Working with Children and Families: Therapeutic alliance and engagement.

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Overview

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Firstly the role of the working alliance in treatment outcome will be introduced. The importance of alliance in treatment outcome will be examined, followed by an overview of alliance models and specific issues in alliance with children and young people.

Secondly common factors in building alliance will be discussed:

- Expectancies
- Goal clarification

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Alliance

Definition:

“that aspect of the relationship between the therapist system and the patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy”

Pinsof and Catherall, 1986

Therapeutic Alliance

- The Working Alliance (Greenson, 1967)
  - Analytic
- The Treatment Alliance (Sandler et al, 1970)
  - Analytic
- Family Therapy Alliance (Pinsof and Catherall, 1986)
  - Systemic

Working Alliance and Client Outcome in Counselling

- 25 years of research has established the working alliance is an important part of successful therapy with its overall quality influencing final outcome
- Horvath (1994) in a review of the literature concluded that the working alliance was responsible for .26 of treatment outcome variance independent of therapeutic approach. Hubble et al. (2000) in a review of the alliance literature found the working alliance accounted for 30% of all positive treatment outcome across approaches.

Working Alliance and Client Outcome in Counselling

- In a more recent meta analytic review of alliance studies Martin et al. (2000) found that working alliance is moderately related to outcome (r =.22).
- This effect was consistent regardless of therapy type, client, group or other variables thought to influence the relationship with outcome.
- The working alliance has been shown to be a significant factor, not only in individual, but also in group therapy and marital therapy (Pinsof 1994).

NIMH Depression Study (Therapeutic Alliance): Krupnick et al., (1996)

'The results showed a significant relationship between total therapeutic alliance ratings and treatment outcome across modalities, with more of the variance in outcome attributed to ***alliance*** *than to treatment method.'*

Krupnick et al., 1996, p 536

Level of Alliance

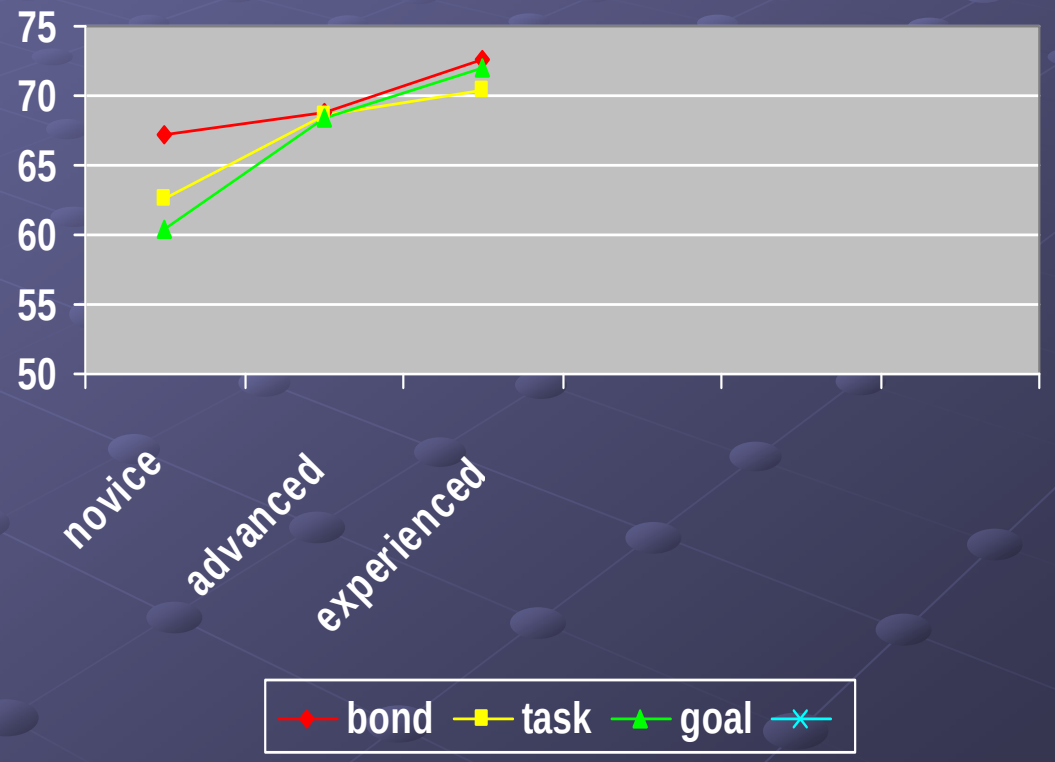
- Level at the start of therapy predicts Outcome

