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Kara Maltese
Parental Perceptions of
Parent-Therapist Alliance
And Adolescent Self-Disclosure
on the Perceived Efficacy of
Adolescent Psychotherapy Treatment

ABSTRACT

This quantitative study explored the impact of parental perceptions of adolescent therapy disclosures on parental perceptions of therapy and therapist. Questions examined were (1) whether parental perceptions of their adolescent's therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age and parent gender and (2) if parent-therapist alliance ratings, parent-reported closeness, and parent-reported warmth were associated with parental perceptions of treatment efficacy, and if perceived disclosures moderated this association. Participants were 42 parents who had adolescents (ages 12 to 18) who attended outpatient psychotherapy for a minimum of 6 weeks. Demographic information and perceptions of adolescent therapy disclosures, treatment efficacy, therapeutic alliance, closeness, and warmth were reported in an anonymous online survey. Fathers perceived more closeness with older adolescents than younger adolescents. Therapeutic alliance was significantly associated with treatment efficacy for parents of both genders; disclosure moderated this association when therapeutic alliance was low. Findings indicate gender differences in parental perceptions of parent-adolescent relationships, and suggest adolescent disclosures moderate how parents form perceptions of therapy. Findings have implications for how social workers working with adolescents can balance the facilitation of a client's autonomy with the parental involvement that is so crucial to the therapeutic process.

PARENTAL PERCEPTIONS OF PARENT-THERAPIST ALLIANCE AND ADOLESCENT
SELF-DISCLOSURE ON THE PERCEIVED EFFICACY OF ADOLESCENT
PSYCHOTHERAPY TREATMENT

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER 1

Introduction

Significant changes occur in the parent-child relationship during adolescence. In an effort to exert more autonomy, adolescents spend more time out of the home with a reduction in parental supervision, knowledge, and control (Keijsers, Branje, Frijns, Finkenauer, & Meeus, 2010; Larson, Richards, Moneta, Holmbeck, & Duckett, 1996). As a result of these changes during adolescence, parents often experience disengagement in communication and decreases in adolescent disclosure (Fleming, Catalano, Haggerty, & Abbott, 2010; Keijsers & Poulin, 2013), increases in conflict, and decreases in warmth and closeness (Fleming et al., 2010; McGue, Elkins, Walden, & Iacono, 2005). In general, adolescents become less willing to disclose to parents, particularly about matters they view as “personal,” such as choices about friends, style, and the state of one’s body (Smetana, 1995, 2006; Turiel, 1983, 1998). While parent-child relationships might change during adolescence, staying close and connected remains an important factor for the adolescent’s individual and relational development, as adolescents still need much support and guidance from caregivers (Finkenauer, Engels, & Meeus, 2002; Kerr, Stattin, & Trost, 1999).

This disengagement in communication and disclosures might be problematic for adolescents in general, but it can be particularly harmful and even life-threatening for adolescents suffering from mental illness, as adolescents may not disclose that they are having problems, increasing their risk for self-harm and other negative things. About one

out of every five adolescents ages thirteen to eighteen experience mental illness in a given year (Kessler, Berglund, Demler, Merikangas, & Walters, 2005), thus this impacts a significant number of youth and families. Adolescence is a particularly vulnerable time, as half of all lifetime mental illnesses first begin by age fourteen (Kessler et al., 2005), and often continue into adulthood with life-long effects (Fombonne, Wostear, Cooper, Harrington, & Rutter, 2001). If left untreated, these problems are more likely to lead to drug and alcohol use (Schwartz, 2009), high school drop-out (U.S. Department of Education, 2001), juvenile delinquency and detention (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), and suicide (Shaffer & Craft, 1999).

Despite its harmful impacts, a significant number of adolescents with mental illness do not receive appropriate treatment (U.S. Public Health Service, 2000; National Institute of Mental Health, 1999) or do not continue treatment (National Institute of Mental Health, 1999). These outcomes not only impact the quality of life for each individual youth living with mental illness, but also their families, friends, schools, and communities. Adolescents struggling with mental illness need even more support and guidance from parents during this time as they are more likely to experience issues such as sadness, irritability, anger, withdrawal, and difficulties with peer and family relationships than adolescents without mental illness diagnoses (Mental Health America, 2013; Schwartz, 2009). However, adolescents are unlikely to overtly ask for help, as doing so directly conflicts with their desire for autonomy and independence from parents (Oetzel & Scherer, 2003). Due to decreased communication and desire to seek help, parents play an important role in buffering their adolescents from negative impacts of mental illness.

Since adolescents are often not overtly asking for help, parental perceptions of the presenting problem become central to adolescent psychotherapeutic treatment. For example, parental perceptions of their adolescent's presenting problem that brings them to treatment determine whether their adolescent receives help (Wahlin & Deane, 2012). Parental perceptions of treatment also impact how adolescents engage in treatment. Parents who have favorable attitudes towards or experience with psychotherapy are more receptive to their youth's treatment (Bonner & Everett, 1986; Gustafson, McNamara, & Jenson, 1994), while parents who perceive psychotherapy as unhelpful or ineffective are more likely to prematurely terminate treatment (Day & Reznikoff, 1980; Kazin, Holland, & Crowley, 1997). Parents also play a significant role in the therapeutic process, with the level of their engagement directly impacting the duration of treatment and perceptions of treatment efficacy (Oetzel & Scherer, 2003; Shirk & Karver, 2003). If adolescents are not communicating to parents about their mental illness symptoms and treatment process, then treatment might be unsuccessful. More important than actual adolescent disclosures, however, are parental perceptions of adolescent disclosures; it is parental perceptions of such disclosures that influences parental behaviors and engagement in treatment. However, the relationship between perceived disclosures, warmth, and closeness in the parent-adolescent relationship and the therapeutic process of adolescents' with mental illness is an unexplored realm.

To address this gap in the literature, the purpose of the present study is to determine parental perceptions of disclosures made by adolescents about psychotherapy, and how these disclosure perceptions relate to parental perceptions of treatment efficacy, therapeutic alliance, parent-adolescent closeness, and parenting warmth. Thus, the

research questions raised in this study are: (1) Do parental perceptions of their adolescent's therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age, adolescent gender, and parent gender? And, (2) Are parent-therapist alliance ratings, parent-reported parent-adolescent closeness, and parent-reported parenting warmth associated with parental perceptions of treatment efficacy, and is this association moderated by parent-reported disclosure?

For the purposes of this study, psychotherapy is defined by Norcross (1990) as "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (p. 218-220). Mental illness is defined as a condition that disrupts a person's thinking, feeling, mood, relatedness to others, and daily functioning, including schizophrenia and psychotic disorders, mood disorders, anxiety disorders, eating disorders, personality disorders, posttraumatic stress disorder, autism spectrum disorders, and obsessive compulsive disorder (National Alliance on Mental Illness, 2013).

CHAPTER 2

Literature Review

In order to examine parental perceptions of treatment efficacy, parent-therapist alliance, and adolescent disclosures, I will first outline a theoretical orientation for understanding adolescent development and changes in the parent-adolescent relationship which will emphasize the increasing need for autonomy and identity formation, changes in how parents and adolescents stay connected to each other, and what this means for adolescents with a mental illness. Next, I will review the literature on the importance of parents in adolescent psychotherapy, outlining the current research on parental perceptions of therapy and therapist. Then I will outline the need to better understand factors that influence parental perceptions of their adolescent's therapy and therapist. To address this gap in the literature, I will outline the current research on adolescent disclosures, highlighting factors that may moderate what and how adolescents disclose. Finally, I will summarize the gaps in the current research before I present implications for the present study.

Theoretical Orientation for Understanding Adolescent Development and Changes in the Parent-Adolescent Relationship

From a psychodynamic orientation, parent-child relationships are central to understanding individual development (Freud, 1905; Bowlby, 1969). Even in the earliest conceptualization of psychoanalytic theory, Freud indicated the impact of early childhood relationships with parents on later relationships and psychological functioning (Freud,

1905). From birth, parents become their child's primary attachment figure (Bowlby, 1969). They model social and moral expectations, provide nurturance and protection, and (presumably) secure all other physical, emotional, educational, and psychological needs for their child (Bowlby, 1969).

During adolescence, youth begin to pull away from parents as they begin to exert more autonomy and independence. Margaret Mahler (1963, 1968) theorized that the process of separation-individuation, in which a child progresses from being completely fused with mother to developing awareness of their separateness, is completed by age three. However, Blos (1967) theorized that the child continues to separate from parent figures throughout adolescence, moving away from viewing the parent as omnipotent and becoming more capable of independence. Blos's extension of Mahler's separation-individuation theory followed the work on human development theory by Erik Erikson, who conceptualized adolescence as a time faced with the psychological conflict of "identity formation versus role confusion" (Erikson, 1950). During this psychosocial stage, an adolescent navigates the task of establishing a sense of personal identity, which is characterized by individuating from parents, seeking higher levels of autonomy, trying on different roles and ideological values, emphasizing peer relationships over parental relationships, and consolidating their unique identity, which often requires a repudiation of parental and familial views that once characterized childhood (Erikson, 1950).

