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REVIEW

Youth Working Alliance: A Core Clinical Construct in Need of Empirical Maturity

Sanno Elena Zack, MS, Louis Georges Castonguay, PhD, and James Franklin Boswell, MS

The therapeutic alliance has long been recognized as an important component of successful psychotherapy for adults; research has established robust links to outcome. Until recently, however, research on the alliance between youth and their therapists has been sparse. The present review synthesizes the existing findings regarding the youth alliance and utilizes the adult alliance literature and the child and adolescent developmental literatures to suggest future avenues of research. Weak alliance was found to predict premature termination, and strong alliance predicted symptom reduction, with some support for differential effects of the youth-therapist and parent-therapist alliances. In addition, the youth alliance is moderated by several patient and therapist characteristics, including the particular problems of patients and the interpersonal skills of therapists. The field has yet to coalesce around a single definition of the youth alliance, however, making it difficult to assess research results. Adult models of the alliance continue to be used heuristically despite some evidence that the alliance operates differently for youth. Tightening the operational definition of the youth alliance and addressing methodological issues will be essential in future efforts to understand how the alliance develops and what role it may play in the treatment process for youth. (HARV REV PSYCHIATRY 2007;15:278–288.)

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Youth psychotherapy, once subsumed under the rubric of adult mental health treatment and assumed to operate identically, has exploded in recent decades as a research area in its own right.[1] Growing recognition of the role of development in the onset, presentation, and treatment of child and adolescent mental health problems has made clear that an understanding of the change process for youth must be directly studied within this population, rather than extended downward from findings with adults.[2,3] Nevertheless, the longer-standing adult psychotherapy literature has historically played, and can continue to play, a valuable role in suggesting hypotheses and potentially productive avenues of investigation for child and adolescent researchers.

Coming of age in a time when "empirically supported treatments" have represented a major focus in the field, youth psychotherapy research has, to date, focused more on technique variables and treatment packages than relationship or participant variables.[4] Although this research has demonstrated that psychotherapy is effective for youth,[5,6] there has been a recent push to better understand *why* treatment works.[7–10] If we look to the literature on the adult psychotherapy process for suggestions regarding which variables are likely to play a role in successful treatment with youth, one of the leading candidates is the patient-therapist relationship and, more specifically, the working alliance.

Within the adult literature, the patient-therapist relationship has long been recognized as a vital component of successful psychotherapy. In fact, with more than 2,000 empirical studies to date, the alliance is the most studied

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process of adult therapeutic change[11] and has received empirical attention even within treatment orientations that have not traditionally considered the relationship to be the primary change mechanism.[12] The relationship between alliance and outcome has been modest yet robust, representing an effect size of .22 to .26, and explains a greater proportion of the variance than many technique factors.[13]

The alliance-outcome link for adults appears to cut across a number of patient diagnoses, treatment modalities, and theoretical orientations of providers, making the alliance a potentially unifying construct in a field where, historically, both researchers and clinicians have been tied to particular approaches.[12] Whether the adult patient-therapist relationship is viewed as curative in and of itself or as a necessary condition to allow techniques to have their effect—either by retaining the patient in therapy or by enhancing engagement and motivation—few would dispute that the alliance is an important aspect of effective adult mental health treatment (see DeRubeis, Brotman, & Gibbons[14] for an especially noteworthy contrary analysis). Given that interpersonal relationships are developmentally important across the life span, and given especially that the therapeutic relationship plays such a central role in psychotherapy, the relationship between youth and their therapists seems to be an especially fruitful target for further clinical research.

In addition to a preponderance of empirical evidence suggesting that the alliance is linked to outcome for adults, arguments for studying the therapeutic relationship with youth have also come from clinicians who treat youth, as well as from youth and their families. In a study of over 1,000 youth clinicians, greater than 90% of those surveyed identified the therapeutic relationship as extremely or very related to therapeutic change, citing it far more frequently than technique variables and second only in frequency to parental cooperation.[4] Youth-patients and their parents also frequently endorse a positive therapeutic relationship as an important aspect of their therapy experience,[15] and problems in the therapeutic relationship are the most frequently endorsed reason for discontinuing treatment, predicting a greater degree of variance in dropout than actual patient need or pragmatic barriers.[16] These findings lend credence to a growing consensus among youth psychotherapy researchers that the therapeutic relationship warrants further empirical consideration.

