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Therapeutic alliance between youth and staff in residential group care: Psychometrics of the therapeutic alliance quality scale☆,☆☆

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ABSTRACT

Therapeutic alliance has been frequently studied in individual counseling sessions; however, research on therapeutic alliance in residential settings for youth with mental health diagnoses has been limited. This may be due, in part, to the presence of multiple service providers often in caregiving roles. The purpose of this study was to examine the psychometric quality of a widely utilized measure of therapeutic alliance used in psychotherapy with youth in residential care where the treatment is provided by a trained married couple. We also compared the relationship between youth ratings of their male and female service providers, as well as examined correlations in ratings between youth and staff on therapeutic alliance. Finally, we investigated the direction, magnitude, and trajectory of change in therapeutic alliance over a 12-month period following admission into residential care. The method was a longitudinal assessment of 135 youth and 124 staff regarding therapeutic alliance over the course of 12 months or discharge from services. Results indicated strong psychometric properties and high correlations for youth ratings of both their male and female service providers. However, the correlation was low between youth and service provider ratings of alliance. Longitudinal analyses indicated that rates of therapeutic alliance changed over time.

1. Introduction

Therapeutic alliance, also known as the working relationship between a therapist and client, has been extensively researched in the context of adult psychotherapy with over 7000 articles on the topic (Horvath, Del Re, Fluckiger, & Symonds, 2011). Meta-analyses that have been predominately focused on outpatient adult counseling have demonstrated that therapeutic alliance is a strong predictive indicator of treatment engagement and outcomes (e.g., Horvath & Bedi, 2002; Horvath & Symonds, 1991; Horvath et al., 2011; Martin, Graske, & Davis, 2000; Sharf, Primavera, & Diener, 2010). Therapeutic alliance has been conceptualized as consisting of three components: the bond or affective components of the relationship, agreement on the tasks or activities of the therapy, and shared agreement on the goals of the therapy (Bordin, 1979). This perspective also often incorporates a perception of openness, honesty, and trustfulness within the working relationship (Doucette & Bickman, 2001).

Recently, therapeutic alliance research has been extended to child and adolescent-centered therapy. As with the adult research, a number of review studies have found evidence that therapeutic alliance between the youth and therapist is predictive of treatment outcomes (Karver, Handelsman, Fields, & Bickman, 2006; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011), although a few studies have found only weak associations among therapeutic alliance and youth outcomes (Green, 2006; McLeod, 2011). The vast majority of these studies with youth are focused on traditional, out-patient settings (e.g., McLeod, 2011; Shirk et al., 2011). However, many youth receive mental health treatment in alternative settings, such as in-home family based services or out-of-home services such as residential group homes or treatment foster. Such settings bring with them a variety of challenges to the assessment of therapeutic alliance.

While 15% of youth in out-of-home placements are served in residential care (Kids Count Data Center, 2012), there has been minimal research into the role of therapeutic alliance in this intensive treatment setting that serves youth 24/7. Most of the work on therapeutic alliance in out-of-home care has been descriptive in nature. For example, Manso, Rauktis, and Boyd's (2008) study of therapeutic alliance in a

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youth wilderness camp setting conducted focus groups with 11 youth regarding their relationships with their counselors. This study found that youth identified three essential aspects of their counselors: the counselor's personal qualities (e.g., caring and trustworthiness), the counselor's behaviors (e.g., listening to youth and providing accurate feedback), and the relationship between the youth and counselor (e.g., respect, caring and trust). Notably, youth were also looking for counselors to be professional, yet provide a personal, more parental role. Another study based in a similar wilderness camp program found a minimal correlation between youth and counselor ratings of therapeutic alliance (Bickman et al., 2004), a discrepancy that has also been found in out-patient settings (e.g. Hawley & Garland, 2008). Findings from a descriptive study of therapeutic alliance in a residential setting in the Netherlands suggested that attachment representations to counselors could predict relationship quality (Zegers, Schuengel, Van IJzendoorn, & Janssens, 2006). Likewise, a descriptive study by Moses (2000) indicated that it was beneficial if counselors focused on rules and expectations when dealing with interpersonal conflicts among the youth, but used personalized, youth-focused approaches when addressing individual youth behavior.

