Alliance with patient and collaboration with parents throughout the psychotherapeutic process with children and adolescents: a pilot study

Alleanza con il paziente e collaborazione con i genitori lungo il processo psicoterapeutico con bambini e adolescenti: uno studio pilota

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Summary

Aim

This study evaluates the relationship of the alliance with youths affected by mental disorders aged 6 to 18 years and the collaboration between their parents and the clinician with the aim to analyse the relation of these variables with therapeutic compliance and clinical outcome.

Methods

The sample consisted of 84 males and 37 females ranging 6-18 years of age. They were split into two categories on the basis of age: ≤ 11 years and > 11 years. Patient alliance and Collaboration with parents were considered and evaluated in the diagnostic process, using the WAI (Working Alliance Inventory). Data about patients' therapeutic compliance and clinical outcome were collected during a follow-up visit six months later.

Results

"Therapeutic compliance" appears to be a crucial variable in influencing the outcome of psychotherapy. In groups of different ages "collaboration with parents" and "patients' alliance", respectively, influence compliance.

Conclusions

This pilot study shows that therapeutic compliance is the most predictive element of positive outcome. If compliance is the element common to all patients aged 6 to 18, factors influencing compliance in under-11s and over-11s are different.

Key words

Psychopathology • Developmental age • Alliance • Therapeutic compliance • Clinical outcome

Introduction

Therapeutic alliance is the relational, emotional and cognitive connection between the youth client and a therapist (e.g., bond, trust, feeling allied and positive working relationship). Client involvement means cooperating with, being involved in, making suggestions about, and/or completing therapeutic tasks (e.g., homework, discussing feelings, responding to therapist requests) [1 2]. The development of alliance is considered essential for the onset of client involvement in treatment [3].

A substantial body of research has emerged on the relationship between the alliance and treatment outcome in the adult psychotherapy literature. Across multiple measure of the alliance and multiple forms of intervention, the alliance is one of the most consistent predictors of treatment outcome [4]. Particularly Scott Miller [5] found that a number of systems provides feedback regarding client progress and experience of the therapeutic alliance to clinicians, and available evidence indicates that access to such data improves retention and outcome for clients most at risk for treatment failure. In fact age, gender, and diagnosis of the client have no impact on the treatment success rate, nor do the experience, training, and theoretical orientation of the therapist. In attempting to go deeply in these issues, Miller et al. [6] have found that the best of the best simply work harder at improving their performance than others and attentiveness to feedback is crucial. When a measure of the alliance is used with a standardized outcome scale, available evidence shows that clients are less likely to deteriorate, more likely to stay longer, and twice as likely to achieve a change of clinical significance.

Although the importance of the alliance has been recognised in child and adolescent therapy for many years, research on the alliance with children and adolescents has only recently emerged and still needs to be improved [7]. Besides, working with children and adolescents means working with parents too from the very beginning, when evaluating the problem; collaboration with parents is an essential requirement for therapy, therefore it should al-

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ways be preserved [8 9]. Daily clinical practice with children and adolescents, in contrast to diagnostic and therapeutic interventions with adults, often provides for parallel spaces for parents [10-12]. Some studies focused on several pre-treatment strategies to prepare parents and children for intervention have highlighted that prepared children and parents display greater knowledge about the therapy than their unprepared counterparts, with evidence linking increased pre-treatment knowledge to increased engagement in therapy attendance [13-22].

Despite the importance of collaboration with parents, many Authors consider that, when working with the adolescent, the therapeutic treatment should be focused on the separation-individuation process and that patient's motivation becomes the most relevant element for the development of psychotherapy [23-27].

Given the importance of the alliance relationship when working with psychiatric children and adolescents, with compliance and a positive outcome as objectives [4 28 29], we aim to analyse the relevance of patient's alliance versus collaboration with his/her parents, particularly according to age. Our initial hypothesis is that, to attain compliance and a positive outcome when working with children and adolescents, collaboration with parents is always important and, in adolescents particularly, alliance with patient is relevant too.

