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Youth Versus Parent Working Alliance in Usual Clinical Care: Distinctive Associations With Retention, Satisfaction, and Treatment Outcome

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We investigated associations between both youth–therapist and parent–therapist alliances and retention, satisfaction, and symptom improvement among 65 youth and their parents receiving usual community-based outpatient mental health services. Parent (but not youth) alliance was significantly related to more frequent family participation, less frequent cancellations and no-shows, and greater therapist concurrence with termination decision. In contrast, youth (but not parent) alliance was significantly related to both youth and parent reports of symptom improvement. Youth and parent alliance were each significantly related to their satisfaction with services. Findings suggest that youth and parent alliance may play important but distinctive roles in the processes and outcomes of usual clinical care.

All psychotherapy occurs in the context of an interpersonal relationship, and the influence of this client–therapist relationship on the process and outcome of therapy is one of the oldest themes in the psychotherapy literature, discussed since at least the time of Freud (1913). Psychotherapy researchers, treatment developers, and clinicians alike have hailed the importance of a positive working alliance for client persistence in therapy, motivation to work on problems, compliance with therapy tasks, and positive outcomes; indeed, some have argued that alliance is *the* curative mechanism in psychotherapy (Bordin, 1979; Horvath & Luborsky, 1993; Rogers, 1957; Shirk & Saiz, 1992; Stark, Rouse, & Livingston, 1991).

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To date, much research exists on the role of alliance in adult psychotherapy. Among adults, alliance has proven to be a consistent predictor of retention and outcome for various conditions (e.g., substance abuse, depression, anxiety) across various treatment lengths and models (e.g., psychodynamic, cognitive–behavioral, interpersonal) and using varied methods for assessing alliance (e.g., observation, self-report, therapist report). In the first quantitative meta-analysis of the alliance–outcome association, Horvath and Symonds (1991) found alliance showed a mean correlation coefficient of $r = .26$, corresponding to 5% of the variance in outcomes ($N = 24$ studies with 21 published, 3 unpublished). In an updated meta-analysis, Martin, Garske, and Davis (2000) found a slightly lower mean correlation of $r = .22$, corresponding to 7% of the variance in outcomes ($N = 79$ studies with 58 published, 21 unpublished).

Despite such consistent evidence with adults, there has been relatively little empirical work on alliance in youth psychotherapy (Durlak, Wells, Cotten, & Johnson, 1995; Kazdin, Siegel, & Bass, 1990; Shirk & Karver, 2003; Shirk & Saiz, 1992; Weisz, Huey, & Weersing, 1998). Shirk and Karver recently conducted an exhaustive review of research examining associations between various therapy process variables (e.g., client–therapist relationship, client motivation to change, participation in sessions) and outcomes in education, psychotherapy, and medical research. They identified 23 studies (18 published; 5 unpublished) spanning nearly three decades, showing a mean corre-

lation of $r = .20$, corresponding to 4% of the variance in outcomes. Their findings suggest that therapy process variables, including working alliance, may be important to youth outcomes and worthy of further investigation.

A review of the 23 studies also points to a noticeable absence: There are no studies examining *both* youth and parent alliances and comparing their patterns of association with outcomes in outpatient therapy. As noted by Shirk and Karver (2003), alliance in youth therapy may be more complex than in adult therapy, in part because it involves not a single relationship but, instead, both youth and parent connections to the therapist. Youth–therapist alliance and parent–therapist alliance may be driven by different factors and associated with different aspects of therapy process and outcome. Thus, inclusion of both youth–therapist and parent–therapist alliances is critical for understanding the alliance–outcome association in youth therapy.

Beyond its possible association with outcome, alliance may also be related to youth and family retention in therapy. An often-cited challenge for clinicians who work with youths and families is attrition from therapy, with estimates from 28% to 85% of youths terminating prematurely (e.g., Armbruster & Kazdin, 1994; Kazdin, 1996; Pekarik & Stephenson, 1988). Despite investigations into a broad array of youth and family characteristics, research to date has not identified consistent predictors of dropout from outpatient therapy (Armbruster & Kazdin, 1994; Kazdin, 1996). Thus, retention of clients in therapy remains an important area for research (Duan et al., 1999), with some (e.g., Armbruster & Kazdin, 1994) arguing that research must go beyond assessments of parent and youth characteristics and attempt to assess potential processes underlying attrition.

The working alliance may be a key process underlying retention among youths and their parents seeking treatment. Among families of delinquent adolescents receiving behavioral family systems therapy, Alexander, Barton, Schiavo, and Parsons (1976) found that supervisor ratings of therapists' relationship skills accounted for 45% of the variance in therapy completion. In an investigation of factors associated with attrition among families of children and adolescents in community mental health clinics, Garcia and Weisz (2002) found lack of therapist–client rapport significantly related to termination, with many parents reporting that they discontinued treatment because they or their child did not like the therapist, the therapist did not seem to understand, or the therapist focused on the wrong problems. Among families of children and adolescents referred to the Yale Child Conduct Clinic, Kazdin, Holland, and Crowley (1997) similarly found that attrition was predicted by parent perceptions of a poor parent–therapist alliance (e.g., not liking the therapist, not perceiving support from the therapist, not bonding with the therapist). Finally, among adolescent boys in correctional homes, Florsheim, Shotorbani, Guest-Warnick, Barratt, and Hwang (2000) found that adolescent reports of poor alliance with staff predicted running away from the treatment program. Thus, several lines of evidence suggest that alliance may be related to retention in treatment.