Compared to the adult literature, youth alliance research is sparse. However, it has also grown exponentially over the last two decades. Although findings require cautious interpretation in view of the small number of studies on which they are based, they also suggest exciting early results and reveal a host of unanswered questions awaiting greater clarity. In this article we attempt to synthesize what is currently known about the therapeutic relationship for youth, using both the adult alliance literature and the child/adolescent developmental literature to suggest more fine-tuned hypotheses for future study.

WHAT IS THE "YOUTH ALLIANCE"?

Within the adult literature, the relationship between therapist and patient has been conceptualized as involving several subcomponents, including the actual relationship, transference, and working alliance (see Gelso & Hayes).[17] Historically, the construct of the working alliance has emerged from, and has long been associated with, the psychodynamic tradition. Due in no small part to the seminal contribution of Bordin,[18] however, the alliance is now regarded as a therapeutic process that cuts across theoretical orientations (having even been coined as the "quintessential integrative variable").[19] Viewed by many as the cornerstone of the current conceptualization of the alliance, Bordin's trans-theoretical definition includes three major components: a bond, an agreement on the tasks of therapy, and an agreement on treatment goals.[18]

More has been written about the affective component of the alliance (Bordin's "bond") than about any other therapeutic relationship component with children and adolescents. As noted by Shirk and Saiz,[2] this interest can be traced to Anna Freud's clinical writing, which emphasized the importance of "affectionate attachment" to the successful treatment of children. The emphasis on attachment was carried forward for several decades as child treatment focused predominantly on play therapy. Within this modality the therapeutic relationship—more specifically, the therapist's offer of warmth, nonjudgmental acceptance, and respect—was seen as the curative factor that offered a corrective emotional experience for inadequate parenting and that provided the conditions for growth.[2] Although clinically valued, these views represented hypothetical conceptual underpinnings that had little empirical basis.

With the rise of behaviorism in the 1960s and 1970s, focus on the relationship with children declined in favor of a focus on observable tasks and on contingent reward and punishment. Although greater empirical research accompanied this shift, little of it was directed toward the relationship, though there were a few notable exceptions (e.g., the work by Truax, Altmann, Wright, & Mitchell).[20] Only in the last couple of decades has there been renewed interest in the therapeutic relationship from an empirical perspective, as representing the context in which treatment takes place and thus as a potentially vital force for both process and outcome. However, as interest in the youth therapeutic relationship has shifted from an exclusively clinical to an empirical one, it has become evident to many that the concept of the "alliance" for youth is currently quite hazy.[7,21,22]

As efforts to operationalize youth therapy relationships have emerged, Bordin's tripartite model of the alliance has been a logical conceptual starting point, frequently invoked by youth psychotherapy researchers.[2,23] Using several different self-report and observer measures, factor-analytic techniques have been employed to assess the model's applicability for youth. Notably, however, several studies of the therapist-youth relationship have failed to support the components of bond, task, and goal, finding instead a single unified construct.[23,24] Others have identified two separate factors—bond (e.g., affective orientation to the therapist and to therapy in general) and task (e.g., participation in, and collaboration with, the activities of therapy)[2,25]—but have failed to find a separate goal dimension.

Developmental differences between youth and adult patients may account for the failure to fully support Bordin's model of the alliance, especially with respect to the individuation of goals. For instance, children and adolescents have less developed cognitive abilities, and it is often someone other than the youth-patient who recognizes the need for treatment and who defines treatment priorities. A variety of cognitive skills is necessary in order to articulate long-term therapeutic goals and to conceptualize the link between such broad, often more abstract goals and the concrete, session-to-session tasks of therapy. These skills include the capacity to think hypothetically and instrumentally, to generalize outside the therapeutic setting, and to delay gratification. Although some empirically supported youth-treatment approaches address these concerns through the use of tangible, immediate rewards and simple, concrete, short-term goals, the requisite cognitive skills may still be advanced beyond the developmental level of some child-patients. For those patients the affective connection to the therapist may play a bigger role than the tasks and goal components.[23] DiGuiseppe and colleagues[23] suggest that different elements of the alliance may play a more important role at different developmental ages. This hypothesis could be directly tested by examining the relationship between age (a proxy for cognitive development) or cognitive skill sets and the ability to define realistic therapeutic goals.