Although adolescents are developing autonomy, they must also stay connected to parents to successfully navigate the difficult transitions and psychosocial stressors characterized by this life stage. According to the autonomy relatedness theory by Cooper, Grotevant, and Condon (1983), adolescent development involves an ongoing interplay

between individuality and connectedness, and this ability to develop autonomy while simultaneously staying connected to parents is key for healthy psychosocial development (Finkenauer, Engels, & Meeus, 2002; Kerr, Stattin, & Trost, 1999). However, for adolescents with a mental illness, this connectedness to parents is even more important, as symptoms associated with mental illness, such as depressed mood, irritability, limitations in emotional regulation, impulse control difficulties, anger, social withdrawal, and changes in eat and sleep patterns may make it even more difficult to navigate the task of increased autonomy (Mental Health America, 2013; National Alliance on Mental Illness, 2015). In addition, these symptoms often lead to negative outcomes such as poor school performance and attendance (Glied & Pine, 2002), school dropout (U.S. Department of Education, 2001), strained family and peer relationships (Schwartz, 2009), substance abuse issues and delinquency (Ellickson, Saner, & McGuigan, 1997). These symptoms can also endanger the lives of these adolescents and those around them, with mental illness also correlating with higher rates of suicidal ideation (Glied & Pine, 2002), suicide (Shaffer & Craft, 1999), and violent behaviors towards others (Ellickson et al., 1997). Parental connectedness, including parental warmth, closeness, and communication, can decrease these risks (Fan & Chen, 2001; Jeynes, 2003; Quach, Epstein, Riley, Falconier & Fang, 2013) and is a crucial component to understanding adolescent development.

Adolescents, although seeking greater autonomy, can still stay connected to parents through a re-negotiation of what it means to be “connected;” as adolescents develop, parents must change the ways in which they interact and communicate to successfully stay connected. In order to understand the interplay of adolescent

development and parental relationships, as well as the intricacies of the changing role of parents, a theoretical basis of parenting concepts must first be examined. For the purposes of the current study, the construct of parent-adolescent “connectedness” entails parenting warmth, closeness of parent and adolescent via strong and frequent interactions, and communication via adolescent disclosures.

Baumrind (1967) offers a comprehensive model of parenting styles that has been widely used to conceptualize differences in the balance of parental control and warmth. In this context warmth is defined as behaviors that convey affection, acceptance, and support while control is related to enforcing rules and limits (Baumrind, 1967). Three parenting styles with different balances of warmth and control were originally identified, with authoritarian parenting referring to high levels of control and low levels of warmth, permissive parenting referring to low levels of control and high levels of warmth, and authoritative parenting referring to high levels of control that is developmentally appropriate and fair and high levels of warmth (Baumrind, 1967). Based on this research, Baumrind (1967) theorized that the authoritative archetype is the most effective parenting style, as children need both structure that is firm and fair, but also need warmth, acceptance, and emotional support to thrive.

Thus, one way parents are able to stay connected to their adolescent is by maintaining parental warmth as the adolescent is granted increased autonomy. Theoretically, as adolescents develop parents should be using less control in order to respond to their needs and facilitate psychosocial competency (Baumrind, 1991; Steinberg & Silverberg, 1986). As parenting control is naturally decreasing, the ability to maintain warmth is crucial in the parent-adolescent relationship and for positive

adolescent outcomes (Fan & Chen, 2001; Jeynes, 2003; Quach, Epstein, Riley, Falconier & Fang, 2013). Parenting warmth has been found to be associated with better school performance and psychological functioning (Fan & Chen, 2001; Jeynes, 2003) and has also been found to reduce the negative impacts of life stressors, such as reducing the association between academic stress and psychopathology symptoms (Quach et al., 2013). While parenting control and parenting warmth have been theorized as two major constructs of parenting, there should be an emphasis on conveying warmth while granting increased autonomy to maintain connectedness in the parent-adolescent relationship.

Another way parents stay connected to their adolescent in the face of increased autonomy and conflict is by maintaining frequent, strong, and influential interactions with one another. Despite possible increased conflict during adolescence (Fleming, Catalano, Haggerty, & Abbott, 2010; McGue et al., 2005), adolescents and parents can remain close by staying interdependent. In the parent-adolescent relationship, closeness not only entails subjective measures of affect such as positive attitudes towards one another, but also the interdependence of the activities of the parent and youth, such as how often they interact, what activities they do together, and how strongly they impact each other (Kelley, Berscheid, Christensen, Harvey, Huston, & Levinger, 1983; Repinski & Zook, 2005). Using this framework of closeness, individuals in close relationships have frequent and strong influence on each other, the influence involves various domains of activities, and this interconnectedness occurs over a long duration of time (Kelley et al., 1983). For a parent-adolescent dyad, the parent's daily activities are likely strongly impacted by meeting the needs of their adolescent, while the adolescent's daily activities are strongly impacted by the parent's parenting styles, rules, financial resources, and

work hours. In the context of adolescents with a mental illness, parents are strongly impacted by their adolescent's symptoms and struggles, while the adolescent is strongly impacted by if and how their parent decides to access treatment (Wahlin & Deane, 2012).

Parents also stay connected to their adolescent by realigning communication patterns. Adolescents exert increasing amounts of differentiation in communication by disclosing less information and disagreeing more often with parents (Keijsers & Poulin, 2013; Ryan & Lynch, 1989). While there are decreases in parent-adolescent communication, adolescents are still communicating with parents through spontaneous disclosures. Adolescents who can anticipate a warm and supportive response from parents are likely to disclose more to them, and in this way parents can stay close to their adolescents by supporting disclosures while also instilling a sense of autonomy over what is disclosed.

Although adolescents are exerting autonomy, parents are still able to stay connected and buffer their youth from negative outcomes of stressors through the maintenance of warmth, closeness, and communication. For adolescents with a mental illness, the ability to stay connected to parents is even more important. However, adolescents with mental illnesses are often decreasing connectedness and disclosures in a time when they need increasing support. (Keijsers et al., 2010; Crouter, Bumpus, Davis, & McHale, 2005; Frijns, Finkenauer, Vermulst, & Engels, 2005). This has direct implications for how adolescents with mental illness receive treatment. In their theoretical research, Oetzel and Scherer (2003) note that in an effort to gain more autonomy and repudiate parent authority, adolescents often refuse to engage in or attend psychotherapy. In fact, the very act of seeking help directly conflicts with adolescents'

desire for autonomy and individuation (Oetzel & Scherer, 2003). This makes effectively treating adolescents with a mental illness incredibly difficult, and is why understanding the roles of parents in psychotherapy for adolescents with mental illnesses and adolescent's disclosures about therapy is so important.

Importance of Parents in Adolescent Psychotherapy: Perceptions of Therapy and Therapist

Since adolescents are often not overtly asking for help, parental perceptions become incredibly influential in whether and how adolescents get psychotherapeutic help. In fact, in a quantitative study of 119 parent-adolescent dyads, Wahlin and Deane (2012) found that it is parental perceptions of the adolescent's need for help, rather than the adolescent's perceptions, that determine whether psychotherapy is pursued. When adolescents do seek help for mental illness symptoms, parents are the most influential person impacting this decision, with 90.9% of adolescents reporting a parent impacted their decision (Wahlin & Deane, 2012). While parental perceptions of mental illness are often discrepant with the adolescent's perception of the problem (De Los Reyes & Kazdin, 2005), and many parents have difficulty recognizing internalizing mental illness symptoms such as anxiety and depression (Angold, Messer, & Strangl, 1998; Logan & King, 2002), their perceptions prove to be incredibly influential on whether and how their adolescent receives help. Thus, the lens of parental perception is used in the present study. In the following sections I will outline parental perceptions of their adolescent's psychotherapy, contextual factors impacting perceptions of therapy, perceptions of parent-therapist alliance, and the impact of adolescent autonomy development on parental perceptions of treatment.

Perceptions of Therapy. Despite the significant developmental changes that occur during adolescence, the subsequent changes to the parent-adolescent relationship, and yet the continued importance of parents in the therapeutic process, there is limited research on parental perceptions of their adolescent's therapy. This is surprising, given the extent of their involvement and influence on the treatment process; without parental support and engagement, youth are likely to not access or attend treatment. Yet, what is known suggests that parent attitudes towards therapy and perception of parent-therapist alliance influence receptivity, engagement, and longevity of treatment. Research on parental attitudes toward their child's therapy, which has largely focused on children rather than adolescents, finds that parental attitudes toward their child's treatment impact engagement and longevity of treatment as well as treatment outcomes (Bonner & Everett, 1986; Armbruster & Kazdin, 1994; Nock, Phil, & Kazdin, 2001; Nevas & Farber, 2001; Staudt, 2007). In a robust longitudinal study of 405 diverse parents and children and adolescents (ages 2-15), Nock and colleagues (2001) used interviews and questionnaires to measure pre-treatment characteristics and expectations before the first session, then measured perceived barriers to treatment after the last session, and measured treatment attendance throughout treatment. Results indicate that parent pre-treatment expectancies about therapy were associated with treatment engagement such that parents who did not expect therapy to be effective experienced less therapeutic engagement, lower attendance ratings, and poorer relationships with the therapist than parents who did expect therapy to be effective (Nock et al., 2001). This study is particularly strong considering its robust sample size, pre- and post-treatment mixed measures design, and use of treatment participation records rather than reliance on parental self-reports.