Alliance may also be associated with satisfaction in youth therapy. Garland and colleagues (2000) found that aspects of the client–therapist relationship (e.g., feeling the therapist understands, agreeing with the therapist about what problems to address) loaded highly on a measure of adolescent satisfaction with outpatient mental health services. In a study of children and adolescents who had received cognitive–behavioral therapy for anxiety, Kendall and Southam-Gerow (1996) found that 44% of youths reported the therapeutic relationship was the *most important* aspect of their treatment, and 28% reported it was the aspect *they liked the most* about treatment. In a study of behavior therapy for children and adolescents with learning and behavior disorders, Motta and Lynch (1990) found that parents viewed their child's relationship with the therapist as very important for their child's outcomes and significantly more important than the particular techniques used by the therapist. Regardless of whether those parent perceptions were warranted, the therapeutic relationship may figure significantly in determining satisfaction with the care received.

In summary, the available research on working alliance in youth psychotherapy, although limited, does suggest that youth–therapist and parent–therapist alliances may be associated with therapy retention, satisfaction with services, and symptom improvement. Indeed, despite the traditional focus on therapeutic techniques by youth treatment researchers, many practicing clinicians report a pressing need for research addressing the working alliance (see, e.g., Addis & Krasnow, 2000; Kazdin et al., 1990). Given the largely eclectic use of techniques by practicing youth and family clinicians (Kazdin et al., 1990; Weersing, Weisz, & Donenberg, 2002), understanding the role of factors common across all orientations, such as the working alliance, may contribute importantly to an understanding of treatment effectiveness in usual clinical service settings. Research into the role of alliance in these settings may enrich understanding of the relation between process and outcome and help identify steps toward improved clinical care (Hibbs, 1998; Weisz et al., 1998).

To our knowledge, there have been no previous investigations of the associations between youth–therapist and parent–therapist alliances and the process and outcome of usual outpatient community mental health care. Inclusion of both youth–therapist and parent–therapist alliance within the same study is important because there is a distinct possibility that the two forms of alliance may be associated with different aspects of

the treatment process. For example, whether youths attend therapy appointments may depend primarily on their parents, but whether youths change during the course of treatment may depend more on the youth themselves. Thus, parent–therapist alliance and youth–therapist alliance may be reflected in rather different indexes of treatment process and outcome.

Equally important is the context of usual clinical care. Currently, the evidence base on youth therapy consists primarily of university-based clinical trials, which may limit our understanding of community-based clinical practice. Many of the conditions of practice differ from those of clinical trials research, including characteristics of the youth, family, clinician, and the therapy itself (e.g., Hammen, Rudolph, Weisz, Rao & Burge, 1999; Kazdin et al., 1990; Southam-Gerow, Weisz, & Kendall, 2003; Weisz, Donenberg, Han, & Weiss, 1995). Furthermore, findings from clinical service settings have been discouraging; although there is a fair amount of variability between clients in outcomes, the average effects across clients hover around zero (e.g., Bickman, Lambert, Andrade, & Penaloza, 1999; Bickman, Noser, & Summerfelt, 1999; Weisz et al., 1995). Given this state of affairs, several prominent research policy directives and experts in youth mental health services have called for a closer link between research and practice, and specifically for investigations of usual clinical processes to improve our understanding of factors that improve or impede retention and outcomes in community-based clinical care (Burns, Hoagwood & Mrazek, 1999; National Advisory Mental Health Council Clinical Treatment Workgroup, 1999; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health, 2001; Street, Niederehe, & Lebowitz, 2000; Weisz et al., 1998.

In this study, we obtained both youth and parent ratings of alliance for 65 cases treated in community-based outpatient mental health clinics, and we gathered measures of therapy retention, satisfaction with services, and symptom improvement. We investigated whether youth or parent alliance was associated with (a) frequency of family presence in therapy sessions, (b) frequency of missed or cancelled sessions, (c) therapist concurrence with termination decision, (d) youth- or parent-reported satisfaction with therapy, or (e) improvement in youth- or parent-reported youth symptom severity over 2 years post-intake (see the following for further description of variables).

Method

Participants

Participants were 65 youths ages 7 to 16 years, their parents, and their therapists, drawn from four community-based outpatient mental health centers in Los Angeles. The clinics each offer services on a sliding fee scale according to income, and most families pay for services with a combination of Medicare or private insurance and out-of-pocket fees. Youths with mental retardation (IQ < 70) or psychotic symptoms, and families whose treatment was court-mandated, were excluded.

The sample of 65 included 38 (58.5%) boys and 27 (41.5%) girls ages 7 to 16 years (see Table 1 for sample description). The caregivers interviewed were 89.3% female (51 biological, 2 adoptive, 5 foster mothers) and 10.7% male (5 biological, 2 foster fathers). The client characteristics are similar to those in other examinations of community-based outpatient mental health care (e.g., Garland et al., 2001; Lewczyk, Garland, Hurlburt, Gearity, & Hough, 2003).