Alternatively, the lack of data to support Bordin's tripartite model with regard to the youth alliance—in particular, the goal-formation component—may reflect the variable degree to which youth goals, per se, are emphasized in most child and adolescent treatments. Because youth are often referred to treatment by others—including adult caregivers, teachers, and social service agencies—they often enter treatment with a different level of awareness, agency, and motivation than the typical adult and may have different goals for treatment than their referrers, or even have no interest in goals or therapy at all.[3]

Child and adolescent patients are often characterized in the literature as seeing themselves as not having problems or not in need of treatment, and at a precontemplative stage of change,[26,27] due to defensive processes, developmental limitations, or different perspectives on, and relative lack of concern about, the problems identified by the adults in their lives. At least one empirical study suggests that adolescent patients have negative attitudes toward treatment and see themselves as not in need of help.[27] However, the characterization of adolescents as unmotivated for treatment may have been overemphasized. Notably, the study by Taylor and colleagues[27] was conducted through a school setting in which referral for treatment may have been experienced as more stigmatizing for the youth involved, influencing their attitudes. Few other direct empirical investigations of youth attitudes toward treatment have been published; existing studies do suggest, however, that the majority of adolescents in treatment acknowledge having problems and can identify therapeutic goals.[28] If so, the underlying problem may be a lack not of goals, but of *consensus* as to what they should be.

A study of 170 adolescents in community treatment found that child and adolescent patients cited different sources for their difficulties and different treatment goals than parents and therapists, often identifying problems within the family and other environmental issues as targets of change.[28] Shirk and Saiz[2] suggested that this tendency of youth to attribute their problems to external sources may be due to their still-developing social-cognitive skills. However, Los Reyes and Kazdin[29] have argued that external attributions of their problems by youth may be due to a fundamental attribution error in which problems of the self are externalized. Regardless of the explanation, these discrepancies among the goals of youth, caregivers, and therapists may contribute to the apparently marginal role of goals in the construct of the youth alliance, especially if youth's goals are being overlooked in favor of caregivers' goals.

A possible third explanation for the apparently peripheral importance of goal formulation to the youth alliance is that tasks and goals may not be substantially different in the minds of youth patients. Several studies of adults using the Working Alliance Inventory suggest that although therapists differentiate the task and goal dimensions of the alliance, patients make relatively little distinction between the two.[11] Thus, the small relative contribution of the goal component to the alliance may be broader than a youth model issue.

Further research assessing the components of the youth alliance is obviously warranted. As things stand, it appears that the youth alliance may comprise two elements, one affective and the other collaborative.[21,25] Although this distinction is less fine grained than Bordin's proposed model, it is in keeping with the definition of the alliance recently distilled from a review of the adult literature. "It is generally agreed that the alliance represents interactive collaborative elements of the relationship (i.e., therapist and patient

abilities to engage in the tasks of therapy and to agree on the targets of therapy) in the context of an affective bond or positive attachment."[30] Accordingly, for the purposes of this article, we define the youth alliance as involving two parts—one affective and the other collaborative—while recognizing that additional empirical investigation is warranted.

DOES THE YOUTH ALLIANCE RELATE TO OUTCOME?

Because the alliance in youth psychotherapy has received less focused study relative to adults, researchers of child psychotherapy have been hesitant to assert a conclusive link between alliance and outcome for youth.[25] We think it fair to say, however, that there is strong preliminary evidence of a positive correlation between the therapeutic relationship and outcome for youth populations. The first meta-analysis of the alliance for patients 18 years of age and younger included 23 studies and found an alliance-outcome association of $r = .24$,[22] which is, based on Cohen's criteria,[31] a small to medium effect size. Although the alliance thus appears to explain a relatively modest portion of the overall variance, it has been argued that—given the complexity of the therapeutic process—a small to medium effect represents meaningful explanatory power.[11] Moreover, this effect size is comparable to that found in studies of the alliance within adult samples, which have demonstrated a range of .22 to .26 across multiple meta-analyses.[11,13] Importantly, however, the alliance in the above meta-analysis was broadly defined—based upon the use by individual study authors of terms containing "alliance" or "therapeutic bond." Given the aforementioned inconsistencies in the definition of this term for youth, it is unclear which aspects of the therapeutic alliance were predictive of outcome.