Few studies of youth and therapeutic alliance examine how it predicts youth outcomes. A recent meta-analysis requiring temporal order of therapeutic alliance in predicting outcomes in more traditional outpatient settings found only 16 studies that meet the inclusion criteria (Shirk et al., 2011). A couple of studies in residential settings have attempted to examine the role of therapeutic alliance in relation to the prediction of treatment outcomes. For example, a large residential service provider examined the role of therapeutic alliance between youth and their professional mental health counselors (whom they visit with one to two hours per week) and found no relationship between therapeutic alliance and youth outcomes (Handwerk et al., 2008). Another study found that gains in therapeutic alliance with residential staff from intake to three months predicted improvement in youth outcomes; whereas youth with high alliance scores at intake seemed to be related to negative outcomes (Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000). This finding is intriguing, as minimal research has been conducted on the developmental trajectories for youth in psychotherapy treatment. However, it is consistent with a recent study that found evidence suggesting that increasing youth therapeutic alliance scores over time was related to improved outcomes in an outpatient setting (Bickman et al., 2012). This is also supported by study in foster care that examined how therapeutic alliance scores for youth changed over time (Rauktis, Andrade, Doucette, McDonough, & Reinhart, 2005). They found that youth therapeutic alliance scores typically started high, declined, and then gradually began to increase. This study was limited by a small sample of 25 youth but is a promising approach for future research. Research seeking to understand the relationship between therapeutic alliance trajectories and outcomes would help to better inform practice and has led to a call for more research examining therapeutic alliance longitudinally (Bickman et al., 2012; Hawley & Garland, 2008; Shirk et al., 2011).

Conducting research on therapeutic alliance for youth in residential settings is inherently complex. In some treatment settings, youth live in homes served by rotating shift staff, and thus may have different types of working relationships with the different providers. In other situations, such as Teaching Family Model programs (Wolf et al., 1976), youth reside with a married couple that lives with them daily. In these situations, the youth alliance would be shared between the male and female spouses. In both the married couple or shift-staff arrangements, the providers are the primary source of discipline and decision-making; far more like a parent role than a traditional clinician role. This brings to the forefront issues regarding the measurement of therapeutic alliance in residential settings.

There are few measures of therapeutic alliance with strong psychometric properties that have been used with youth in traditional psychotherapy settings (Bickman et al., 2010, 2012; Fjermestad et al., 2012; Hawley & Weisz, 2005; Horvath & Greenberg, 1989; Kazdin, Marciano, & Whitley, 2005; McLeod & Weisz, 2005; Shirk & Saiz, 1992; Tracey & Kokotovic, 1989). Early versions of youth therapeutic alliance measures were used in two studies of residential care (Bickman et al., 2004; Florsheim et al., 2000); however, the psychometric properties of the alliance measures were only briefly addressed. Moreover, the studies did not examine if there were differential ratings of alliance among the youth's residential providers. Thus, it is important to discover if the existing therapeutic alliance assessment approaches based upon the outpatient model can be modified to be used in out-of-home settings such as group residential care while retaining the strong psychometric properties of the assessments. If not, perhaps new therapeutic alliance instruments will need to be developed for use in residential care.

Consequently, the purpose of this study was three-fold: 1) to examine the psychometric quality of the TAQS (Bickman et al., 2010) a widely utilized measure of alliance used in out-patient settings; 2) to investigate the relationship among the male and female service provider TAQS ratings as provided by the youth, as well as compare the youth-provided TAQS ratings to the perspectives of the service providers; and 3) to examine the direction, magnitude, and trajectory of change in therapeutic alliance over a 12-month period following admission into care for a sample of youth in residential care. This was accomplished with a psychometric study to address goals one and two, and a longitudinal study to assess goal three.

2. Methods

2.1. Setting

The study was conducted at a residential facility that serves over 500 girls and boys in 70 family-style group homes in a large Midwestern city. The agency has implemented an adaptation of the Teaching Family Model (TFM; Davis & Daly, 2003; Wolf et al., 1976) since the 1980s and employs a married couple as the primary service delivery agents. This treatment-providing couple live in a family-style home with up to eight adolescent girls or boys. The focus of the TFM intervention is to teach youth skills to manage their behavior using coaching, practice, and feedback along with a token economy (Wolf et al., 1976).

2.2. Participants

Youth eligible to participate in the study were identified with a disruptive behavior diagnosis (via a professional diagnosis, Diagnostic Interview Schedule for Children (DISC; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000)), or the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001), were at least 10 years old, were experiencing their first admission to the agency, and were assigned to service providers participating in the study (124 service providers participated in this study representing 62 group homes, almost 79% of the group homes at this agency). Based on these criteria, over a two year period, 170 youth were eligible for participation and 145 (85%) had guardian consent and youth assent to participate. All recruitment and consent procedures for youth and staff were approved by the University of Nebraska-Lincoln IRB and the agency IRB.

For the psychometric study, we used a subset of 135 youth that had responded to at least 80% of therapeutic alliance items in the first wave of data collection (about 2 months after admission). Youth demographics include 59 girls and 76 boys, 30 youth indicated that they were Hispanic, 71 Caucasian, 50 African American, and 29 other. Age at enrollment ranged from 10 to 17 years, with a mean age of 15.2 (sd = 1.39).

For the longitudinal study, we used a subset of the total sample consisting of youth who had at least two data points and did not change group home during the course of data collection. Thus, the sample for the longitudinal study consisted of 101 youth. We excluded youth that changed group-homes during data collection because their