Clients were treated by 42 therapists, 8 (19%) men and 34 (81%) women (see Table 1). Some 43.9% were licensed professionals (e.g., PhD, PsyD, LCSW), 7.3% were post-degree but unlicensed (e.g., PhD, PsyD, MSW), and 48.8% were trainees (e.g., clinical psychology and social work interns) as is common in community-based outpatient mental health care (e.g., Aarons, 2004; McCabe, 2002). Families attended an average of 23 therapy sessions over 37 weeks.

Sequence of the Investigation

During the standard clinic intake, parents received a brief written description of the project and provided their name and phone number if they wished to be contacted by project staff for an interview. To reduce potential demand characteristics, parents and youths were interviewed in a location other than the clinic by independent research assistants and were told that the information given would not be communicated to their therapist, with the exception of safety issues. At the pretreatment interview, parents and youths provided written informed consent and assent (including consent to review clinic records post-therapy) and demographic information and separately completed measures (e.g., the Child Behavior Checklist [CBCL] and Youth Self-Report Form [YSR]) with graduate research assistants. The same information was gathered at interviews conducted approximately 6 months, 1 year, and 2 years after intake. Parents were also asked whether their child was still in therapy; if not, parents and youths separately completed measures of working alliance and satisfaction with services. Parents were paid $50 for each interview, and youths received a small prize (e.g., movie passes). All procedures were reviewed and approved by the relevant Institutional Review Boards.

Measures

Working alliance. Youth–therapist alliance was measured using the Therapeutic Alliance Scale for Children (Shirk & Saiz, 1992). All seven items were

Table 1. *Description of Sample*

Variable	*M*	*SD*	Minimum	Maximum
Youth age	11.90	2.47	7	16
CBCL total *T* score	62.35	9.22	36	81
YSR total *T* score	58.89	11.37	30	79
Parent age	41.15	9.55	27	76
Therapist age	36.63	10.79	23	66
Total years of therapy training	5.21	1.74	2	8
Years of youth therapy training	1.51	0.89	0	3
Youth ethnicity	37% Caucasian American			
	22% African American			
	20% Hispanic American			
	22% Mixed and Other Ethnicities			
Highest parent education	13% Less than high school			
	26% High school			
	30% Some college			
	20% College degree			
	12% graduate/professional degree			
Family Income	49% $0-15,000			
	25% $15–30,000			
	12% $30–45,000			
	9% $45–60,000			
	3% $60–75,000			
	2% $75–90,000			
Therapist education	10% Bachelor's degree			
	54% Master's degree			
	37% Doctoral degree			
Therapist discipline	78% Psychology			
	22% Social work			
Therapist primary orientation	54% Psychodynamic/object relations			
	14% Cognitive-behavioral			
	7% Family systems			
	25% Eclectic			

Note: CBCL = Child Behavior Checklist; YSR = Youth Self-Report.

rated on a 4-point scale from 1 (*not like me*) to 4 (*very much like me*). The Therapeutic Alliance Scale for Children is unique among alliance measures in that it was designed specifically for use with children and adolescents. It assesses positive and negative aspects of the therapeutic alliance (e.g., "I liked spending time with my therapist" ; "When I was with my therapist, I wanted the session to end quickly") and has demonstrated reliability and validity in previous investigations (DeVet, Kim, Charlot-Swilley, & Ireys, 2003; Shirk & Saiz, 1992). In this study, youth alliance demonstrated excellent internal consistency ($\alpha = .93$), and adequate 7- to 14-day test–retest reliability of $r =. 79$ ($N = 16$). We developed a parallel parent-report form to assess the parent's relationship with the therapist (i.e., "I looked forward to meeting with my child's therapist"; "When I was with my child's therapist, I wanted the sessions to end quickly"; "I liked spending time with my child's therapist"; "I liked my child's therapist"; I'd rather have done other things than meet with my child's therapist"; "I feel like my child's therapist was on my side and tried to help me"; "I wished my child's therapist would leave me alone"). It demonstrated good internal consistency with $\alpha = .81$, and 7- to 14-day test–retest reliability of $r = .82$ ($N = 25$). Parent and youth alliances were correlated $r = .32$ ($N = 65$) in this sample.

Therapy retention. As part of standard clinic record-keeping procedures, therapists document much information in client charts, including (a) number of sessions, (b) session participants (e.g., youth only, parent–youth, youth in peer group), (c) number of sessions cancelled and no-showed by the client, and (d) reason for termination. Therapy retention was operationalized in three parts as (a) percentage of sessions for which another family member attended all or part of the session (number of family-present sessions divided by total number of sessions), (b) percentage of scheduled sessions that were cancelled or missed by the client (number of missed sessions divided by total number of scheduled sessions), and (c) level of therapist concurrence with termination decision (rated on a 4-point Likert scale from 1 (*complete disagreement with termination decision*) to 4 (*complete agreement with termination decision*). Three research assistants coded this information from clinic charts. To establish interrater reliability, 40 records were randomly selected and coded by all coders who demonstrated mean Pearson correlations of .85 for percentage of fam-

ily-present sessions, .89 for percentage of cancellations, and .73 for level of therapist concurrence.