In a second meta-analysis conducted with 49 studies assessing youth-therapist relationship variables more broadly and examining contributing components, the overall link between the quality of the therapeutic relationship and outcome was found to be .26 (weighted effect size, adjusted for one large study).[32] Notably, when the youth relationship to therapist and the youth alliance were considered separately, the relationship showed a larger weighted effect than the alliance (0.37 vs. 0.21). This difference again raises questions regarding how best to define the construct of the alliance for youth. However, the authors noted that study size played a large role in this unexpected finding, with nonweighted effect sizes showing equivalence between the alliance and the relationship. Although the nuances remain to be further explored, the finding of a small to medium effect for the alliance in this second meta-analysis mirrors the finding of Shirk and Karver[32] and suggests strong evidence that the therapeutic alliance/relationship is important to youth outcomes. A greater body of studies, however, would help strengthen our understanding of this relationship and its nuances. For example, although the alliance appears positively linked to youth outcome, the causal direction of this effect is currently unknown (see Kazdin and Nock[33] for a discussion of this issue). In addition, and as illustrated in the next sections, more research on various methodological and conceptual issues related to the measurement of the alliance is likely to clarify the conditions under which the alliance is most strongly related to improvement for youth.

HOW IS THE YOUTH ALLIANCE MEASURED?

Within the adult psychotherapy research literature, decades of testing and refinement have led to a half dozen psychometrically sound self-report measures of the therapeutic alliance.[13,34] Each of these measures has an empirical base and has been used in multiple studies of the psychotherapy process. Within the youth psychotherapy subfield, however, research has yet to coalesce in the same manner around a set of widely used measures. The Shirk and Karver[22] meta-analysis of 23 studies found a modal frequency of use for youth measures to be 1, with no most commonly used measure. The meta-analysis of 49 studies found 27 different scales measuring the youth, parent, and family alliances and relationships to the therapist—which underscores the lack of a conceptual consensus for understanding the youth alliance or therapeutic relationship.[32] Utilized measures spanned the methodological range, from modification of existing adult alliance measures, to family measures and general relationship measures, to the development of new study-specific youth alliance measures.

The lack of a unified approach to measuring the youth therapeutic relationship broadly, and alliance more specifically, represents a methodological problem for several reasons. First, many of the measures being used lack a sound, established psychometric base. Second, it is unclear what aspects of the therapeutic relationship each scale actually measures and to what degree these measures and factors correlate with one another. Third, the same terms (e.g., "alliance") are used for measures that appear to assess different, albeit related, constructs (e.g., affective bond vs. affective bond/collaborative tasks). In total, the absence of an agreed set of measures further contributes to the lack of clarity regarding the construct of the youth alliance.

In addition to the lack of consensus regarding alliance scales, several other methodological issues affect youth alliance research, including the timing of the alliance measurement, shared method variance, and the choice of a rater. Measurements of the youth alliance taken later in treatment are more strongly linked to outcome than are measurements taken early in treatment.[22] Within the adult literature this same temporal finding has been widely noted to be confounded with treatment gains—which may color

alliance ratings, which suggests that early alliance ratings may provide cleaner measures of alliance; better still, studies should incorporate repeated measures of the alliance and outcome over time to decouple measurement effects and to understand how alliance fluctuates over treatment. It is also possible that the relative superiority of later alliance ratings to predict outcome reflects the developmental course of the youth alliance; in particular, positive alliance shifts may best predict youth outcome (for further discussion see the section below on "Developmental Course of the Youth Alliance"). Finally, although for completers of therapy, late alliance better predicted outcome than early alliance, the relationship between alliance and dropout or premature termination was not considered in the Shirk and Karver meta-analysis.[22] For adults, a positive early alliance is strongly related to treatment completion.[35] There is evidence from a few studies that this same relationship may also hold for youth, with a negative or weak alliance as early as the third session predictive of treatment noncompletion.[36]

With regard to rater, the therapist-rated alliance has been shown to predict outcome better than youth-, parent-, or observer-rated alliance.[22] The apparent superiority of provider-rated alliance over that of youth to predict outcome stands in direct contrast to the adult literature, which traditionally has shown that *patient* ratings are the most predictive.[37] Some have suggested that a restricted range of responses may account for the relatively poorer explanatory power of youth self-report. Studies of both anxious youth and substance abusing youth have shown problems with restricted range—which is, in particular, skewed toward the positive end.[38–40] It has also been suggested, however, that these two groups of patients have somewhat different underlying motivations from other youth, possibly accounting for the differences in ratings of the alliance. Anxious youth to tend to seek direct approval from adults and to try to form more positive relationships with them, which perhaps positively skews ratings of the alliance. In contrast to anxious youth, those with substance abuse disorders are more likely to be mandated for treatment or to have a negative relationship history with authority figures. Globally, positive ratings within these samples may reflect an effort by some patients to "play nice" in early sessions, obscuring alliance effects because these patients distort their true feelings about the relationship.[40]

