day Program - The Southern Health Butterfly Eating Disorders Day Program is a joint project between The Butterfly Foundation and Southern Health. The day program provides specialist, intensive treatment for individuals aged 12-24 years with an eating disorder, and their families and operates from 9.30am to 3.15 pm five days a week with the option of part time or full time attendance. Referrals can be accepted from Public Mental Health Case Managers or Private Mental Health Clinicians via our Psychiatric Triage Service 1300 369 012.

Wellness and Recovery Centre - A Centre of Excellence in the Treatment of Eating Disorders. The Wellness and Recovery Centre (WRC), is a specialist adult service operating out of Monash Medical Centre, Clayton. The service offers comprehensive assessment and evidence-based treatment to individuals (aged 18 years or older) affected by anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorder not otherwise specified. For clinical services for clients (of all ages) with eating disorder symptoms, please ring Psychiatric Triage on 1300 369 012 (available 24 hours).

MonashLink Community Health's Disordered Eating Service (DES) - Type of treatment: Low-cost Psychological/Dietetic Service (individual & group therapy). Catchment: Public Health Service. Priority is given to those living and/or working in the City of Monash. Out-of-area clients are also eligible. 5 sites: Clayton, Ashwood, Glen Waverley, Hughesdale, Batesford. Main site: Clayton (all correspondence) Level 1, 9-15 Cooke St, Clayton 3168. Phone: 1300 552 509 (Service Coordination and enquiries). Referral: A referral form needs to be completed by the client’s GP. To obtain a referral form or for further information please do not hesitate to contact the Service Co-ordination office at MonashLink on 1300 552 509 during business hours.

Drug and Alcohol Services:

Eastern Health Alcohol and Drug Service (EHADS) - EHADS is a compassionate and accessible service, offering a range of treatments and other support for people affected by substance use problems. EHADS offers a suite of outpatient services and as well as a residential withdrawal unit which are located at two separate sites in central Box Hill. To book an assessment, please phone 9843 1288 between Mon – Fri, 9am – 5pm or you are welcome to ‘drop-in’ to the service between Mon – Fri 9am – 11am. Ground Floor, 43 Carrington Rd BOX HILL, 3128, VIC Contact Phone: 03 9843 1288. Service hours Monday to Friday - 9am to 5p.m. (except public holidays)

Eastern Drug and Alcohol Service (EDAS) - EDAS provides free and confidential alcohol and other drug counselling, support and education in Melbourne's eastern metropolitan region. Our service is available to adults, young people & family members who live, work, study or spend a significant amount of time in the Cities of Boroondara, Manningham, Maroondah, Monash, and Whitehorse. People with co-occurring substance use and mental health issues are welcome. EDAS also provides an ABI service for people with alcohol and other drug related acquired brain injuries. For more information please call: 1300 650 705.

South East Alcohol & Drug Services (SEADS)
SEADS is committed to improving the health and quality of life of individuals, families and communities by providing holistic alcohol and other drug services.
For 24-hour info, referral and counselling concerning alcohol and other drugs call 1800 888 236
Other Services at SEADS: Acquired Brain Injury (ABI)/ with alcohol and or drug problems; Adult counselling; Consultancy and continuing care; Youth specific programs; Specialists Cambodian, Laotian and Vietnamese programs; Aboriginal programs; Alliance family counselling; Clinical services: Residential; Withdrawal/detoxification; Outpatient withdrawal; Home-based withdrawal; Hospital liaison; Pharmacotherapy; Natural therapy; Women’s and men’s sexual health; Massage; Naturopathy; Care co-ordination; Dual diagnosis service. LEVEL 2 229 Thomas Street (PO Box 208) DANDENONG 3175; Tel: 8792 2330, Hours Mon-Fri 9am-5pm.