Satisfaction with services. Youth satisfaction was assessed with a four-item, self-report measure (each item rated on a 4-point scale from 4 [*very true*] to 1 [*very false*]) constructed for this investigation to assess the youth's overall satisfaction with services received at the clinic (i.e., "I liked going to the clinic"; "Going to the clinic helped me with my problems"; "If I were ever having problems again, I would want to come back to this clinic"). It demonstrated good internal consistency with $\alpha = .74$, and 7- to 14-day test–retest reliability of $r = .73$ ($N = 12$). Parent satisfaction was assessed with a five-item, self-report measure (each rated on a 5-point scale). Items included (a) Overall, how satisfied were you with the help that your child received at this clinic? (b) If you were to seek help again, would you come back to this clinic? (c) If a friend's child were in need of similar help, would you recommend this clinic to that friend? (d) In general, how much progress did your child make in treatment at this clinic? (e) How satisfied were you with the help your child received at this clinic? It demonstrated good internal consistency with $\alpha = .83$ and 7- to 14-day test–retest reliability of $r = .76$ ($N = 24$).

Symptom improvement. The CBCL and YSR are widely used, standardized, parent- and self-report measures consisting of 118 youth problems, each rated on a 3-point scale. From these ratings, *T* scores are computed reflecting the youth's severity with regard to other youths of the same age and gender. Evidence of the reliability and validity of these scores is extensive (Achenbach & Edelbrock, 1991a, 1991b). The CBCL and YSR (for youths 11 and over) total problem scores were used as measures of youth symptom severity at each assessment.

Results

Analytic Procedures

Hierarchical linear modeling procedures were used to accomplish the study aims for several reasons. First, the data have a hierarchical structure; multiple clients were nested within therapists, and, for some dependent variables, repeated measures (pretreatment, 6 months, 1 year, and 2 years post-intake) were nested within clients who were, in turn, nested within therapists.[1] Second, as is common in longitudinal data collection, particularly with clinical samples, the timing of repeated measures varied somewhat across participants, and some clients missed one or more interviews; hierarchical linear modeling allows for differences in the number and spacing of assessments across participants because it treats them as sampled occasions over time (Hedeker, Gibbons, & Davis, 1991). Third, hierarchical linear modeling allows for unbalanced designs such as this where therapists saw different numbers of clients (Hedeker et al., 1991). Analyses were conducted with the software program Hierarchical Linear and Nonlinear Modeling (version 5.0; Raudenbush, Bryk, & Congdon, 2000). Prior to analysis, variables were examined within SPSS 10.1.3 (2001) for outlying values and for normal distribution of dependent variables. All dependent variables were within acceptable bounds of normality, with no outliers, based on visual examination, skewness, and kurtosis statistics (i.e., no skewness above 2; no kurtosis above 7).

Therapy Retention

We generated separate multilevel models to predict (a) frequency of family participation in sessions, (b) frequency of cancellations and no-shows, and (c) level of therapist concurrence with termination, from youth and parent alliances. Analyses began by fitting unconditional or one-way random-effects analysis of variance models to partition the variance into client-level and therapist-level effects. Then, we examined whether youth or parent alliance accounted for significant between-client variability in the dependent variable by examining youth alliance and parent alliance as client-level covariates in separate models, and both youth and parent alliance together in a single model (see Tables 2 to 4 for specified models and fixed effects; partitioning of variance is reported in the text). Unless otherwise noted, results were the same whether youth and parent alliances were examined individually or together.

Family participation. As noted previously, analysis began by fitting a one-way random-effects analysis of variance model to determine the variability in family participation due to between-client (or client-level) versus between-therapist (or therapist-level) effects. This unconditional model indicated an overall mean level of family participation of 51.5% of sessions with a standard error of 3.6% ($t = 14.159$, $df = 39$, $p < .001$; see Table 2a). Total variability was partitioned into 55% at the client level and 45% at the therapist level, indicating that family participation was roughly equally determined by characteristics of the youth and family and by characteristics of the particular therapist they saw. Next, we

[1] As expected, due to the similarities in treated populations, funding, and personnel, we found no evidence of clinic-to-clinic variation in alliance, retention, or outcomes in preliminary three-level random-effects analysis of variance models, so we dropped the clinic level from analyses (i.e., none of the intraclass correlations for the clinic level were significant, and all were essentially zero).