Self-report study designs support associations between parental perceptions of treatment, engagement in treatment, and treatment outcomes. Nevas and Farber (2001), who surveyed parents of children up to age twelve receiving services at a community outpatient clinic, found that on average, parents reported they believed that the therapy was effective and beneficial. In this study, there was a correlation between parents with positive attitudes towards psychotherapy, active participation and engagement in treatment, and longevity of treatment (Nevas & Farber 2001). On the other hand, lack of parental engagement, including lack of treatment attendance, treatment adherence, and active participation in treatment, are associated with ineffective treatment, early termination, and negative outcomes for youth and families (Armbruster & Kazdin, 1994; Staudt, 2007). Clearly, parental perception of their child's therapy is related to their level of receptivity to and engagement in treatment, as well as to longevity of treatment and treatment outcomes.

Much less is known about parental perceptions related specifically to adolescent therapy, but what is known suggests that their perceptions continue to be impactful to their adolescent's therapy, despite these perceptions being potentially discrepant with their adolescent's perceptions of symptoms and treatment goals (De Los Reyes & Kazdin, 2005). Since adolescents are often resistant to accessing and accepting help for mental illness and are unlikely to refer themselves to treatment (Reavley, Cvetkovski, & Jorm, 2010; Sawyer, Arney, Baghurst, Clark, Graetz, Kosky, Nurcombe, Patton, Prior, Raphael, Rey, Whaites, & Zubrick, 2000), it is important to better understand their perceptions of efficacy of their adolescent's treatment. While parents might be less involved in the therapy sessions for adolescents than they would for children, they are primarily

responsible for initiating and locating services, providing legal consent, managing treatment adherence and attendance, providing transportation, providing payment, and reinforcing therapeutic gains at home (Wahlin & Deane, 2012; Nock & Ferriter, 2005), so clearly parental perceptions can have an impactful role in the adolescent treatment process and the effectiveness of the treatment.

This study aims to fill the gap in the current literature by more closely examining parental perceptions of adolescent psychotherapy. It is predicted that as parents become less centrally involved in treatment and adolescents exert more autonomy in the therapeutic process (for example, being able to disclose to the therapist and withhold from parents), parents might feel less positive in general about their adolescent's psychotherapy. Nevas and Farber's (2001) findings suggest that parents of children involved in psychotherapy on average have positive perceptions of the therapy, and this was associated with active engagement and involvement in the therapy. It is expected that there will be differences in parental perceptions when the youth involved in therapy is an adolescent rather than a child. Meeks and Bernet (1990) cite that parental attempts to maintain the family homeostasis and prevent adolescent separation from the family can lead to feelings of ambivalence about their adolescent's psychotherapy. While parents are struggling to maintain order, cohesion, and authority, adolescents are trying to establish more autonomy, withhold more information, and exert independence in personal domains (Smetana, 2006). The therapeutic process supports the adolescent's developmental struggle for more autonomy and independence, which might feel threatening to parents. This struggle is predicted to occur in the therapeutic process as well, impacting parental perceptions of the therapeutic process and therapist. Thus, it is expected that as parents

take on a more detached role from the therapy and active participation decreases, parents will have more negative perceptions of the therapeutic process.

Contextual factors impacting perceptions of therapy. Parents' general attitude toward and previous experiences with psychotherapy impact their adolescent's psychotherapeutic treatment. Specifically, parents who have more favorable attitudes toward psychotherapy in general, or who have received some type of preparation prior to the beginning of treatment, are more receptive to their youth's therapy and are more likely to engage in and support treatment (Bonner & Everett, 1986; Gustafson, McNamara, & Jenson, 1994), making psychotherapy a more effective treatment option for their youth's mental health illness. Research on psychotherapy with children up to age twelve identifies parental involvement and engagement in therapy as supportive and helpful for treatment (Nevas & Farber, 2011). On the other hand, parents who have negative attitudes and misconceptions about psychotherapy, and parents who are pessimistic about the potential helpfulness of psychotherapy, are more likely to prematurely terminate treatment (Day & Reznikoff, 1980; Kazin et al., 1997). Financial strains of the parent and family has also been found to be associated with early termination from treatment (Garcia & Weisz, 2002), indicating that socioeconomic status is also a significant contextual factor in how parents perceive and engage in their adolescent's treatment.

Cultural factors may also influence parental perceptions of psychotherapy. The act of emotional expression is valued differently based on cultural context (Hays, 2010). Self-expression is valued in the field of psychotherapy and Western cultures (Hays, 2010). However, Asian cultures typically view reserve as indicative of maturity and self-

control (Kim, 1985). If parents do not view emotional expression and discussing problems with a person outside of the family as acceptable, then perceptions of psychotherapy will certainly be more negative. Thus, differences in cultural expectations influences participation in Western psychotherapy and parental perceptions of psychotherapy.

Perceptions of therapeutic alliance. In addition to parent perceptions of therapy, research also highlights the significance of perceptions of therapeutic alliance. Much of the literature in the field of psychotherapy points to the therapeutic alliance as one of the most important factors in outcomes and duration of treatment. Two meta-analyses by Shirk and Karver (2003) and Shirk, Karver, and Brown (2011), which examined 23 studies with a combined 1406 participants receiving outpatient treatment, found that the therapeutic alliance in child and adolescent psychotherapy is consistently associated with therapeutic outcomes across an extensive body of literature, and were not moderated by treatment modality. This suggests that associations of therapeutic alliance were comparable for behavioral and non-behavioral treatments, individual, parent and family treatments, manualized and non-manualized treatments, and service versus research treatments (Shirk & Karver, 2003; Shirk et al., 2011). This indicates that perceptions of therapeutic alliance may be a better predictor of therapeutic outcomes than the type of treatment received. In their study involving parents of children up to age twelve receiving treatment in an outpatient clinic, Nevas and Farber (2001) found that parental involvement and collaboration with the therapist is a crucial factor in effective treatment with children. Hawley and Garland (2008) extended these findings to the adolescent population. In a study which surveyed both parents and adolescents receiving treatment

in a community outpatient setting, Hawley and Garland (2008) found that parent-therapist alliance and “buy-in” to the therapy was associated with treatment outcomes, with a significant association with decreases in externalizing youth behaviors. On the other hand, parents who do not perceive a positive therapeutic alliance are more likely to prematurely terminate treatment, regardless of whether they thought their youth (ages seven to eighteen) still needed or benefited from therapy (Garcia & Weisz, 2002). Taken together, the literature indicates that parent-therapist alliance is clearly an important factor in both child and adolescent psychotherapy and should be taken into account for any study examining this topic, but most literature does not specifically look at parent-therapist alliance in adolescent therapy.

Adolescent Autonomy and Implications for Parental Perceptions. Parents continue to play an important role in adolescent psychotherapy, and based on the current literature, parental perceptions of both therapy and therapist can be highly influential in how adolescents access and adhere to treatment. At the same time, however, adolescent psychotherapy should be cultivating a sense of autonomy to match the psychosocial needs of development. Even though parents are crucial in accessing and engaging in treatment, this does not mean that adolescents are giving up their autonomy; rather, autonomy becomes an important aspect of adolescent therapy, extending the need to re-negotiate parent-adolescent roles to the psychotherapeutic arrangement. This is an important point to consider, as parents are centrally involved in child psychotherapy, including direct involvement in some or all of the therapy sessions or even direct parent management training; however, their role needs to shift to a more indirect role to meet the developmental needs of their adolescent. According to Meeks and Bernet (1990),

adolescent psychotherapy must promote emotional and psychological growth and independence and must support the process of separation and individuation from parents to facilitate healthy psychological development. In fact, Meeks and Bernet (1990) outline basic conditions for adolescent outpatient psychotherapy which aim to create a therapeutic arrangement which can foster autonomy and privacy, which include the adolescent having a clear understanding of what therapy is and having a choice about continuing it, the adolescent being allowed to come to therapy for his or her own personal problems and goals rather than the parents' problems and goals, and the adolescent's communication with the therapist is confidential unless there is a clear danger. While parents have a strong influence on when, where, and how their adolescent receives and continues psychotherapy, therapists tend to grant a growing sense of autonomy, privacy, and the right to manage disclosure of what he or she shares in therapy to their adolescent clients (Gustafson & McNamara, 1987; Melton, 1999; Nevas & Farber, 2001). The minimization of direct parental engagement likely impacts parental perceptions of the treatment and the therapeutic alliance.

Since parents are less actively involved in adolescent treatment sessions and there is an increased emphasis on their right to privacy, the question becomes what influences parental perceptions of their adolescent's therapy? Since parents are likely not involved in the therapy directly, adolescent self-disclosures might be the main source of parental knowledge about their therapeutic process. It is likely that parents, who are the most influential figures in determining treatment outcomes for adolescents, know very little about the treatment process occurring and how to assist their adolescents. Therefore, it is important to better understand what influences parental perceptions of their adolescent's

therapy and therapist, and how parental perceptions are related to adolescent disclosures, which are likely a main source of parental knowledge.

Adolescent Disclosure

Since parents have less direct control and involvement in many aspects of their adolescent's life, their adolescent becomes the gatekeeper of information. Adolescents increasingly spend more time out of the home with a reduction in parental supervision, knowledge, and control (Keijsers et al., 2010; Larson, et al., 1996). At the same time, there is a marked reduction in intensity and frequency of parent-adolescent communication (Keijsers & Poulin, 2013). Yet, parents are still communicating with their adolescent and receiving information about their lives. As discussed, one of the main sources of parental knowledge becomes direct, spontaneous disclosures from the adolescent. In this way, adolescents are able to regulate what parents know about their life and can still continue to be close to their parents. However, there are many caveats that influence what, when, and how adolescents decide to disclose to parents. The content of the disclosure, parent-adolescent connectedness, mental illness symptoms, adolescent age, adolescent and parent gender, and ethnicity all influence how adolescents disclose information.