As a whole, rater effects must be carefully tempered by an understanding of *which* alliance is rated—an issue taken up in the following section. In the Karver and Shirk meta-analysis,[22] the small number of sample studies prevented the interaction between rater and target alliance from being assessed. As the youth alliance literature grows, however, the study of these potential interactive effects may offer more nuanced understanding of the therapeutic relationship and its measurement in youth psychotherapy.

ALLIANCE TO WHOM?

Unlike traditional individual adult psychotherapy, in which the alliance is based on a single, dyadic relationship between patient and therapist, treatment of youth typically necessitates a relationship between multiple parties. As previously noted, because children and adolescents rarely refer themselves for treatment, the impetus and goals for therapy are often first identified by someone other than the youth-patient. Not only does this dynamic introduce an added complexity for the youth-therapist alliance (as youth may or may not agree with the need for treatment), for the primary presenting problem, and for the focus of intervention, there is also an additional alliance to be negotiated—that of the therapist and the adult caregiver.

There has been an increasing emphasis on directly involving caregivers or the entire family in youth treatment. For example, the most frequently employed child treatment approach for externalizing disorders—parent management training—is provided directly to the caregivers.[41] Additionally, childhood anxiety research has focused on whether supplementing child treatment with caregiver and family interventions is beneficial.[42] Even when the identified youth is the sole patient in therapy, however, caregivers are typically responsible for bringing the child or adolescent to the sessions and for handling financial obligations.[43] In addition, caregivers provide implicit or explicit feedback about how therapy should be viewed, utilized, or valued by the youth, making caregivers integral to the success of youth treatment.

Research has begun to address the differential effects of the youth and caregiver alliances, with early results finding that both independently contribute to treatment success. Meta-analytic findings from 23 studies (14 of youth and 9 of parents) suggest that the therapeutic alliance with youth is more strongly related to outcome than the therapeutic alliance with parents ($r = .21$ and .11, respectively).[32] However, wide variability within individual studies should be taken into account. Moreover, although meta-analyses have been useful for examining youth and parent alliances considered in isolation from one another, the individual studies included did not examine both alliances together.[22] Direct comparisons between the effects of parent-therapist alliance and youth-therapist alliance on outcome are consequently complicated by confounding issues of study methodology and sample effects.

Several recent studies have addressed the above concerns, with mixed findings.[36,40,44–46] In general, these studies find that a strong parent alliance predicts treatment persistence, whereas the youth alliance best predicts symptom reduction. However, this pattern is not cleanly or fully supported across all studies. An examination of youth psychotherapy in community outpatient centers found that

positive parent-reported parent-therapist alliance predicted family participation (for positive alliance) and cancellation, no shows, and premature termination (for negative alliance), whereas a positive youth alliance predicted both youth- and parent-rated youth symptom reduction.[44] Strong, self-reported parent and youth alliances were also predictive of each party's own satisfaction with the treatment. Supporting the link between a strong, positive youth alliance and symptom reduction, a study of the alliance for youth with disruptive behavior disorders treated with parent management training or with training in problem-solving skills found that *both* strong child and strong parent alliances predicted youth symptom reduction, though the effect was *larger for children* than parents ($r = .25$ vs. .09).[46] Strong child and parent alliances in youth anxiety treatment also both predicted symptom reduction; however, in this case, the *parent*-reported alliance predicted reduction in global internalizing problems, including symptoms of depression and anxiety, whereas the youth-reported alliance predicted only anxiety symptom reduction. Three studies of the observer-rated alliance in multisystemic family therapy for adolescents with substance abuse disorders support the finding that a weak parent-therapist alliance predicts dropout. However, observer ratings in one study showed that dropout was also predicted by a declining youth alliance across the first two sessions.[36] In another study, an early strong parent alliance positively predicted youth symptom reduction post-treatment for substance-abusing youth; perhaps paradoxically, a weaker youth alliance early in treatment predicted greater treatment gains.[45] The authors' post hoc analyses suggest that this surprising result was due to alliance shifts: the most positive outcomes were seen in youth who had poor early alliances that improved across treatment, whereas symptoms escalated in youth with declining alliances. Finally, findings from Shelef and colleagues[40] suggest a potential interaction ($p = .06$) between youth and caregiver alliances such that strong, observer-rated youth alliances predicted symptom reduction only for those youth whose parents exhibited a medium to strong alliance with the therapist.