Table 2. *Models for Family Participation*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	Participation = $\beta_{0j} + r_{ij}$				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
Fixed effect					
Overall mean participation, γ_{00}		0.515***	0.036	14.159	39
b. Model specified					
Level 1	Participation = $\beta_{0j} + \beta_{1j}$ (Parent alliance) + β_{2j} (Youth alliance) + r_{ij}				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
	$\beta_{1j} = \gamma_{10}$				
	$\beta_{2j} = \gamma_{20}$				
Fixed effects					
Overall mean participation, γ_{00}		0.514***	0.036	14.384	39
Mean parentalliance–participation slope, γ_{10}		0.016*	0.008	1.996	60
Mean youthalliance–participation slope, γ_{20}		–0.0001	0.005	–.024	60

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 3. *Models for Frequency of Cancellations and No-Shows*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	Cancellation = $\beta_{0j} + r_{ij}$				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
Fixed effect					
Overall mean cancellation rate, γ_{00}		0.250***	0.024	10.458	39
b. Model specified					
Level 1	Participation = $\beta_{0j} + \beta_{1j}$ (Parent alliance) + β_{2j} (Youth alliance) + r_{ij}				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
	$\beta_{1j} = \gamma_{10}$				
	$\beta_{2j} = \gamma_{20}$				
Fixed effects					
Overall mean cancellation rate, γ_{00}		0.255***	0.026	9.777	39
Mean parentalliance-cancellation slope, γ_{10}		–0.013*	0.006	–1.979	60
Mean youthalliance-cancellation slope, γ_{20}		–0.0004	0.004	–.112	60

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 4. *Models for Therapist Concurrence With Termination*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	Concurrence = $\beta_{0j} + r_{ij}$				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
Fixed effect					
Overall mean concurrence, γ_{00}		2.666***	0.144	18.499	37
b. Model specified					
Level 1	Concurrence = $\beta_{0j} + \beta_{1j}$ (Parent alliance) + r_{ij}				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
	$\beta_{1j} = \gamma_{10}$				
Fixed effects					
Overall mean concurrence, γ_{00}		2.603***	0.142	18.306	37
Mean parentalliance-concurrence slope, γ_{10}		0.096*	0.044	2.207	58

*$p < .05$. **$p < .01$. ***$p < .001$.

examined whether youth or parent alliance accounted for significant client-level variability in family participation by introducing youth and parent alliances as covariates at Level 1. As seen in Table 2b, youth alliance did not account for significant variability in family participation (γ_{20} = –0.0001, standard error (*SE*) = 0.005, t = –0.024, df = 60). Parent alliance was, however, significantly positively related to the level of family participation (γ_{10} = 0.016, *SE* = 0.008, t = 1.996, df = 60, $p < .05$), corresponding to 3.7% of the between-client variability (2.0% of the total variability) in family participation.

Frequency of cancellations and no-shows. As mentioned previously, analysis began by fitting an unconditional model. Here, we found an overall mean cancellation rate of 25% of scheduled sessions with a standard error of 2.4% (t = 10.458, df = 39, p < .001; see Table 3a). All significant variability was accounted for by client-level effects (99.8%). Next, we examined associations with youth and parent alliances by introducing youth and parent alliances as covariates at Level 1. Youth alliance was again unrelated (γ_{20} = –0.0004, SE = 0.004, t = –0.112, df = 60), whereas parent alliance was significantly negatively related to cancellation rate (γ_{10} = –0.013, SE = 0.006, t = 1.979, df = 60, p < .05; see Table 3b), accounting for 18% of the between-client variability in cancellation rate (essentially 18% of the total variability as well).

Therapist concurrence with termination decision. The unconditional model indicated that the average family ended therapy with somewhat limited therapist concurrence (mean = 2.666 on 4-point scale ranging from 4 [*complete agreement with termination decision*] to 1 [*complete disagreement with termination decision*]; SE = 0.144, t = 18.499, df = 37, p < .001; see Table 4a). All significant variability in therapist concurrence was due to client-level effects (99.9%). Neither parent nor youth alliance were significantly related to therapist concurrence when entered together as covariates. However, when examined separately, parent alliance was significantly associated with therapist concurrence (γ_{10} = 0.096, SE = 0.044, t = 2.207, df = 58, p < .05; see Table 4b), accounting for 16.3% of between-client variability in therapist concurrence with termination. Youth alliance was not a significant predictor when examined separately.

Satisfaction with Services

Parent satisfaction with services. The unconditional model indicated that the overall mean satisfaction rating was 15.615 (out of 25) with a standard error of 0.576 (t = 27.104, df = 41, p < .001; see Table 5a). All significant variability in parent satisfaction was due to client-level effects (87.3%). Parent alliance and youth alliance were each significantly positively associated with parent satisfaction when examined separately (t ratio = 5.13, df = 63, p < .001 and t ratio = 2.76, df = 63, p < .01, respectively). When entered together, however, youth alliance was no longer significantly related to parent satisfaction (γ_{20} = –0.127, SE = 0.075, t = 1.691, df = 62); parent alliance remained significant (γ_{10} = 0.544, SE = 0.122, t = 4.464, df = 62, p < .001; see Table 5b), accounting for 21.5% of between-client variability (18.8% of total variability) in parent satisfaction.

Youth satisfaction with services. The overall mean youth satisfaction rating was 7.769 (out of 16) with a standard error of 0.412 (t = 18.865, df = 41, p < .001; see Table 6a). All significant variability in youth satisfaction was due to client-level effects (86.1%). Parent alliance was not significantly related to youth satisfaction with services (γ_{10} = –0.010, SE = 0.074, t = –0.138, df = 62; see Table 6b). However, youth alliance was significantly positively related to youth satisfaction (γ_{20} = 0.354, SE = 0.046, t = 7.747, df = 62, p < .001), corresponding to 41.5% of between-client variability (35.7% of total variability) in youth satisfaction.