We mean the 'alliance with patient' and the 'collaboration with parents' as cooperative relationships, based on mutual trust and characterised by common aims; this kind of the relationship can be detached by the way of interaction and the participation mode of patients and their parents during the sessions.

Procedures

Participants

Among 201 individuals aged between 6 and 18 years who attended the Padua Neuropsychiatric Unit over a year because of psychological disease without associated any known organic pathology, 149 received, after the psychodiagnostic process, the suggestion about undergoing a further treatment. Among them, 121 patients and their familiars gave the consent to participate to the study, engaging themselves to return six month later for a follow-up clinical visit: they were 84 males and 37 females, ranged between 6 and 18 years of age. They were split into two categories on the basis of age: ≤ 11 years (49 males and 17 females); > 11 years (35 males, 20 females). Diagnosis were formulated according to the ICD-10 (ICD-10: WHO, 1992), they are summarised in Table I. The characteristic of parents are shown in Table II.

TABLE I.
Diagnosis according to ICD 10. *Diagnosi secondo i criteri dell'ICD 10.*

ICD 10 Diagnosis		
	Frequency	Percent
Not mental disorder according to ICD 10	5	4,1
Neurotic, stress and somatoform disorder	36	29,75
Affective disorder	11	9,1
Psychotic disorder	7	5,78
Personality disorder	13	10,74
Conduct disorder	8	6,61
Mixed emotional and conduct disorders	27	22,31
Soft mental retardation	8	6,611
Eating disorder	3	2,5
Comorbility (personality and neurotic or affective disorder)	3	2,5
Total	121	100

TABLE II.
Parents' characteristics (age and educational level). *Caratteristiche dei genitori (età e livello culturale).*

Parents' age		
	Mother	Father
Mean	43,36	46,16
Std. Deviation	7,8	7,58
Minimum	29	34
Maximum	58	59
N	121	121
Parents' educational level		
	Frequency	Percent
Low	39	32,24
Medium	59	48,76
Hight	23	19,00
Total	121	100

Material and methods

The neuropsychiatric consultation, which aim was to formulate a psychiatric diagnosis and to evaluate the alliance between clinician and patient, was organized with separate diagnostic interviews with children or adolescents and their parents, conducted by a child and adolescent neuropsychiatrist and a trained psychodynamic

psychologist. In the Neuropsychiatric Unit where this research was conducted, when first meeting the client, it is standard procedure in order to go on with diagnostic and/or therapeutic processes to ask youths' parents to sign document concerning privacy, civil service, sanitary and research activities, eventual videotaping or sound recording during sessions.

The consultation was arranged according to the following protocol:

- with the child or adolescent (by the neuropsychiatrist):
  - a first interview for acceptance;
  - two clinical interviews with any tests;
  - a final interview (to communicate the diagnosis and therapeutic recommendations);
- and in parallel with the parents (by the psychologist):
  - a first interview for acceptance;
  - two clinical interviews, collecting the child/adolescent's clinical history;
  - a final interview (to communicate the diagnosis and therapeutic recommendations);

The last session, with patients and their parents together, was led by the couple of operators. It was as usual devoted to communication of diagnosis and therapeutic suggestions, besides, it was the occasion to explicit the project and to collect the signed informant consent by young patients and their familiars. It was explained about the aim of the study: to evaluate the alliance with patient and collaboration with his parents in relation to therapeutic compliance and clinical outcome; particularly, it was explained that the third videotyped diagnostic session with both children and parents would had been analysed to fill the WAI-O-S in by a neutral observer, granting the anonymity. We chose the last diagnostic session to propose the study plan, rather then at the beginning, to avoid any influences on the behaviour of the participants on which would had been based the evaluation of relationships with both children and parents. The treatment that children and adolescents received were of different kind: psychotherapy structured into weekly o fortnightly sessions, clinical monitoring that means a neuropsychiatric control visit every two months, parental couple counselling, family therapy, pharmacotherapy often needing hospitalisation.