Taken together, these recent findings suggest that both the youth and parent alliances may have a significant, though complex, relationship to outcome and may not be as straightforwardly consistent as adult patient-therapist alliance effects. Broadly, a weak parent-therapist alliance seems to predict dropout (four studies), although observer-rated declining alliance has also predicted dropout (2 studies), as has parent report of a negative youth alliance.[16] The link between a weak parent alliance and dropout appears logical in that parents who are not invested in the treatment of their children or adolescents may be less likely to provide instrumental support (e.g., securing transportation). With regard to symptom reduction, there is some evidence that the youth-rated alliance is a better predictor than the parent-rated alliance (four studies examining parent vs. youth alliance to therapist). However, in the case of depression and substance abuse, two studies showed better prediction by the parent alliance.

Although caution should be used in interpreting the outcome of this small pool of studies, the emerging results suggest that the youth and parent alliances may contribute important, unique variance to the treatment process. However, since the findings have not been straightforward or consistent across studies, we need to gain a better understanding of moderator effects in order to disentangle the relative contributions of the youth and caregiver alliances under different treatment conditions and with different patients. In addition, a larger base of studies on the alliance in youth psychotherapy could allow for testing of interactions between the ratings by therapist, parents, and youth of the therapist's alliance to youth and to parents.

WHAT IS THE DEVELOPMENTAL COURSE OF THE YOUTH ALLIANCE?

Although preliminary evidence suggests that the therapeutic relationship with youth is important in treatment retention and symptom reduction, we have little knowledge of the developmental course of the alliance with youth, including how it develops or changes over time. This issue is not unique to youth. In their recent review of the adult alliance literature, Castonguay and colleagues[12] identified five major areas in need of further research with adults, several of which related to the development and maintenance of the alliance. Specifically, they noted that a number of therapist behaviors have been linked to the fostering of the alliance (e.g., demonstration of warmth, honesty, and interest; attending to the patient's experience; use of exploration, reflection, and accurate interpretation).[47] In addition, a handful of studies has begun to investigate methods for enhancing the alliance (e.g., training therapists in alliance-fostering techniques)[48] as well as for detecting and repairing alliance ruptures (e.g., identifying potential markers of rupture such as patient withdrawal and confrontation, and addressing these problems using meta-communication skills, including discussion of negative feelings toward the therapist).[49–51]

Although empirical study of the process of adult alliance formation and effective repair of alliance problems is emergent and preliminary, for youth there has been even less study of the formation and developmental course of the alliance. However, a few studies point to important hypotheses for further testing. Based on discovery-oriented observations of instances in which the alliance improved for adolescents in a multidimensional family-therapy intervention, six alliance-building behaviors were identified in an

alliance development study.[52] These interventions included: (1) attending to the adolescent's experience, (2) orienting the adolescent to the collaborative nature of therapy, (3) formulating meaningful goals, (4) presenting self as an ally, (5) challenging control and contingency beliefs, and (6) addressing issues of trust, honesty, and confidentiality in the therapeutic relationship.

These elements were examined for five adolescents with chronic poor alliances and five adolescents whose poor alliances in the first session had improved by the third. Given the small sample, effects did not reach statistical significance and so must be interpreted cautiously; large differences were noted between the two groups, however, on three dimensions. Findings suggested that the therapist's presenting as an ally was the factor most related to improved alliance. Additionally, in cases in which the alliance improved, the therapist had increased in attending to the adolescents' experience and in helping them to formulate personal goals for the therapy. This last finding is especially intriguing in light of the question regarding the role of goals in alliance formation for youth.