Symptom Improvement

For symptom severity, we collected data at up to 4 time points over 2 years. For these analyses, data had a three-level hierarchical structure: level 1 units were repeated measures over time, which were nested within the level 2 units of clients, who were nested within the level 3 units of therapists. Thus, we estimated rate of improvement in youth problem severity over the 2 years of the study, and examined whether youth or par-

Table 5. *Models for Parent Satisfaction*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	Satisfaction = $\beta_{0j} + r_{ij}$				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
Fixed effect					
Overall mean satisfaction, γ_{00}		15.615***	0.576	27.104	41
b. Model specified					
Level 1	Satisfaction = $\beta_{0j} + \beta_{1j}$ (Parent alliance) + β_{2j} (Youth alliance) + r_{ij}				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
	$\beta_{1j} = \gamma_{10}$				
	$\beta_{2j} = \gamma_{20}$				
Fixed effects					
Overall mean satisfaction, γ_{00}		15.514***	0.449	34.531	41
Mean parentalliance-satisfaction slope, γ_{10}		0.544***	0.122	4.464	62
Mean youthalliance-satisfaction slope, γ_{20}		–0.127	0.075	1.691	62

*p < .05. **p < .01. ***p < .001.

ent alliance accounted for significant variability in rate of improvement beyond that accounted for by initial severity alone.

Parent-report symptom severity. First, we estimated the average initial status (i.e., pretreatment, or intake, score) and growth trajectory (i.e., rate of improvement) across youths, with an unconditional model of linear growth for CBCL total problem scores. The average pretreatment CBCL *T* score was 61.423 (*SE* = 1.055, *t* = 58.224, *df* = 41, $p < .001$), and youths dropped an average of 4.261 points per year (*SE* = 0.774, *t* = –5.505, *df* = 41, $p < .001$; see Table 7a). There was substantial between-client variability in both initial severity (97.6% of the total variability was due to client-level effects) and rates of improvement (62.9% of the total variability was due to client-level effects). There was no significant variability between therapists in initial CBCL scores, as might be expected because clinic cases were assigned based on therapist availability rather than client severity. However, there was substantial variability between therapists (37.1%) in their average improvement rates indicating that, on average, some therapist's cases improve more quickly than others. Second, we examined whether youth or parent alliance accounted for a significant portion of the between-client variability in rate of improvement, beyond that accounted for by initial severity. There was

Table 6. *Models for Youth Satisfaction*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	$\text{Satisfaction} = \beta_{0j} + r_{ij}$				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
Fixed effect					
Overall mean satisfaction, γ_{00}		7.769***	0.412	18.865	41
b. Model specified					
Level 1	$\text{Satisfaction} = \beta_{0j} + \beta_{1j}\,(\text{Parent alliance}) + \beta_{2j}\,(\text{Youth alliance}) + r_{ij}$				
Level 2	$\beta_{0j} = \gamma_{00} + u_{0j}$				
	$\beta_{1j} = \gamma_{10}$				
	$\beta_{2j} = \gamma_{20}$				
Fixed effects					
Overall mean satisfaction, γ_{00}		7.631***	0.271	28.131	41
Mean parentalliance-satisfaction slope, γ_{10}		–0.010	0.074	–.138	62
Mean youthalliance-satisfaction slope, γ_{20}		0.354***	0.046	7.747	62

*$p < .05$. **$p < .01$. ***$p < .001$.

Table 7. *Models for CBCL Total Problem Score*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	$\text{Score} = \pi_0 + \pi_1\,(\text{Year}) + e$				
Level 2	$\pi_0 = \beta_{00} + r_0$				
	$\pi_j = \beta_{10} + r_1$				
Level 3	$\beta_{00} = \gamma_{000} + u_{00}$				
	$\beta_{10} = \gamma_{100} + u_{10}$				
Fixed effect					
Mean initial score, γ_{000}		61.423***	1.055	58.224	41
Mean growth rate, γ_{100}		–4.261***	0.774	–5.505	41
b. Model specified					
Level 1	$\text{Score} = \pi_0 + \pi_1\,(\text{Year}) + e$				
Level 2	$\pi_0 = \beta_{00} + r_0$				
	$\pi_j = \beta_{10} + \beta_{11}\,(\text{Baseline}) + \beta_{12}\,(\text{Parent alliance}) + \beta_{13}\,(\text{Youth alliance}) + r_1$				
Level 3	$\beta_{00} = \gamma_{000} + u_{00}$				
	$\beta_{10} = \gamma_{100} + u_{10}$				
	$\beta_{11} = \gamma_{110} + u_{11}$				
	$\beta_{12} = \gamma_{120}$				
	$\beta_{13} = \gamma_{130}$				
Fixed effects					
Mean initial score, γ_{000}		61.497***	1.052	58.469	41
Mean growth rate, γ_{100}		–3.865***	0.855	–4.521	41
Mean baseline-growth association, γ_{110}		0.116	0.113	1.025	41
Mean palliance-growth association, γ_{120}		–0.004	0.177	–0.024	61
Mean yalliance-growth association, γ_{130}		–0.191*	0.089	–2.134	61

*$p < .05$. **$p < .01$. ***$p < .001$.

no relation between parent alliance and improvement (γ_{120} = –0.004, *SE* = 0.177, *t* = –0.024, *df* = 61), but youth alliance was associated with significantly steeper improvement (i.e., higher youth alliance was associated with greater decrease in severity scores; γ_{130} = –0.191, *SE* = 0.089, *t* = –2.134, *df* = 61, $p < .05$; see Table 7b). Youth alliance accounted for 6.1% of client-level variability (3.8% of total variability) in CBCL improvement beyond that accounted for by initial severity.