Content of disclosures. It is important to first understand what type of information adolescents will disclose to parents, as it is directly associated to what parents will know about their adolescent's lives and what they might not know. Research on adolescent disclosure using the framework of social domain theory suggests the content of information has much to do with what types of disclosures adolescents make to parents (Smetana, 1995, 2006; Turiel, 1983, 1998). In terms of disclosure of information

from adolescents to their parents, adolescents reject parental control over the realm of “personal issues,” which are seen to not have consequences for others (Smetana, 1995, 2006; Turiel, 1983, 1998). These personal issues might encompass preferences regarding friends, activities, and personal style, privacy, and the state of one’s body (Smetana, 2006; Turiel, 1983, 1998). However, adolescents and parents generally agree to legitimate parental control over moral issues which, relate to the rights of others, conventional issues, which relate to social norms, and prudential issues, which relate to one’s safety and health (Fulgini, 1998; Smetana, 2006; Smetana & Asquith, 1994). Issues around mental illness, drug and alcohol use, and self-harm might be viewed as a prudential issue relating to the adolescent’s health and safety. If the adolescent’s mental illness involves externalizing or violent behaviors, this might also be viewed as a moral issue impacting the safety and rights of others. For example, if an adolescent has difficulties with anger and impulse control and has injured a peer in a fight, this might be an issue impacting the rights and safety of others. However, an adolescent might also view mental illness and psychotherapy as a personal issue, which does not impact others, particularly if internalizing symptoms are experienced. For example, a depressed, withdrawn adolescent who spends her time in her room and does not sleep at night might view her actions as a personal choice that only impacts her. In this case, she might view what she discusses with her therapist as strictly a personal issue that her parents should not know. This can be quite problematic, because in an effort to have more autonomy adolescents become less willing to voluntarily disclose information to parents that relate to “personal” matters (Kerr et al., 1999). Therefore it is hard to know whether, what, and how adolescents disclose information about symptoms of mental illness and

psychotherapy. However, the topic of adolescent disclosures regarding psychotherapy, and how such disclosures might relate to parental perceptions that drive adolescents' treatment (Wahlin & Deane, 2012) has been empirically ignored.

Parent-child connectedness and disclosures. In addition to content, adolescent disclosures are associated with parent-adolescent connectedness, including closeness and warmth. Frequent adolescent self-disclosure to parents is related to positive parental relationships, high levels of parental trust, warmth, and acceptance (Darling, Cumsille, Peña-Alampay, & Coatsworth, 2009; Smetana, Metzger, Gettman, & Campoine-Berr, 2006; Vieno et al., 2009). When adolescents feel that their parents will be receptive and accepting of their disclosures, they are more likely to disclose. Vieno and colleagues (2009) gave both parents and their adolescent quantitative surveys and found the most prominent factor moderating adolescent disclosures was parental closeness, with a positive correlation between closeness and disclosure rates. On the other hand, nondisclosure is related to fear of parental punishment or disapproval (Hunter, Barber, Olsen, McNeely & Bose, 2011). Parents who experience a close relationship with their adolescent and who exhibit higher amounts of warmth in parenting styles experience more disclosures from their adolescents than parents who do not experience a close, warm relationship with their adolescent. This might suggest that parents who have a close, warm relationship with their adolescent are more knowledgeable about their lives and better able to buffer their adolescents from negative outcomes. For adolescents with mental illness particularly, these parents might be better able to protect them from negative consequences by accessing treatment in a timely manner. Taken together, the literature indicates that parent-adolescent closeness and warmth impact adolescent

disclosure rates. While parent-adolescent connectedness is a critical factor related to adolescent disclosures, there are also demographic factors that impact both connectedness and adolescent disclosures. These factors include adolescent age, adolescent and parent gender, and ethnicity.

Mental illness and disclosure. Even though parents can help support adolescent disclosures when relationships are warm and close, factors relating to adolescent mental illness might inhibit disclosures. Several psychological factors that relate to symptoms of mental illness, such as depression (Keijsers et al., 2010; Smetana et al., 2008), increased behavioral struggles (Crouter et al., 2010), and less self-control and self-concept (Frijns et al., 2005) have been linked to adolescent nondisclosures. The associations between lack of disclosures and depression, behavioral problems, self-control, and self-concept are particularly relevant in considering adolescents with mental illness. These findings may indicate that adolescents with certain symptoms of mental illness disclose less frequently than their peers without these symptoms. This means that not only are adolescents with mental illness at a higher risk for dangerous behaviors such as drug and alcohol use (Schwartz, 2009), high school drop-out (U.S. Department of Education, 2001), juvenile delinquency and detention (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), and suicide (Shaffer & Craft, 1999), but are also less likely to tell their parents about these struggles. While adolescents with mental illness are more likely to experience issues that can interfere with their wellbeing, they are less likely to disclose these problems and solicit help from their parents.

Age, disclosure, and connectedness. Research indicates that adolescent age influences both parent-child connectedness and disclosure rates (Fleming et al., 2010;

Marceau, Ram, & Susman, 2014; McGue et al., 2005). Current quantitative research obtained through surveys indicates that during early adolescence, parent-child conflict increases while warmth and closeness decrease (Fleming et al., 2010; McGue et al., 2005), and the relationship does not move into a state of cohesion, autonomy, and decreased conflict until late adolescence (Steinberg & Morris, 2001). Marceau, Ram, and Susman (2014) found increases in parent-child conflict and decreases in closeness during early to mid-adolescence, but also found that most parent-adolescent relationships are marked by changes in conflict and closeness, with ups and downs from year to year. While trends in general show that early to mid-adolescence is a period of increased conflict and decreased communication, these measures are not necessarily stable throughout the years. Keijsers and Poulin (2013), in a robust study of 390 adolescent-reported questionnaires, found that changes in parent-adolescent communication begin in early adolescence (ages 12-14) as youth are beginning to individuate from parents, but the period of late adolescence (ages 17-19) tends to show shifts toward connectedness and more communication. In general, early to mid-adolescence marks decreases in communication, but disclosures typically increase during late adolescence. It is likely that adolescent disclosure rates about their psychotherapy will be higher for late adolescents than young to mid adolescents.

Gender, disclosure and connectedness. Gender is another moderating factor for disclosure rates and connectedness, such that adolescent disclosure rates and parental closeness ratings are generally higher for females than males. In an extensive review of forty-seven studies on reported parental knowledge and youth disclosures, Racz and McMahan (2011) found that across the literature, girls report higher levels of parental

knowledge, parental control, solicitation, and report more disclosure to parents. In addition, in Stattin and Kerr's (2000) extensive study that surveyed 703 fourteen year olds and 539 parents in Sweden, it was found that both adolescents and parents reported higher disclosure rates for girls.

Gender has also been found to interact with age such that decreases in disclosure during early to middle adolescence are less pronounced for girls than for boys (Keijsers et al., 2010; Masche, 2010). Also, late adolescent girls are more interdependent in regard to their parents than late adolescent boys, as girls tend to experience a better quality relationship with parents and rely on parents as a source of support than boys (De Goede et al., 2009; Furman & Buhrmester, 1992). These gender differences point to more frequent disclosures and higher rates of connectedness amongst girls and their parents than their male counterparts, and possibly less pronounced decreases in closeness and disclosures. Based on these findings, it is likely that parents of female adolescents will report higher levels of disclosure and closeness, and less pronounced decreases in disclosure during early and middle adolescence, than parents of male adolescents in general.

These gender differences in disclosure rates are likely related to gendered perceptions and expectations of parents. Stattin and Kerr (2000) found similarities between adolescent-reported and parent-reported disclosure rates, indicating a relationship between parental perceptions of disclosure and actual disclosure rates. However, there are likely different expectations for disclosure for female adolescents than male adolescents due to cultural context and gendered behavioral norms. For example, there is more cultural acceptance for females to be emotionally expressive than

males. Thus, parents might be more perceptive to female adolescent disclosures, particularly disclosures about emotionality and mental illness, but might not take notice when males are not disclosing on these topics. Even more, it is possible that parents might be unconsciously missing their son's disclosures about emotionality and struggles with mental illness if it does not fit the cultural expectation of masculinity and emotional "toughness."

In addition, parental perceptions on what should be disclosed likely differ by gender of their adolescent. For instance, parents of a female adolescent might have different perceptions regarding domains of safety than parents of a male adolescent. Parents of a female adolescent might view walking alone at night as an issue of safety that she should disclose to them, whereas parents of a male adolescent might view their son walking alone at night as insignificant. Since literature shows that both parents and adolescents tend to agree that issues of safety and health should be disclosed to parents (Smetana, 2006), gender differences in parental perceptions of safety and health, and subsequent perceptions of these disclosures, are important to consider when discussing disclosures related to mental illness and therapy.