Alliance-building behavior has also been examined within a cognitive-behavioral treatment for youth with anxiety disorders. The authors examined therapists' levels of playfulness, pushing the child to talk, offering hope and encouragement, being overly formal, collaboration, validation, general conversation, and working to find common ground. Both child and therapist ratings of the alliance were positively predicted by collaboration.[21] Additionally, the quality of the child-rated alliance was negatively predicted by pushing the child to talk and by the therapist's efforts at finding common ground. The quality of the therapist-rated alliance was negatively predicted by being overly formal. Notably, child ratings of alliance at session 3 were predicted by the therapist's behavior in the first three sessions, whereas the therapist's behavior during those sessions was not predictive of therapist-rated alliance at session 3 but was predictive of therapist-rated alliance at session 7. These results seem consistent with findings from the adult literature suggesting that therapists' rigid adherence to treatment protocols are linked to alliance difficulties.[53–55] In addition, these findings offer more support to the notion of an important collaborative element in the definition of the youth alliance, and raise additional methodological questions about the timing of alliance measurement for youth.

Although the pattern of alliance that best predicts positive outcomes for youth is unknown, at least two studies suggest that positive shifts in alliance across sessions may be beneficial, paralleling some adult findings that positive outcome is predicted not just by a static positive alliance, but by a globally improving, yet oscillating, alliance.[56,57] Chu and Kendall[58] found in a study of youth treatment for anxiety disorders that involvement in treatment best predicted outcome when measured at midphase and that positive shifts were as beneficial as a strong, constant level of engagement. Similarly, a study of multisystemic family therapy found that positive shifts in alliance predicted retention in treatment and symptom reduction.[36,45]

Further research is needed to illuminate the most effective manner of handling alliance ruptures with children and adolescents. Potentially effective techniques for addressing alliance ruptures with adults—such as addressing the patient's negative feelings toward the therapist—may not be effective with adolescents: broadly speaking, more frequent use of silence, questions about feelings, and transference interpretations were found by DiGuiseppe and colleagues[23] to negatively predict alliance ($R = -.47$). These results were interpreted by Creed and Kendall[21] as indicating that adolescents do not respond well to the same rupture-repair strategies as adults, which may be the case. However, DiGuiseppe and colleagues[23] did not study these factors within the context of alliance ruptures per se; consequently, empirical questions remain as to when, how, and if these strategies are useful. To date, no studies have empirically investigated alliance-rupture repairs with children.

DiGuiseppe and colleagues[23] have suggested a detailed approach for handling youth-patient resistance and for enhancing alliance through a multimodal strategy developed from emotional script theory, social problem solving, motivational interviewing, and strategies from systems theory. These recommendations could be reasonably tested in a training paradigm similar to that used by Crits-Cristoph and colleagues[48] for adults, but they await empirical validation.

POTENTIAL MODERATORS OF THE ALLIANCE

Although treatment approaches vary in the degree to which they emphasize the relationship as a potential change mechanism, neither the adult- nor youth-treatment approach appears to moderate the alliance-outcome relationship.[13,22] Nor has modality been shown to affect the alliance-outcome link;[22] this result is especially interesting for youth populations, as alliance might be anticipated to operate differently in individual, as opposed to family, treatment. Because treatment type and modality have been assessed via meta-analysis only with a small number of studies, however, analyses have not been able to examine more nuanced interaction effects. For instance, within family treatments or those that heavily emphasize parent participation, parent alliance may affect outcome more than in treatments that focus only on youth. In addition, several studies of cognitive-behavioral therapy with youth have failed to find the expected alliance-outcome link.[38,39] Although in meta-analyses no significant treatment effect was found based on treatment approach,

it may be that there is again an interaction effect. Specifically, in two studies in which there was no alliance-outcome link,[15] the patients were being treated for anxiety—which raises diagnosis-treatment interactions as a potential hypothesis; anxious patients may show less alliance variability as a group than externalizing patients since their particular difficulties may lead them to work harder at forming a positive alliance than more interpersonally confrontational patients.

In contrast to the lack of strong connection between the alliance and treatment approach, the quality of the alliance has been shown to correlate positively with some youth-patient characteristics and negatively with others. These findings must be considered preliminary, however, since the number of such studies is so small in comparison to studies of adult patients. Shirk and Karver's meta-analysis[22] did find that the type of youth problem moderated the alliance-outcome link.[22] Externalizing disorders showed a stronger link to outcome than internalizing problems (mean = .30, vs. .10). However, Green[7] noted that youth with externalizing disorders also exhibit greater alliance variability as a group, perhaps accounting for the stronger association to outcome. The willingness of youth to participate in treatment and their actual levels of participation have also been linked to more positive alliance.[32]

In addition, there is some preliminary evidence of matching effects for youth gender and ethnicity that may affect the alliance. Specifically, a study of adolescents being treated for substance abuse found higher alliance ratings for youth who were matched with therapists of the same gender.[59] Although the same study found no youth-reported alliance effects based on ethnic matching, therapists reported weaker alliances with patients who were not ethnically matched.