Youth-report symptom severity. Again, we estimated the average initial status and growth trajectory with an unconditional model of linear growth for YSR total problem scores for youths 11 years and older. The average pretreatment YSR *T* score was 57.333 (*SE* = 1.574, *t* = 36.434, *df* = 30, $p < .001$), with scores dropping an average of 1.932 points per year (*SE* = 0.791, *t* = –2.444, *df* = 30, $p < .05$; see Table 8a). There was significant variability between youths in both their pretreatment scores (99% of total variability was due to client-level effects) and rates of improvement (98.9% of total variability was due to client-level effects), but no significant variability between therapists in initial status or rate of improvement. We found no relation between parent alliance and improvement (γ_{120} = 0.190, *SE* = 0.232, *t* = 0.820, *df* = 39; see Table 8b). On the other hand, youth alliance was significantly related to improvement (γ_{130} = –0.273, *SE* = 0.131, *t* = –2.084, *df* = 39, $p < .05$), corresponding to 12.4% of client-level variability (12.3% of total variability) in YSR improvement beyond that accounted for by initial severity.

Discussion

In this investigation, we examined whether alliances built with youths and parents by therapists in community-based outpatient mental health clinics were associated with therapy retention, satisfaction, and outcome. Overall, our findings suggest that the working alliance *may* be an important factor in youth therapy. Additional research is necessary to determine whether alliance will prove as consistent a predictor of the process and outcome of youth therapy as it has in adult therapy. Our findings also indicate that understanding alliance in youth therapy will require close attention to both youth and parent connections to the therapist.

We found parent–therapist alliance significantly related to each of our measures of therapy retention (family participation, frequency of cancellations and no-shows, and therapist concurrence with termination). Youth alliance, on the other hand, was not significantly related to any of our retention measures. These findings may be understood partly in light of the parent's role in youth therapy. In the vast majority of youth therapy cases, the parent is responsible for providing transportation to the clinic and, ultimately, for deciding when to stop going to therapy (Armbruster & Kazdin, 1994; Gould, Shaffer, & Kaplan, 1985; Pekarik &

Table 8. *Models for YSR Total Problem Score*

		Coefficient	*SE*	*t* Ratio	*df*
a. Model specified					
Level 1	$\text{Score} = \pi_0 + \pi_1\,(\text{Year}) + e$				
Level 2	$\pi_0 = \beta_{00} + r_0$				
	$\pi_j = \beta_{10} + r_1$				
Level 3	$\beta_{00} = \gamma_{000} + u_{00}$				
	$\beta_{10} = \gamma_{100} + u_{10}$				
Fixed effects					
Mean initial score, γ_{000}	57.333***	1.574	36.434	30	
Mean growth rate, γ_{100}	–1.932*	0.791	–2.444	30	
b. Model specified					
Level 1	$\text{Score} = \pi_0 + \pi_1\,(\text{Year}) + e$				
Level 2	$\pi_0 = \beta_{00} + r_0$				
	$\pi_j = \beta_{10} + \beta_{11}\,(\text{Baseline}) + \beta_{12}\,(\text{Parent alliance}) + \beta_{13}\,(\text{Youth alliance}) + r_1$				
Level 3	$\beta_{00} = \gamma_{000} + u_{00}$				
	$\beta_{10} = \gamma_{100} + u_{10}$				
	$\beta_{11} = \gamma_{110} + u_{11}$				
	$\beta_{12} = \gamma_{120}$				
	$\beta_{13} = \gamma_{130}$				
Fixed effects					
Mean initial score, γ_{000}		57.480***	1.685	34.118	30
Mean growth rate, γ_{100}		–2.860**	0.817	–3.501	30
Mean baseline-growth association, γ_{110}		–0.106	0.088	–1.200	30
Mean palliance-growth association, γ_{120}		0.190	0.232	0.820	39
Mean yalliance-growth association, γ_{130}		–0.273*	0.131	–2.084	39

*$p < .05$. **$p < .01$. ***$p < .001$.

Stephenson, 1988). Of course, youth alliance may matter more in situations in which the youth controls attendance. As noted before, among adolescent boys in correctional homes, Florsheim and colleagues (2000) found youth reports of poor alliance predicted running away from the program. Youth alliance may also be strongly associated with other indicators of engagement that rely more heavily on the youth, such as active collaboration in therapy tasks (e.g., Shirk & Saiz, 1992). These possibilities should be examined in future studies.