The psychotherapy could be led by some psychologists in psychodynamic oriented training who were attending the Neuropsychiatric Unit because of their traineeship for the purposes of completing the specialisation; they would actually take their specialisation in psychotherapy within a year. Otherwise patients could go outside the service, in other public or private sanitaries strucures, where the therapeutic orientation can be psychodynamic or cognitive or systemic. Clinical monitoring and pharmachotherapy were granted by neuropsychiatrists of the unit, eventually in collaboration with the paediatrics' Hospital of Padua.

All operators that led the therapeutic intervention were different operators from who formulated the diagnosis and blind to the tests' ratings by the observers.

Our starting point was the assumption that patient's involvement is intertwined with the alliance relationship and it is expressed by a patient's participation mode which can be observed in patient-therapist interaction during sessions. Since there is no specific test to measure the alliance relationship in developmental age and in a process that is not strictly therapeutic, in order to evaluate the patient-clinician relationship during the *diagnostic* process (which we named *alliance with patient*), we used the WAI-O-S (Working Alliance Inventory – Observer short version) translated into Italian language [29-31]. This scale consists of 12 items, 10 positively worded and 2 negatively worded, rated on a 7-point Likert-type scale. The items are divided into three subscales of 4 items each, based on Bordin's working alliance theory [32]: Goal (agreement about goals of therapy; e.g., "The client and therapist have established a good understanding of the changes that would be good for the client"), Task (agreement about the tasks of the therapy; e.g., "There is agreement on what is important for the client to work on"), and Bond (the bond between the client and therapist; e.g., "There is mutual trust between the client and therapist"). The WAI-O-S has been previously shown to have a good reliability and research has also shown strong support for the reliability of the WAI scales in general, as well as some support for their validity [33 34]. Ratings, ranging from a minimum of 14 to a maximum of 70, were split into three groups: 14-32 (poor alliance), 33-50 (moderate alliance) and 51-70 (good alliance).

Collaboration with parents was assessed using the WAI-O-S too. Given our purpose, ie, to evaluate parental capacity to collaborate with the adolescent's treatment, we selected the WAI-O-S task subscale (items 1, 2, 8, and 12), to be filled in during diagnostic interview (the last one). Ranging from a minimum of 0 to a maximum of 28, the ratings were coded as follows: uncollaborative parents (scoring 0-14) and collaborative parents (15-28). Ratings about WAI-O-S for both patients and parents were based on the third diagnostic session and carried out by two neutral observers, psychodynamic oriented psychologist trainers, each one blind to the ratings assigned by the other observer. Psychiatric diagnosis was formulated by trained clinicians using criteria of ICD-10 [35]. An anamnesis schedule to collect data about patient's ID, their family, psychosocial situation and clinical elements was filled in for each participant.

Data about patient's therapeutic compliance and clinical outcome were collected during a follow-up clinic visit six months after the last session. They are based on the symptomatology changes verified by the therapist over a six-month period. The part 2 of Clinical Global Im-

pressions (CGI) Italian version [36] – which refers to Global Improvement – was filled in for each patient: he/she was considered improved when the score was 1-2, unchanged when the score was 3-5, worse when the score was 6-7. The clinician who filled the CGI at the follow-up, who obviously was the same that had formulated the diagnosis, was blind to the ratings obtained by the patient in the other crucial variables considered in the present study ("compliance", "collaboration with parents" and "alliance with patient").

We classified compliance according to three levels: it was considered *good* when the patient went into psychotherapy and continued it (even discontinuously but attending at least 50% of sessions till that moment), *partial* when the patient had begun therapy but dropped out (interruption without negotiating the end with the therapist or discontinued attending loosing more than 50% of sessions), *negative* when the patient did not follow the therapist's indication.

In summary, a couple of operators made the diagnosis, formulated a therapeutic proposal and evaluate both the compliance and the outcome six months later; during the first phase of this process (diagnosis and therapeutic suggestion), two different neutral observers rated the alliance with patients and collaboration with parents. Therapists who led therapeutic processes that received the cases basing on their vacancy from time to time were blind to the study.

Our statistical analysis considers the following variables: 'alliance with patient', 'collaboration with parents', 'therapeutic' compliance' and 'outcome', cross-tabled with participants' age and sex.