One significant limitation of research on parent-adolescent research relates to consideration of parental gender in terms of communication and disclosure. In the current literature, most studies group "parents" into one category without controlling for differences in gender or relationship with the child (Baker-Ericzen et al., 2013; Smetana et al, 2006). In addition, many studies have been limited to primarily surveying mothers due to availability. For example, Hawley and Garland (2008) surveyed 88.5% mothers and only 11.5% fathers. Nock, Phil, and Kazin (2001) surveyed 91.4% biological mothers

and 4.5% adoptive or stepmothers in their work on parental expectations of therapy. In their research on developmental changes in parent-adolescent communication patterns, Keijsers and Poulin (2013) did not differentiate between mothers and fathers, and thus could not account for mother-father differences in communication. In her research, Smetana (2006) notes that future research in the field of adolescent disclosure should aim to obtain both mothers' and fathers' perceptions so that interactions between parent-adolescent gender in disclosure can be examined. To address this shortcoming in the literature, the present study accounts for mothers and fathers separately and considers interactions between parent-adolescent gender combinations in relation to disclosures and relationship variables.

Ethnicity and disclosure. Ethnicity is also an important contextual factor which may impact levels of adolescent disclosures. While the research on ethnic and racial differences in adolescent disclosure patterns is limited and displays mixed results, some findings show ethnic differences. Yau, Tasopoulos-Chan, and Smetana (2009), in a very robust study of 489 adolescents (14-18 years old) who identified as European-American, Asian-American, and Latino, found that Asian-American adolescents voluntarily disclosed less to parents about their personal feelings than their European American and Latino counterparts. Latino adolescents disclosed less to parents about their prudential issues of risk (such as substance use) than European-American teenagers (Yau et al., 2009). Another study, which surveyed 2,100 adolescents in Costa Rica, Thailand, and South Africa, examined ethnic differences in adolescents' reasons for self-disclosing to parents and found that across these ethnicities, adolescents disclose for similar reasons and in similar ways (Hunter et al., 2011). For the present study, ethnic differences in

beliefs on psychotherapy might impact how an adolescent discusses psychotherapy with parents.

Contextual factors that influence adolescent disclosures are complex. As outlined, adolescents do not disclose all information equally, and thus will choose whether the information in question is something they want parents to know. Additionally, adolescent disclosure rates are strongly associated to connectedness with parents, including levels of warmth and closeness in the relationship. This association between disclosures and connectedness is bidirectional; adolescents must feel that parents will respond with warmth, support, and receptivity in order to make disclosures, and disclosures in turn help parents and adolescents stay connected. To complicate this, there are differences in disclosure rates due to mental illness symptoms, age, gender of both parent and adolescent, and ethnicities. In order to capture the complexity of disclosure influences, parent-adolescent connectedness (closeness and parental warmth), mental illness, age, parent and adolescent gender, and ethnicity should be examined for the present study.

Current Study

Due to the changing nature of the parent-adolescent relationship, parents exhibit less control and less involvement in their youth's life, while the adolescent experiences more autonomy, control, and independence. As discussed, this pattern also exists in the context of adolescent psychotherapy in an effort to facilitate and support age-appropriate psychosocial development. While this time can be difficult to navigate for any parent and adolescent, it can have detrimental impacts on adolescents suffering from mental illness. For those with a mental illness, parents are even more essential for guidance, support, and treatment. In order to buffer these negative impacts, parents and adolescents can still stay

connected through parental warmth, relational closeness, and adolescent disclosures, although the content and frequency of disclosures vary due to contextual differences. However, there is little research on how these changes in parental warmth, closeness and disclosure are associated with parent perceptions of treatment efficacy and therapeutic alliance, two factors found to be significant in the therapeutic process with youth. Given that most of the youth therapy literature focuses on younger children populations rather than adolescents, yet the therapeutic arrangement differs significantly for adolescents based on developmental needs, this is a gap in the current research that this study aims to fill. Since adolescent disclosures and parent-adolescent connectedness becomes the vehicle through which parents understand their adolescent's life, the question arises how parental perceptions of their adolescent's therapy and therapist are influenced by adolescent disclosures and parent-adolescent connectedness.

Thus, the present study seeks to determine (1) how parent perceptions of adolescent therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age, adolescent gender, and parent gender and (2) if parent-therapist alliance ratings, parent-reported parent-adolescent closeness, and parent-reported parenting warmth are associated with parental perceptions of treatment efficacy, and is this association moderated by parent-reported disclosure?

CHAPTER III

Methodology

The purpose of this exploratory study was to examine the relationships among parents' perceptions of adolescent disclosure about therapy, parental closeness and warmth, parents' perceptions of the therapeutic alliance and treatment efficacy. The research questions were:

1. Does parental perception of adolescent's therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age, adolescent gender, and parent gender? It was hypothesized that:
 - A. There will be a positive correlation between parent-perceived disclosures, closeness, and warmth such that when perceived warmth and closeness ratings are higher, reports of disclosure will increase.
 - B. Disclosure, warmth, and closeness will be higher for daughters and mothers and older teenagers (15-18) and lower for males and younger teenagers (12-14).
2. Are parent-therapist alliance ratings, parent-reported parent-adolescent closeness, and parent-reported parenting warmth associated with parental perceptions of treatment efficacy, and is this association moderated by parent-reported disclosure? It was hypothesized that:
 - A. Parents' perceptions of alliance will positively predict treatment efficacy; this effect will be moderated by disclosure, with more disclosure related to higher perceptions of treatment efficacy.

- B. Parenting warmth will positively predict treatment efficacy; this effect will be moderated by disclosure with higher amounts of disclosure associated with higher perceptions of treatment efficacy.
- C. Parent-adolescent closeness will positively predict treatment efficacy; this effect will be moderated by disclosure, with higher amounts of disclosure associated with higher perceptions of treatment efficacy.

Research Design

To address the above research questions, a quantitative study was conducted using an online survey taken by parents of adolescents, ages twelve through eighteen, who are currently in, or who have been in, psychotherapy for at least six weeks. The survey was composed of five pre-existing empirically reliable Likert scales that measured parental perceptions of: adolescents' disclosures about therapy, treatment efficacy, therapeutic alliance, parent-adolescent closeness, and parental warmth (see Appendix L).

Quantitative methodology was chosen for this study as the majority of the current literature on adolescent disclosure, treatment efficacy, and therapeutic alliance uses a quantitative design (Garcia & Weisz, 2002; Nevas and Farber, 2001; Nock, Phil, and Kazdin, 2001; Smetana, 1995, 2006; Stattin and Kerr, 2000; Vieno et al., 2009). The current study aimed to bridge the gap between the literature on parental perceptions of adolescent therapy and therapist and parental perceptions of adolescent disclosures by exploring associations among perception of disclosure and parental perception of treatment efficacy and therapeutic alliance. Likert scales measure perceptions and degrees of agreement, and can be used to determine associations between concepts (Engel & Schutt, 2013). Thus, Likert scales and multiple choice questions were able to

adequately address the present study's questions regarding associations between parental perceptions of adolescent disclosures about therapy, perceptions of therapeutic alliance, perceptions of treatment efficacy, parent-adolescent closeness, and parental warmth.

Sample

There were 116 initial respondents. However, only 43 participants met the inclusion criteria, having an adolescent between the ages of twelve and eighteen who currently attends or attended outpatient psychotherapy for a minimum of six weeks, and of those 43, 42 chose to participate. A total of 42 participants (31 women, 10 men, 1 transgendered) completed this study.

Inclusion Criteria. Eligible parents included biological parents, adoptive parents, step-parents, and guardians. Adolescents of participating parents were between the ages of twelve to eighteen years old, which is often used as the range of adolescence in most literature on similar topics (Erikson, 1950; Jager, De Winter, Metselaar, Knorth, and Reijneveld, 2014; Keijsers & Poulin, 2013; Smetana et al., 2006;). The adolescent in therapy was in treatment for at least six weeks before the parent was eligible to participate, so parents had the opportunity to know their child's therapist and treatment to answer questions on therapeutic alliance and efficacy perceptions. In addition, in order to better control for the type of treatment, the adolescent was specifically in individual outpatient psychotherapy, excluding inpatient treatment, partial hospitalization treatment, family treatment, and group therapy settings. Higher levels of psychiatric treatment, such as inpatient and partial hospitalization, signify a certain level of crisis and instability and often focus on crisis stabilization treatment. In-home or outpatient family-focused treatment also have a much different dynamic than individual therapy. In family work,

the parents and adolescent often attend sessions together, creating a different dynamic and need for disclosure about therapy sessions than individual adolescent treatment. Thus, individual outpatient psychotherapy was chosen to control for the severity of symptomology as well as the different levels family involvement in the treatment sessions. In individual outpatient therapy, the adolescent is presumably maintaining some level of stability and safety since they are not requiring a more intensive level of care. In addition, the focus is primarily on the individual, even if there is some involvement of the parents in the therapy.

Exclusion Criteria. Potential participants were excluded from the present study if they were not a parent or guardian of an adolescent between the ages of twelve and eighteen , if the adolescent did not attend therapy between ages twelve and eighteen, and if the adolescent did not attend therapy for at least six weeks. Initially, the study excluded participants whose adolescent did not have a mental illness diagnosis and whose adolescent has been out of therapy for more than three years (see Appendix I for original eligibility questions). However, due to high rates of exclusion and subsequent low participation, these criteria were expanded to include parents whose adolescents did not have a mental illness diagnosis and who have been out of therapy for more than three years (see Appendix J for expanded eligibility questions). This time restriction was originally set to minimize the effects of recall loss or inability to accurately remember the details and attitudes regarding their adolescent's therapy (Engel & Schutt, 2013). While recall of information after more than three years might be limited or inaccurate, this expansion was necessary for recruitment purposes.