Although our findings should not be interpreted causally, they do suggest the possibility that parent–therapist alliance may be one of the processes underlying the high attrition rates found so frequently in community-based outpatient mental health centers. Evidence suggests that youths who do not attend sessions consistently, do not participate wholeheartedly in the therapy process, or do not complete treatment show less improvement than those who do (e.g., Ansari, Gouthro, Ahmad, & Steele, 1996; Kazdin, Mazurick, & Seigel, 1994). Parent involvement in youth treatment is also beneficial; cases showing greater family involvement evidence more improvement than cases with less family involvement (e.g., Barrett, Dadds, & Rapee, 1996; Epstein, Valoski, Wing, & McCurley, 1994; Kazdin et al., 1990; Kendall, 1994). If poor parent–therapist alliance does lead to poor retention, therapists may do well to focus on developing a positive connection with parents. The role of parent–therapist alliance in usual clinical services certainly seems worthy of further empirical investigation.

In contrast, we found stronger youth–therapist alliance, but not parent–therapist alliance, associated with greater decreases in symptom severity. This finding was robust across parent- and youth-report outcomes. Perhaps the parent–therapist relationship is important for attendance, but a solid working alliance with the youth is critical for engendering youth motivation to work on problems, active attention and participation in session, skill acquisition, and application of skills outside of therapy (Stark et al., 1991). Indeed, developing a good working relationship with the youth may be particularly important (but difficult) given that youths, unlike adults, rarely refer themselves for treatment and may not enter treatment recognizing a problem or desiring change (Armbruster & Kazdin, 1994; Ollendick & Vasey, 1999; Shirk & Saiz, 1992).

We also found support for an association between alliance and satisfaction, particularly within reporter. The strong within-reporter associations indicate that the alliance–satisfaction associations we found may be at least partially due to shared method variance (i.e., both satisfaction and alliance measures taken from the same reporter).

This study was designed to shed light on associations between youth and parent alliances and retention, satisfaction, and symptom improvement, within the context of usual clinic care where practicing clinicians see youths and parents referred through naturally occurring community pathways. Examining the working alliance and its impact within this context is of great public health significance (National Advisory Mental Health Council Clinical Treatment Workgroup, 1999; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health, 2001) and genuine importance to practitioners (see, e.g., Addis & Krasnow, 2000, and Kazdin et al., 1990). Indeed, our findings suggest that practitioner interest in the working alliance as a key clinical process may be well founded. Further research on the topic certainly seems warranted based on our findings.

In future research, several strategies may be considered. First, future investigations should measure both youth and parent alliances and should do so from multiple viewpoints (e.g., therapy observation, therapist report, youth report, parent report) to obtain a broader picture of the role of alliance in youth therapy process and outcome. Although the adult literature indicates the client's perspective may be most predictive (Horvath & Symonds, 1991), the jury is still out on youth and family therapy.

Second, additional indicators of engagement and participation in therapy would be worthwhile to measure. As noted previously, session attendance is largely determined by the parent. Other indicators, such as in-session participation and completion of homework, may depend more on the youth and may relate significantly to youth alliance.

Third, characteristics of the youth, family, clinician, and treatment may also be investigated as potential predictors of alliance and, in larger samples, as moderators of alliance–outcome associations. If the relations found here between alliance and therapy processes and outcomes prove stable in future studies, clinicians would benefit from greater understanding of the precursors to a strong alliance (e.g., therapist training or use of particular techniques). In addition, youth and parent alliances may be differentially associated with outcomes depending on the modality of treatment (e.g., individual youth, family therapy, parent training) or the predominant problem (e.g., disruptive behavior vs. anxiety). For example, parent–therapist alliance may be more associated with outcome from behavioral parent training than we found in this investigation.

Finally, although our purpose was to determine whether an association existed between youth or parent alliance and therapy retention or outcomes, it remains unclear whether alliance is actually predictive of therapy progress or perhaps an artifact of therapy progress (i.e., those who are improving in therapy like their therapist more than those who are not improving; see Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Feeley, DeRubeis, & Gelfand, 1999; Horvath &

Luborsky, 1993). In future research, it will be important to measure alliance and symptom levels early in therapy and throughout the course of therapy to chart the trajectory of alliance versus symptom improvement. In an interesting body of work, some researchers have attempted to examine the directional nature of the alliance-outcome association (e.g., Feeley et al., 1999; Tang & DeRubeis, 1999). Although spuriousness cannot be completely ruled out because it is impossible to randomly assign level of alliance, DeRubeis and colleagues have argued that temporal precedence can reveal a great deal about the directional nature of the alliance–outcome association. To date, their findings have been inconsistent, finding alliance predictive of subsequent improvement after controlling for prior improvement in some studies (e.g., Tang & DeRubeis, 1999) but not others (e.g., Feeley et al., 1999). Although these investigations have been with adults, they point to a potentially viable means of disentangling the alliance–outcome association in youth therapy.

In summary, this study suggests that both parent–therapist and youth–therapist alliances may be important for retention and outcome in outpatient youth mental health services. It also underscores the need for future research to sharpen the picture of alliance in youth therapy. If the associations found here prove consistent across investigations, attention should also be paid to identifying modifiable youth, family, and clinician characteristics that promote the development of a positive alliance and, thereby, improve retention and outcomes.

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