Several characteristics of therapists have also been associated with the quality of the alliance. A meta-analysis found that therapists' interpersonal skills (e.g., empathy, warmth, and genuineness) in 19 treatment-process studies were correlated (r = .37; SD = .24) with therapy process variables, including alliance. Direct therapist influence (e.g., actively structuring session, providing a rationale, and so on) was positively correlated with alliance at a very low level.[32]

CONCLUSION

Youth alliance research is at an exciting phase of discovery. The emerging empirical evidence indicates that the relationship matters. For example, the quality of the alliance seems to predict both premature termination (in the case of weak alliance, especially as rated by caregiver) and symptom reduction (in the case of strong alliance, as rated by youth) for youth across different treatment approaches. Additionally, we are beginning to clarify some moderators of the alliance, including the patient's diagnosis and the therapist's interpersonal skills.

There are many questions that await further study. For example, the very definition of the youth alliance is not clearly agreed upon, nor is there a standard approach to measuring it. Given the rapid recent growth in youth alliance research, these issues are not entirely unexpected. However, as the field matures, a consensus on constructs and core measures will be essential to identify the nuances of alliance-outcome effects.

In addition, further work is needed to address issues of alliance development and causal direction of effects. As recently discussed by Kazdin and Nock,[33] among others, repeated measures over time and experimental designs, such as training paradigms used in the adult literature,[48] need to be complemented by studies that assess the alliance within treatment as usual in naturalistic settings. Research on alliance training that is specifically focused on recognizing youth alliance ruptures and repair may be an important area of study in view of the nonlinear nature of alliance development that is found in the adult literature. Youth treatment resistance remains a widely cited problem for clinicians treating that population and is an especially salient issue when working with youth who have externalizing disorders.

In order to understand the developmental course of the youth alliance, the client's developmental skills also need to be taken into account. The effect of cognitive development on the alliance has been widely discussed,[2] as have issues of adolescent autonomy as it affects youth resistance to treatment.[21,23,60] Much more empirical research is needed, however, to assess these developmental effects. Additionally, youth are developing across many other domains, including emotional, social, and biological, each of which is likely to play a role in alliance formation and to affect such things as the capacity for insight and the subtleties of the particular bond formed with therapists. From the perspectives of both research and clinical application, studies using child development to inform hypotheses about defining, measuring, and effectively developing the alliance are sorely needed.

It is clear that a greater research emphasis on the youth alliance is warranted. Up to this point, we have used the adult literature as a heuristic for understanding the nature and possible mechanisms of alliance in youth treatment. Proceeding along those lines has been valuable as a starting place. Adult models have helped to suggest operational definitions for the youth alliance, involving both collaborative and affective components; served as a basis for developing youth-specific self-report and observer measures of alliance; and informed the methodological elements of the youth alliance research process (for instance, pointing to pitfalls with regard to the timing of alliance measurements). The utlilization of adult models of alliance has facilitated

the compilation of preliminarily evidence that the quality of the youth alliance predicts both treatment completion and symptom reduction. However, despite the clear contributions of the adult literature, adult models are insufficient to advance knowledge of the youth alliance beyond its current state. Greater infusion of child development principles and child-specific theory is needed to address complexities unique to youth. For instance, developmental theory may be used to examine how family systems affect youth attendance and youth-therapist alliance; how children's developing verbal skills may affect their ability to form collaborative alliances with therapists; or how the normal adolescent process of separation-individuation may affect the definition of, and manner of building, a strong and effective alliance for older youth. By examining such youth-specific developmental issues, we may begin to answer some of the outstanding questions raised by current findings. These questions include the best operational definition for the youth alliance, the developmental course of the alliance across treatment for the youth of different ages and developmental levels, developmentally appropriate measures of the youth alliance, and relative contributions of parent and youth alliance to treatment across time. The youth working alliance has been clearly established as an important clinical construct; further empirical work is now needed to understand the process by which it affects treatment.

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