Recruitment Procedures. Participants were recruited by convenience sampling methods including snowball sampling via emailing personal contacts, social media posts, research host sites, and posting flyers. Participants were initially recruited through emailing personal contacts and Facebook posts. Personal contacts and colleagues were asked to pass along the survey to another person who might meet the inclusion criteria or might know someone who is eligible (see Appendix M for recruitment email). In addition, adolescent therapists and clinics in Connecticut and Massachusetts were emailed recruitment information. To supplement this recruitment method, additional procedures were added. Recruitment information was also posted on Reddit and other websites which host research links (see Appendices B-C for HSR approval). In addition, flyers were posted in local public areas to recruit participants (see Appendices D-F for flyer and HSR approval). Additionally, Mechanical Turk was used to further supplement recruitment procedures (see Appendices G-H for HSR approval). These convenience sampling methods were limited in its ability to generate socioeconomic diversity, as those who are able to access the Internet, social media, and email are likely to represent higher levels of wealth, education, and status, while those of lower socioeconomic status might have more difficulty accessing an online survey. In addition, since snowball sampling was used, participants recruited represented a similar socioeconomic class as the researcher. Despite these limitations in its ability to produce a diverse and randomized sample, snowball sampling was helpful in accessing hard-to-reach populations where there is no identifiable sampling frame (Engel & Schutt, 2013). By utilizing snowball sampling, it was possible to reach participants who did not currently have an adolescent

in therapy, as those who were accessed by this method did not need direct communication with a therapist or clinic to be recruited.

It is important to note the inherent limitation in this research design regarding sampling. As this study targeted parents of adolescents who are or were in therapy for a minimum of six weeks, those who attended therapy and prematurely terminated in less than six weeks were excluded from this study. Parents who might have guilt for ending their child's therapy prematurely or who have negative feelings towards therapy in general might have been excluded, or might not have been willing to participate. The sample, then, did not adequately reflect the experiences of those who terminated treatment early or who had strong negative reactions to therapy.

Additionally, parents who do not participate in their child's treatment or do so from a far distance were difficult to reach. Sampling methods were largely aimed at targeting adolescent therapists, and thus likely recruited a majority of parents who had some degree of communication with the therapist and involvement in the treatment process. Due to sampling methods, these parents' perceptions will be reflected in this study while others may not. These potential issues might influence the generalizability of findings to other populations.

Ethics and Safeguards

Risks of Participation. Risks and benefits of participation were clearly outlined in the Informed Consent (see Appendix K). Although this study did not ask questions believed to be distressing, there is a possibility that some parent experienced discomfort while thinking about their adolescent's mental health and psychotherapy, particularly if they had a negative experience. While some could have experienced discomfort while

reflecting on this topic, it could have been cathartic to express their opinions and experiences (Beck, 2005).

To protect participants from any distress or discomfort during this study, questions were general and brief, and centered around perceptions and attitudes rather than recounting detailed emotional experiences. Questions were asked in a Likert scale method, so parents did not have to provide open-ended details about their experiences. In addition, participants had the opportunity to skip any question or anonymously end their participation at any time, so if any distress was experienced, they were not required to finish the survey.

Benefits of Participation. The potential benefit for participants was for parents to be given an opportunity to share their experiences and express their opinions regarding their child's psychotherapy. This experience can be a cathartic release for parents who have not been able to reflect upon or express their feelings on this matter before (Beck, 2005). In a qualitative Internet survey of forty women around the world, Beck (2005) conducted a content analysis to find repeating themes regarding the benefits of participating in a birth trauma study. Commonly experienced benefits for participating in the study included feeling listened to and acknowledged and feeling empowered by the cathartic experience of self-expression (Beck, 2005). This experience of empowerment and catharsis is a potential benefit for anyone given the opportunity to express their beliefs and experiences for research. Another benefit for participants is the opportunity to help increase the knowledge in the field of adolescent mental illness and psychotherapy, which can be a positive experience for those who might feel that they have contributed to the improvement of adolescent psychotherapy for the future. Additionally, referral

resources will be made available to participants at the end of the study. This will include a sheet of resources, such as psychotherapy services in the area and support groups for parents with an adolescent with mental illness.

Precautions to Safeguard Confidentiality. Participation in this study was anonymous. The survey did not collect names, email addresses, mailing addresses, IP addresses, or any other identifying information, so there was no way for the researcher to know who completed a survey. Participants were able to choose to enter their email into a drawing for a twenty-dollar coffee shop gift card. For these individuals, anonymity was compromised only to the extent that the researcher will know the name and email address of the participant, but it was impossible to match the name of the participant to their survey responses. Demographic data collected was general and did not allow participant's identity to be determined. In addition, privacy of responses was ensured. Data was only be accessed by the researcher, the research advisor, and the Smith College School for Social Work data analyst. All data collected will be stored on Qualtrics, a program which allows data to be encrypted, password-protected, and viewed only on secured servers. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data is be password-protected, firewalled, and encrypted during the storage period and destroyed properly by U.S. DOD methods, per Qualtrics security procedures (Qualtrics, 2014).

Human Subjects Review Board. This study, and all changes made to this study, were approved by the Smith College Human Subjects Review Board. A copy of the original HSRB approval letter is provided in Appendix A.

Data Collection

Data collection for this study occurred via a quantitative online survey form on Qualtrics composed of various modified Likert scales. These modified scales included Disclosure About Therapy Inventory (Khurgin-Bott & Farber, 2011), Satisfaction With Therapy and Therapist Scale, Revised (Oei, Tian, & Green, 2008), Therapeutic Alliance Scales for Caregivers and Parents (Accurso, Hawley, and Garland, 2013), Relationship Closeness Inventory (Berscheid, Snyder, Mark, & Omoto, 1989), and Parenting Styles Questionnaire (Aunola & Nurmi, 2004). After these scales were presented, demographic information was collected. The survey was anonymous, as no identifying information was collected and there was no way to connect participants to their responses.

The online survey began with seven questions that determined eligibility for participation. These questions asked whether the participant is a parent of an adolescent, whether the participant's adolescent has ever attended outpatient therapy, whether the adolescent attended treatment for at least six weeks, whether the adolescent was currently in treatment, if not currently in treatment how long they have been out of treatment, whether the adolescent has a mental illness diagnoses, and to provide the most current diagnosis. As described above, the adolescent was between ages twelve to eighteen when treatment was received, and was in outpatient psychotherapy for at least six weeks. By using an online format, those who did not meet inclusion criteria were easily be screened out which minimized the number of completed surveys that must be discarded due to

exclusion criteria. Once eligible, participants were directed to the informed consent page, and once they agree to participate, they were given five Likert scales to measure parent perceptions of adolescent disclosure regarding therapy, parental perceptions of treatment efficacy, parent-therapist alliance perceptions, and parent-rated parent-child closeness, and parent-rated parental warmth. A preliminary question was presented before presenting the scale measuring parent perceptions of therapeutic alliance. This question measured how frequently the parent interacts with the therapist. If the parent indicated never interacting with the therapist, this scale was skipped. Scores were calculated as indicated by the scale.

Likert scales were chosen for the present study because it is generally an easily understood method and takes minimal time to complete (Engel & Schutt, 2013). In addition, Likert scales allow participants to answer using a broad spectrum of agreement levels to accommodate individuals who do not hold strong opinions on the topics in question. However, Likert scales are limited in that they only provide information about the degree to which someone holds an opinion and cannot provide information about the dynamic experiences of the participant.

After responding to the Likert scales, participants were asked some questions to obtain demographic information. This information included parent and child gender, parents' general perceptions of psychotherapy, adolescent's previous experience in psychotherapy, parent's highest education level, and race and ethnicity status of both parent and child. Previous research indicates that adolescent age and both parent and adolescent gender impacts factors such as adolescent disclosure rates and parent-adolescent closeness (Stattin & Kerr, 2000; Racz & McMahan, 2011; Keijsers & Poulin,

2013; Marceau et al., 2014). Research on parental perceptions of therapy and therapeutic alliance also indicate that parents previous experiences with their own psychotherapy, as well as their general beliefs about psychotherapy, impact their perceptions and involvement in their adolescents' treatment (Bonner & Everett, 1986; Gustafson, McNamara, & Jenson, 1994; Kazdin et al., 1997; Nevas & Farber, 2011). Financial status and socioeconomic status were also found to impact longevity of treatment (Garcia & Weisz, 2002). Since these demographic measures have been found by previous research to impact critical measures of this study, such as parent-adolescent closeness, adolescent disclosure rates, and parent perceptions of therapy and therapeutic alliance, these pieces of information were obtained and analyzed to determine any differences that occur due to demographic status.

Measures

The present study used five pre-existing, published scales, which have been tested for validity and reliability (see Appendix L). These scales were all made available for public research use via the PsychTests database. Each scale is described in detail below in relation to the variable it measured. The present study examines parent-perceived adolescent disclosures about therapy, parent-perceived treatment efficacy, parent-perceived therapeutic alliance, parent ratings of parent-adolescent closeness, and parent ratings of parenting warmth. Each of these measures were addressed by pre-existing scales that were modified for the current study.