Statistical analysis: data are expressed in frequency and percentage. Variables are expressed in nominal and ordinal scales. Cross-tabulations are analysed using the Chi Square test with a significance level of $p < 0.05$. Computations were performed using SPSS version 14.

Results

First, some considerations about the sample. Five Diagnostic Categories were detected to be analysed by age and gender, as shown in Figures 1, 2 and 3.

It is to note that no Personality Disease Diagnosis was present in the sub-sample of participants under 11 years of age. It is interesting to note as well a gender difference in the proportion of behavioural disorders (conduct or mixed emotional and conduct disorders, that are more frequent in males) and of anxiety and mood disorders (more frequent in females). This reflects the findings reported in the literature on the higher proportion of behavioural diseases in males than in females and, conversely, a higher proportion of affective-emotive diseases in females [37-40].

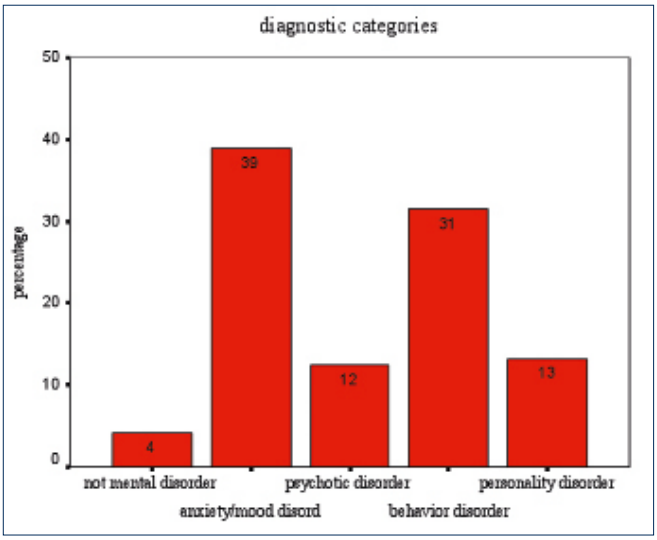

FIGURE 1.
Five diagnostic categories detected. *Cinque categorie diagnostiche individuate.*

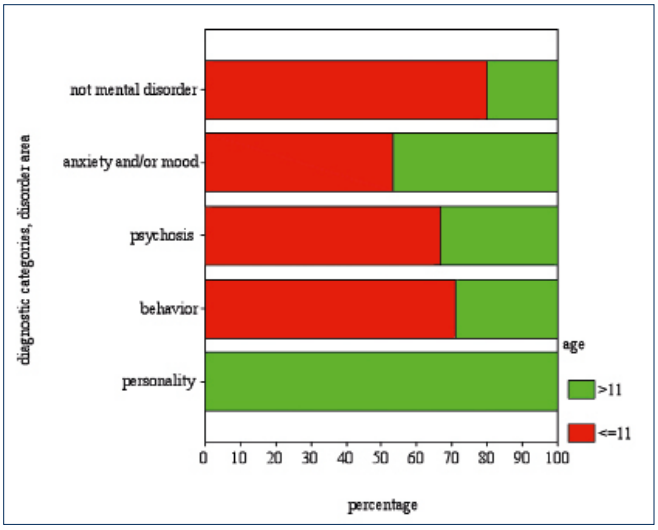

FIGURE 2.
Diagnostic categories by age groups. *Categorie diagnostiche suddivise secondo fascie d'età.*

The treatments that children and adolescents received were of different kind: psychotherapy, parental couple counselling, family therapy, pharmacotherapy, hospitalisation. A significant difference (Pearson Chi-Square value = 23.227, p = 0.026) was found, besides, in the proportion of different kinds of treatment in the five different Diagnostic Categories, i.e. different treatments were suggested to patients with different diagnoses (Fig. 4).