  Ryan and Cichetti, 1985
- Positive patient statements correlate with rated benefits

  Luborsky et al, 1983
- Therapist's personal qualities correlate highly with Outcome

  Luborsky et al, 1985

Level of Therapist Training and Client Working Alliance:Mallinckrodt & Nelson (1991).



Why worry about an alliance model?

- The alliance is a contracted collaborative construct
- If we have some clear strategies how to use alliance we are likely to maximise our counselling effort.
- It allows a high degree of matching: tailoring the alliance to suit the clients idiosyncratic preferences for relational and therapy behaviour.

Client behaviours that strain the alliance in depression

- Overt and indirect expression of negative feelings toward the therapist.
- Disagreement about the goals or tasks of therapy.
- Overcompliance and avoidance manoeuvres.
- Self esteem enhancing communication, such as boasting, that is based in power conflicts with a therapist.
- Nonresponsiveness.
- Covert behaviors such as continued lateness for appointments.

Client perception of non alliance minded therapists in depression

- critical
- nonattentive
- nonempathetic
- forgetful
- not clear about client expectations and goals for therapy

Nonalliance minded therapists create negative client reactions in depression

- negative feelings about themselves.
- guilt.
- anger at their therapist.
- a sense of abandonment

A Three Stage Model of Alliance Management

1. Bond, task & goal for early collaboration and ongoing alliance management in therapy.
2. Providing interventions and structuring therapy according to alliance type.
3. Rupture management to correct problems in the working alliance.

Developing an alliance framework

- Bond
  - empathy
  - managing client anxiety
  - self observation and awareness
- Tasks
  - intervention and the impact on the relationship
  - agreement on the appropriateness of interventions

Developing an alliance framework

- Goals
  - Client and therapist collaboration and the short, medium, long term goals for therapy.
- Develop sensitivity to the status of the alliance.
  - Assessing here and now issues and pressures in the relationship
  - Client feedback - matching
  - Intervening to address problems

Therapist Qualities

Better Outcomes from

- Engagement
- High Credibility
- Warm, empathic approach
- Accepting stance
- Liking the client or family

Specific Issues in the Development of Therapeutic Alliance in the treatment of Children and Adolescents

- **How might TA differ for children and youth?**
  - **Engagement**
  - **Consent**
  - **Alliance**

- **Who brings the child or young person?**
  Parental engagement

Styles of engagement (parents)

- Trust
- Empathy / containment
- Grief: guilt, self-blame, despair,
- Anger and sadness
- Envy
- Expertise/credibility
- Enlistment / allied attitude
- Provide information
- Foster open communication
- Decision-making
- Communication parent knows child better than anyone

Developmental features: children

- Play/activity as mode of communication
- Playful atmosphere where can be thought
- Important to be playful – children put feelings into object and playing
- Non-verbal
- Use of language – culturally and developmentally appropriate
- Use of fantasy/make believe
- Touch
- Separation anxiety
- Assessment of a working alliance
- Influence of parental role in the here and now

Styles of engagement: children

- First contact in waiting room
- Explanation of self and purpose
- Trust
- Safety – limits, rules
- Playfulness
- Comfortable with play/activity
- Empathetic attunement
- Funnel questioning
- Physical and mental setting

Developmental features: adolescents

- Concerns loss of control – respect for independence/ autonomy
- Help seeking behaviours - access
- Resistance to treatment – for many is not voluntary
- Hopefulness that it is an outcome positive from intervention
- Motivation to make changes
- Capacity to sustain scrutiny / defensive measures against experiencing pain – measures typical of age group.
- Openness / truthfulness – identifying what is confidential and what is not
- Clarity in terms what is expected
- Crisis / short term /sudden breaking off then returning later.