Disclosure. In order to measure the way in which adolescents disclose to their parents about their psychotherapy sessions, a modified version of the Disclosure About Therapy Inventory (DATI) was used (Khurgin-Bott & Farber, 2011). The Disclosure

About Therapy Inventory (DATI) was originally used by Khurgin-Bott and Farber (2011) as a self-reported measure about disclosures made about therapy to spouses, partners, and best friends.

For the purposes of this study, this scale was modified from a self-report to reflect parent perceptions. It was also modified to apply to a parent-child relationship rather than an adult relationship with a partner or a friend. Specifically, wording was changed so that the word “confidant” applied to the parent. For example, “Overall, how self-disclosing have you been about your therapy to your confidant?” was changed to “Overall, how self-disclosing is your adolescent to you about his/her therapy? In addition, the complete Disclosure About Therapy Inventory is comprised of three subscales, which are “Attitudes Toward Disclosure About Therapy,” “Nature of Disclosures About Therapy,” and “Reasons for Avoiding Disclosures About Therapy.” The “Nature of Disclosure About Therapy” subscale was chosen, which was originally comprised of twelve items, was chosen to measure the general nature parental perceptions of adolescent’s therapy disclosure. Due to its reflection of parental perceptions rather than self-report, two items were not used; “Overall, how self-disclosing have you been to your therapist?” and “I compare my confidant’s therapy with my own” were not used for the current study because parents would not be able to report how their adolescent discloses to his or her therapist, or how their adolescent compares their therapy to others. The ten remaining measures were rated on a scale from 1 (not at all) to 7 (to a great extent) by parents.

Ratings were averaged to obtain a mean score. The internal consistency reliability coefficient (Cronbach's alpha) for this scale was .90 (Khurgin-Bott & Farber, 2011). In this study, internal consistency as measured by Cronbach's alpha was .75.

Treatment efficacy. For the purposes of this study, treatment efficacy refers to how effective parents perceive their adolescent's therapy to be. To measure perceptions of treatment efficacy, a modified version of the Revised Satisfaction with Therapy and Therapist Scale was used (Oei, Tian, & Green, 2008). This scale is a self-reported measure aimed to measure satisfaction ratings of therapy and therapist for group treatment, where the odd-numbered items measure satisfaction with therapy and even-numbered items measure satisfaction with therapist.

For the purposes of this study, the scale was changed from self-report to a parent-report, and the word "child" was changed to "adolescent. Sample items in this scale include, "I am satisfied with the quality of the therapy my adolescent received" and "My adolescent's needs were met by the program." The scale included twelve items. Items were rated by participants on a scale from 1 (strongly disagree) to 5 (strongly agree).

Only the odd-numbered items were used to specifically target satisfaction with therapy. Odd-numbered scores were averaged to obtain a mean score. Oei and colleagues (2008) calculated high internal consistency; Cronbach's alpha coefficient for "Satisfaction with Therapy" items was found to be .90 (Oei et al., 2008). The Cronbach's alpha for the total scale was .93, reflecting good internal consistency of the combined factors. In this study, internal consistency as measured by Cronbach's alpha was .87.

Therapeutic alliance. The Therapeutic Alliance Scales for Caregivers and Parents (TASCP; Accurso & Hawley, 2013) was used to measure perceived therapeutic

alliance between parent and therapist. There were twelve items on this scale that were rated on a scale ranging from one (not true) to four (very much true). Responses to the twelve items were averaged to obtain a mean score. For the purposes of the current study, the word “child” was changed to “adolescent.” Two sample items in this scale are, “I work with my adolescent’s therapist on solving our problems” and “I like my adolescent’s therapist” (Accurso & Hawley, 2013). The Therapeutic Alliance Scales for Caregivers and Parents (TASCP) has high reliability and internal consistency, with Cronbach’s alphas ranging from .85 to .88 across four, eight, twelve, and sixteen months in treatment, (Accurso & Hawley, 2013). Caregiver-reported therapeutic alliance was significantly associated with therapist-reported caregiver alliance ($r = .67, p < .0001$) by the four month measurement, further displaying high consistency (Accurso & Hawley, 2013). In this study, internal consistency as measured by Cronbach’s alpha was .84.

Parent-adolescent closeness. The Relationship Closeness Inventory (Berschied, Snyder & Omoto, 1989) was used to measure parent-perceived parent-adolescent closeness. This inventory, in its original format, is composed of three subscales. The first subscale measures frequency of interactions using three open-ended questions. An example item from this subscale is “During the past week, what is the average amount of time, per day, that you spent alone with “X” in the morning?” and asks the participant to answer in hours and minutes. The second subscale measures the diversity of interactions with 38 items that identify different activities in a checklist format, for example “went to a restaurant.” The third subscale measured the strength of interactions with 27 items on a Likert scale ranging from one (strongly agree) and seven (strongly disagree). An example of an item from this subscale was “X will influence my future financial security.” Each of

the three subscales were scored individually; scores for each subscale were totaled to obtain an individual score for frequency, diversity, and strength.

For the purposes of the present study, the strength of interaction subscale was chosen and used individually. Eight of the twenty-seven items were chosen, using “my adolescent” as the subject of each item. Examples of items used in this modified version were, “My adolescent will influence my future financial security” and “My adolescent influences the way I feel about myself.” Since this Likert scale was used on its own, scores were averaged to obtain a mean score.

High internal consistency reliability was found for this measure across all relationships types, which included work, family, romantic, friend, and “other” relationship categories, Cronbach’s alpha being .90 (Berschied et al., 1989). The test-retest coefficient for the strength of influence, the selected scale for this study, was .81 ($p < .001$), which represents good test-retest reliability (Berschied et al., 1989). In this study, internal consistency as measured by Cronbach’s alpha was .81.

Parenting warmth. In order to measure parental perceptions of parenting warmth, the Parenting-style Questionnaire (Aunola & Nurmi, 2004) was used. This measure is the Finnish version of the Child Rearing Practices Report (Roberts, Block, & Block, 1984). There are twenty items on this Likert scale, which are rated on a scale ranging from one (not like me at all) to five (very much like me). Items included: aim to measure affection, behavioral control, and psychological control regarding parenting style. An example of an affection item is, “I believe that praise is more effective than punishment.” An example of a behavioral control item is, “If my child misbehaves, I

usually punish him/her.” An example of a psychological control item is, “My child should be aware of how much I have done for him/her.”

For the purposes of the current study, ten of the twenty items were chosen which specifically measure parental affection. These “affection” items measure how positive the parent views their relationship with their child (Aunola & Nurmi, 2004).

Scales are calculated by averaging the score of each item to obtain a mean score. Cronbach’s alpha reliabilities for the affection items were found to be .82 at time 1, .81 at time five, and .82 at time eight and the test–retest correlations ranged between .75 and .78 (Aunola & Nurmi, 2004). In this study, internal consistency as measured by Cronbach’s alpha was .68.

Data Analysis

Preliminary analyses included an examination of correlations among the variables, means, and standard deviations. Variables included in preliminary analyses were disclosure, therapeutic alliance, treatment efficacy, parental warmth, parent-adolescent closeness, general therapy beliefs, and parent-therapist interactions.

Primary analyses for the first research question, “Does parent-reported disclosure, parent-reported closeness, and parent-reported warmth differ by adolescent age, adolescent gender, and parent gender?” was a 2 (parent gender) x 2 (adolescent gender) x 2 (adolescent age, 12-14, 15-18) MANOVA on parent-reported disclosure, parent-reported closeness, and parent-reported warmth with bonferoni adjusted post-hoc analyses. However, due to small sample size within the sub-groups, analysis focused on adolescent age (12-14, 15-18) and parent gender effects on disclosure, closeness, and warmth. A 2 (parent gender) x 2 (adolescent age, 12-14, 15-18) MANOVA on parent-

reported disclosure, parent-reported closeness, and parent-reported warmth with bonferoni adjusted post-hoc analyses was completed in order to examine the three related dependent variables while controlling for the relationship between these variables. A MANOVA analysis was chosen in order to study three related dependent variables while controlling for the relationship between the dependent variables (Engel & Schutt, 2013).

Primary analyses for the second research question, “Are perceptions of parent-therapist alliance, parent-reported closeness, and parent-reported parenting warmth associated with parent perceptions of treatment efficacy, and is this association moderated by parent-reported disclosure?” was a hierarchical regression analysis with the relationship between parent-therapist alliance, parent-reported closeness, and parent-reported warmth predicting the parent perceptions of treatment efficacy, with the level of disclosure as the moderating variable. A regression analysis was chosen in order to study the association between multiple interval or ordinal variables (Engel & Schutt, 2013).

CHAPTER IV

Results

Purpose

The purpose of this study was to examine the relationships among parental perceptions of their adolescent's disclosure about therapy, therapeutic alliance with the therapist, treatment efficacy, and parent-reported warmth and parent-adolescent closeness. The first research question examined whether parental perceptions of their adolescent's therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age and parent gender. The second research question asked if parent-therapist alliance ratings, parent-reported closeness, and parent-reported parenting warmth are associated with parental perceptions of treatment efficacy, and if these associations are moderated by parent-reported disclosure. A hierarchical regression analysis was done with the relationship between parent-therapist alliance, parent-reported closeness, and parent-reported warmth predicting perceptions of treatment efficacy, with the level of disclosure as the moderating variable. A regression analysis was chosen in order to study the association between multiple related independent variables and the dependent variable while taking into account the associations of these independent variables.