The main results of the present paper show interesting and different considerations for the variables involved in the construction and maintenance of an efficacy therapeutic relationship. There are no statistic significant as-

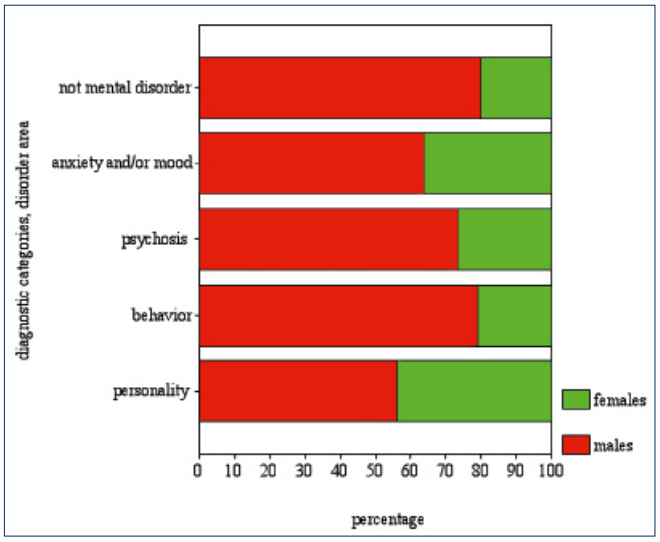

FIGURE 3.
Diagnostic categories by gender. *Categorie diagnostiche suddivise secondo il genere.*

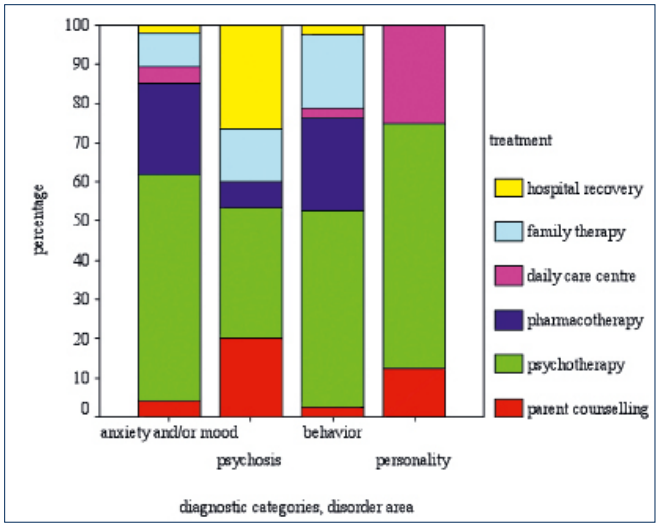

FIGURE 4.
Relation between diagnosis and treatment (Pearson Chi-Square value = 23.227, p = 0.026). *Relazione tra diagnosi e indicazione di trattamento terapeutico.*

sociations between therapeutic compliance and diagnosis neither treatments; similarly there are no associations between outcome and diagnosis and treatments.
Some other critical variables were taken into account in the analysis: "Alliance with patient", "Collaboration with parents" and "Compliance" were studied in relation to the "Outcome" variable for both children and adolescents.
Results show that a different level of outcome is associated to different levels of compliance both for children ($\chi^2_{(4)} = 35.93$; $p < .01$) and for adolescents ($\chi^2_{(4)} = 17.32$; $p < .01$). The correlation analysis indicates that good compliance is significantly associated to better clinical outcome (children: $\rho = .73$; $p < .01$; adolescents: $\rho = .39$; $p < .01$).
In the light of these general results, it becomes crucial to understand which variables determine increased levels of compliance. In this respect the two age groups differ in a very interesting way: on the one hand children's compliance is not related to "alliance with patient", but is related to "collaboration with parents"; on the other hand, adolescents' compliance is not related to "collaboration with parents", while it is related to the alliance with them. The Chi-square test indicates a significant relation between "collaboration with parents" and compliance ($\chi^2_{(2)} = 14, 19$; $p < .01$) in children: the correlation analysis indicates that a higher collaboration is related to a higher compliance ($\rho = .44$; $p < .01$). For adolescents the level of compliance is significantly different at different levels of "alliance with patient" ($\chi^2_{(4)} = 16.96$; $p < .01$) and it was observed that higher 'alliance level' is associated to better compliance ($\rho = .39$; $p < .01$).