Styles of engagement: adolescents

- Acknowledging consent issues (may not be voluntary process)
- Confidentiality (recognising the role of parental responsibility and support)
- Taking problem seriously - attentiveness and listening attitude
- Show concern and non judgemental interest
- Developing Trust
- Demonstrating empathy / respect
- Choice/flexibility (issue short / crisis work rather than long term)
- Appropriate language
- Open questions
- Appearance
- Physical setting – Privacy

Common factors

2 counselling factors which build alliance:

- Addressing expectancies
- Goal clarification

Learning Objectives: Expectancies

- Identify the different types of expectancies clients may have about counseling, based on research in the area
- Explain why expectancies are important to the beginning of the counseling process
- Address the expectancies of caregivers and other key people in the client's life
- Explain how addressing expectancies about counseling enhances alliance and minimizes risk of alliance rupture

Purpose of addressing expectancies :

- It provides the client with education about counseling.
- It promotes collaboration between the counselor and client, by focusing on mutual agreement and understanding of counseling.
- It establishes how counseling will proceed, to minimize confusion about the process and maximize the efficiency of counseling.

Theoretical foundations

- Expectancies about counseling can be described as “anticipatory beliefs that clients bring to treatment and can encompass beliefs about procedures, outcomes, therapists, or any other facet of the intervention and its delivery” (Nock & Kazdin, 2001, p. 155).

Types of expectancies

- Role expectancies
- Outcome expectancies
- Process expectancies

Evidence base

- Indicates that expectancies are potentially important to both the counseling process and counseling outcomes (see Dew & Bickman, 2005 for a review of the research findings).
- Research findings suggest that positive outcome expectancies are associated with client improvement. Findings also indicate that “inaccurate” role expectancies (i.e. expectancies that are not congruent with counselor expectancies) may be associated with client attrition.
- In addition, research suggests that role expectancies and positive outcome expectancies are associated with building a positive therapeutic alliance.

How to address expectancies:

Specific items to cover in expectancies discussion:

- Discuss therapist, client and caregiver roles in counseling
- Discuss how therapy will proceed
- Discuss expected outcomes of counseling

Learning Objectives: Goal Clarification

- Explain why goal clarification is important at the beginning of the counseling process
- Use a systematic procedure to clarify client goals
- Apply goal clarification with caregivers and/or other key people in the client's life
- Explain how goal clarification enhances alliance and minimises risk of alliance rupture

Theoretical foundations

- *Learning theory (self-efficacy)*
- *Empowerment theory*
- *Systems theory*

Evidence base

(research of problem solving therapy)

- Problem solving therapy is effective in reducing family burden and in reducing the rate of readmissions for adults with major mental illness (McFarlane et al., 2003)
- Problem-solving has been applied successfully with adolescent populations (Cleary & Zimmerman, 2004)
- Collaborative goal setting predicts positive outcome in psychotherapy (Tryon & Winograd, 2002)
- Clients with high commitment to treatment goals respond better to treatment of bulimia than clients with low commitment (Mussell, et al. 2000)
- Therapists, clients and caregivers do not start out with shared goals – these need to be negotiated (Hawley & Weisz, 2003)

Goal clarification phases:

- *Identifying the stakeholders*
- *Allocating goals to stakeholders*
- *Ranking stakeholder goals*
- *Identifying shared goals, goals that are not shared and goals that are mutually exclusive*

“Building the Therapeutic Alliance is a creative process, a central issue for all age groups, since in its absence, there can be no therapy”.

Dorothy M Marcus, 1998

References

- Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy Theory Research and Practice, 28,* 534-539.
- Bambling M., & King R., (2001) Therapeutic alliance and clinical practice. Psychotherapy in Australia, November 2001Vol 8 No 1
- Castongnay LG, Goldfried MR, Wiser S, Raue PJ, Hayes AM (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. J Consult Clin Psychol. Jun; 64 (3):497-504.
- Horvath, A. O. (1994). Empirical research on the alliance. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance Theory research and practice* New York: Wiley
- Nock, M.K. & Kazdin, A.E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. Journal of Child and Family Studies, 10, 155-180.