- **Support Groups for people affected by mental illness:**

**GROW VIC:** Grow is a national organisation that provides a peer supported program for growth and personal development to people with a mental illness and those people experiencing difficulty in coping with life’s challenges. [http://www.grow.net.au/index.php/grow-in-your-state/grow-vic](http://www.grow.net.au/index.php/grow-in-your-state/grow-vic), BOX HILL - Wednesdays 12.30pm, Room B, rear of Box Hill Town Hall, 1022 Whitehorse Road, Box Hill
RINGWOOD - Wednesday 7.00pm, Building B, Eastern Access Community Health, 46 Warrandyte Rd, Ringwood
DANDENONG - Tuesday 7:30 pm, Church of Christ Complex, 139 David St, Dandenong
It is essential that all new members ring the GROW Office to confirm meeting details before attending group meetings, as meeting times and locations may change.
Please Phone (03) 9528 2977 OR 1800 558 268.

**ANXIETY DISORDERS OF VICTORIA (ADVIC) Support Group:** ADVIC runs a support group for people affected by anxiety to express their feelings and provides a forum for discussion in a safe and confidential environment, amongst peers. Groups are guided by facilitators who assist in directing discussions and can provide insight and understanding in regard to issues raised. The groups are focused towards supporting people that suffer from: **Generalised Anxiety:** This condition is characterized by chronic anxiety. You are dealing with a large number of worries, and find it difficult to exercise much control over these worries. **Panic Attacks:** A panic attack is a sudden episode of intense fear that can occur ‘out of the blue’ or in response to being in certain situations. **Agoraphobia:** Where you are afraid of being in a situation that may cause a panic attack. **Social Phobia:** Where you constantly fear situations in which you feel you are exposed to the scrutiny of others. **Depression:** Many people may become depressed as a secondary reaction to their anxiety. This is an understandable response to what can seem like an overwhelming situation. The groups are also relevant to: **Carers, Family and Relatives:** For some people it can be stressful living with or caring for a person suffering from Anxiety-related disorders. Support groups can offer insight and perspective, new coping strategies, and may allow carers to vent their frustrations to others who understand the issues and can offer advice. Locations: **Kew Senior Citizen’s Centre** 533 High Street Kew VIC Melways 45 / F5 Tram 24 (North Balwyn) or
Tram 48 (City) **Monday evenings** 7.30pm - 9.30pm For more information:  

- **ONLINE SUPPORT GROUPS**

**ARAFEMI (ONLINE SUPPORT FORUM)**  
The ARAFEMI message board and chat provide an opportunity for carers of people with a mental illness to gain mutual support and encouragement in a safe environment. [http://www.arafemi.org.au/family-support/online-support.html](http://www.arafemi.org.au/family-support/online-support.html)

**BLUEBOARD**  
BlueBoard is an online community for people suffering from depression or anxiety, their friends and carers, and for those who are concerned that they may have depression or anxiety and want some support. We hope that this bulletin board will enable people to reach out and both offer and receive help.  
[https://blueboard.anu.edu.au/](https://blueboard.anu.edu.au/)

**Eating Disorders Victoria**  
Online Carers Forum [http://www.eatingdisorders.org.au/carers/online-carers-forum](http://www.eatingdisorders.org.au/carers/online-carers-forum) Eating Disorders Victoria has created an online community for families, friends and partners of people with eating disorders called 'Care & Share'. It provides a virtual meeting place to share stories, experiences and knowledge, give and receive support, learn coping strategies and feel less isolated. This online community for carers of a loved one with an eating disorder also offers a chat session in real-time (once a week), as well as the opportunity to post questions via the forum (anytime) and share with others in a similar situation.

**ReachOut.com** For youth.  
From everyday troubles through to really tough times, take the first step with ReachOut.com, Australia's leading online youth mental health service.  

**Counselling Online** [http://www.counsellingonline.org.au/](http://www.counsellingonline.org.au/) Counselling Online is a service where you can communicate with a professional counsellor about an alcohol or drug related concern, using text-interaction. This service is free for anyone seeking help with their own alcohol and drug use, or if you are concerned about a family member, relative or friend. Counselling Online is available 24 hours a day, 7 days a week, across Australia. You may choose to use this service anonymously or can register for ongoing assistance.