Discussion and conclusions

Figure 5 presents two hypothetical flow-charts representing the links among the variables highlighted in the analysis.
Many interesting observations may be drawn from the analysis of the graph. Firstly, it can easily be seen that "therapeutic compliance" is crucial in both patient groups.
The results also provide indications on the best working methodology, which seems to be different in the two age categories. In other words, when the patient is a child, it seems reasonable to work mainly on the construction of a positive relationship between clinician and patient's parents, whereas when the patient is an adolescent, it is crucial to work on the construction of an alliance to motivate him/her to the therapy.

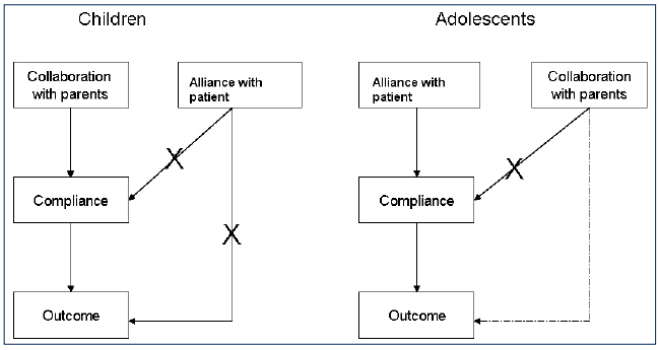

FIGURE 5.
Two possible representative flow charts. *Due ipotetiche flow charts rappresentative.*

It is also possible to argue that when an adolescent is not motivated or is oppositional towards the therapy, the related expected outcome is very poor. In this case, a good relationship between clinician and adolescent's parents can be useful, even if it is not decisive. Indeed, a weak but significant relation between the "collaboration with parents" and the "outcome" variables in the adolescent sample (represented in the graph by the dotted line) has been observed. The weakness of this relation becomes evident in the light of the fact that no relation between "collaboration with parents" and "therapeutic compliance" (the crucial determinant of the "outcome") can be found in the graph. On this basis it can be argued that, when there is a good collaboration between clinician and parents, even when the patient's compliance is not satisfactory, a sort of "homework" factor can be seen, influencing the outcome of the therapy. In these few cases, it is as if most of the therapy was carried out at home rather than in therapeutic settings. Our research seems to suggest that, when working with subjects in developmental age, good therapeutic compliance is the most predictive element of a positive outcome. If compliance is the element common to both age groups (latency and adolescence), the factors influencing compliance are different in under-11s and over-11s. The most influential variable in children is actually the coalition between clinician and parents. A good relationship with parents, built through a multi-system model of work, becomes predictive for the establishment of an alliance with the child [41 42]. Moreover, according to Palacio-Espasa [43] it is possible to claim that the working alliance with the child's parents during the diagnostic process makes it possible to identify the most suitable treatment for the patient and, consequently, to positively influence the outcome of the therapy (that is, the efficacy of psychotherapy).

The conclusions that may be drawn on the variables influencing therapeutic compliance and outcome in adolescence are different: parents' involvement during the diagnostic process plays a minor role in this age group and it is less predictive of compliance and clinical outcome than the adolescent's commitment. Therefore, in adolescence, the collaboration with parents is an important, but not decisive, variable. The crucial element for therapeutic compliance is actually the alliance relationship between patient and clinician. It follows that during the first interviews it is very important to analyse and improve adolescent's motivation to treatment within the alliance relationship, this being the crucial factor for the efficacy of the therapeutic process [44-47].

Limitations

This study presents some limitations. The first one is the heterogeneity of the cohort of families studied in terms of age and diagnosis. This limitation, which stems from the way in which subjects were recruited (arrival to the service), may limit the applicability of our findings to specific diagnostic categories.

A second limitation is the adaptation of the standardized tools used for the evaluation. Since there is no specific test to measure the variables involved in this study regarding the relationship with parents and the diagnostic context, we had to adapt the existing instruments.

A third limitation is the heterogeneity of therapeutic interventions, which was however linked to the main interest about the relation of outcome with alliance and therapeutic compliance, regardless of the kind of treatment.

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