Participant demographics were analyzed first, followed by preliminary analysis, including bivariate analysis and means and standard deviations that explore the data. Primary analyses are divided into research questions: Research Question 1 primary analysis: Does parental perception of adolescent's therapy disclosures, parent-reported

closeness, and parent-reported warmth differ as a function of adolescent age, adolescent gender, and parent gender? and Research Question 2 primary analysis: Are parent-therapist alliance ratings, parent-reported parent-adolescent closeness, and parent-reported parenting warmth associated with parental perceptions of treatment efficacy, and is this association moderated by parent-reported disclosure?

Population demographics

There were 42 participants who completed this study (see Table 1 for sample characteristics). The sample was predominately white, highly educated mothers who had young adolescent daughters (ages 12-14). Thirty-five participants indicated that their adolescent had a mental illness diagnosis including depressive disorders, anxiety disorders, attention deficit hyperactivity disorder, eating disorders, substance abuse disorders, psychotic disorders, autism spectrum disorders, and bipolar disorder. Seven participants chose not to respond to the question. While participants initially were required to provide a mental illness diagnosis in order to be eligible for the study, this criterion was removed due to slow response rate and low survey completion.

Table 1

Characteristics of the Sample

Characteristic	N=42
Racial Identity	
White	34
Black	3
Hispanic	3
Multiracial	1
Other	1
Education Level	
Masters	13
Bachelors	16
Associates	3
High school diploma	10
Gender of Parent	
Female	31
Male	10
Transgender	1
Gender of Adolescent	
Female	24
Male	17
Age of Adolescent	
12-14	26
15-18	16
Mental Illness of Adolescent	
Had diagnosis	35
Did not have diagnosis	7

Preliminary Analyses

Perceived disclosure, perceived treatment efficacy, perceived therapeutic alliance, perceived warmth, perceived closeness general beliefs about psychotherapy, and frequency of parental involvement with therapy were examined (See Table 2 for means and standard deviations of all variables). Most parents reported, on average, moderate levels of adolescent disclosure, parent-adolescent closeness, and involvement with the therapist. However, parents, on average, reported high levels of treatment efficacy,

therapeutic alliance, and warmth, and reported very positive beliefs about psychotherapy with a small range.

Zero-order correlations among variables, are presented in Table 2. Note that perceived closeness and parent-therapist interactions are based on scales which positive perceptions are aligned with lower numerical ratings. The Relationship Closeness Inventory (perceived closeness) operated on a Likert scale which assigned 1 to strongly agree and 7 to strongly disagree. The question on parent-therapist interactions asked, “Please choose the interaction most applicable to your interaction with your adolescent’s therapist” and assigned response 1 with “regularly meeting” and response 4 with “never meeting.” Thus, for these variables, lower numbers indicate higher ratings of perceived closeness and parent-therapist interaction levels.

Table 2

Correlations, Means, and Standard Deviations Among the Variables

Variables	1	2	3	4	5	6	7	<i>M</i>	<i>SD</i>
1. Disclosure	--	0.27	0.29	0.11	-0.10	-0.03	-0.35	3.76	1.03
2. Treatment Efficacy	0.27	--	0.45**	0.26	-0.28	0.27	-0.04	47.41	7.28
3. Therapeutic Alliance	0.29	0.45**	--	0.14	-0.17	0.33*	-0.28	3.14	0.51
4. Warmth	0.11	0.27	0.14	--	-0.27	0.29	-0.24	4.20	0.52
5. Closeness	-0.10	-0.28	-0.17	-0.27	--	-0.04	0.23	2.77	0.75
6. General Beliefs	-0.03	0.27	0.33*	0.29	-0.04	--	-0.03	4.54	0.63
7. Parent-Therapist Interactions	-0.35*	-0.04	0.28	-0.24	0.23	-0.03	--	2.00	0.73

Note: N = 42 *p < .05; **p < .01.

There were four statistically significant relations among the variables. For parents, the positive correlation between treatment efficacy and therapeutic alliance was statistically significant. Thus, parents who perceived treatment as being effective also reported positive perceptions of the therapeutic alliance. Likewise, the positive correlation between disclosure and frequency of parent-therapist interaction was statistically significant. Parents reported more disclosure when they interacted more with their adolescent's therapist. For parents, the positive correlation between general beliefs about therapy and therapeutic alliance was statistically significant. Parents who had positive general beliefs about therapy also reported positive ratings of therapeutic alliance. Similarly, the positive correlation between parents' general beliefs about therapy and parent-therapist interaction was statistically significant. Parents who had positive general beliefs about therapy also reported more frequent interactions with their adolescent's therapist. No significant statistical association was found among the following variables: disclosure and treatment efficacy, therapeutic alliance, warmth, or closeness. In addition, treatment efficacy and therapeutic alliance were not statistically associated with warmth or closeness, and warmth was also not statistically associated with closeness.

For non-significant correlations, there were meaningful trends in the data. Due to the small sample size, it is important to consider effect sizes rather than using statistical significance alone (Cohen, 1988). Effect sizes indicate the strength of an effect independent of sample size; $d = 0.10$ indicates a small effect size, $d = 0.30$ indicates a moderate effect size, and $d = 0.50$ indicates a large effect size (Cohen, 1988). Thus, effects sizes can suggest meaningful associations when sample size is small. Using

Cohen's *d* for effect size, correlations suggest small effect sizes and are approaching moderate effect sizes with the exception of the association between general beliefs and disclosure and closeness, which showed no effect (see Table 2). Effect sizes suggest that while these correlations were not significant, these variables are meaningfully associated.

Primary Analysis: Research Question 1

The first research question sought to determine the influence of parent gender and adolescent age effects on closeness, warmth, and disclosure variables (see Table 3).

Although the original research question wanted to examine adolescent age, adolescent gender, and parent gender on disclosure, closeness, and warmth, this was not possible due to sample sizes within the sub-groups. Since the literature demonstrates that adolescent age matters for parent-adolescent closeness and disclosures, adolescent age was kept as an independent variable. Parent gender, rather than adolescent gender, was chosen for analysis because parents are the respondents to this study and their biases are reflected in self-reports. Additionally, many previous studies have not examined parental gender differences and is a gap in the present literature. Therefore, a 2 (parent gender) x 2 (Age group: 12-14, 15-18) MANOVA was performed on closeness, warmth, and disclosure. There was no main effects (see Table 3 for means and standard deviations) for either parent gender, $F(3, 34) = .23$, Wilk's $\Lambda = .98$, partial $\eta^2 = .02$, or adolescent age, $F(3, 34) = 1.39$, $p = 0.26$, Wilk's $\Lambda = 0.89$, partial $\eta^2 = 0.11$. However, there was a significant interaction between parent gender and adolescent age $F(3, 34) = 3.01$, $p = .04$; Wilk's $\Lambda = 0.79$, partial $\eta^2 = 0.21$. A follow-up Univariate analysis for the gender-age interaction revealed that this interaction was only statistically significant for closeness, $F(1, 40) = 8.47$, $p = 0.006$. The gender-age interaction was not statistically significant for warmth,

$F(1, 40) = 1.08$, $p = 0.26$ or for disclosure $F(1, 40) = 1.08$, $p = .31$. Two post-hoc one-way ANOVAs were run, separated by gender, to determine the difference in closeness based on adolescent age (see Table 4 for ANOVA results). The ANOVA for fathers was statistically significant; fathers reported more closeness with older adolescents ($M = 2.18$, $SD = 0.35$) than younger adolescents ($M = 3.42$, $SD = 0.289$, $F(1, 8) = 40.07$, $p < .001$). There was no difference for mothers in the amount of closeness they reported based their adolescent's age $F(1, 29) = 0.90$, $p = 0.35$.

Table 3

Means and Standard Deviations for MANOVA

Dependent Variables	Parent Gender	Adolescent Age	Mean	SD
Disclosure	Female	12-14	4.00	0.24
		15-18	3.51	0.32
	Male	12-14	3.47	0.43
		15-18	3.80	0.53
Warmth	Female	12-14	4.14	0.12
		15-18	4.21	0.15
	Male	12-14	4.05	0.21
		15-18	4.55	0.26
Closeness	Female	12-14	2.59	0.16
		15-18	2.90	0.21
	Male	12-14	3.42 ^a	0.29
		15-18	2.19 ^b	0.35

Note. Superscripts indicate statistically different values, $p < .001$.

Table 4

Post-Hoc One Way ANOVA: Parent Gender and Adolescent Age on Closeness

Gender	Age Group	df	SS	MS	F	p
Female	Between	1	0.55	0.55	0.91	0.35
	Within	29	17.73	0.61		
	Total	30	18.28			
Male	Between	1	3.63	3.63	40.07	0.000***
	Within	8	0.72	0.09		
	Total	9	4.35			

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

Primary Analysis: Research Question 2

In order to examine the relationship between therapeutic alliance, warmth, and closeness on treatment efficacy with disclosure as a moderating variable, three separate regression analyses were run with treatment efficacy as the dependent variable and therapeutic alliance, parental warmth, parental closeness as the independent variables. The results of each regression are presented separately.

Regression 1: Alliance, disclosure, and treatment efficacy. A multiple regression model was tested to investigate whether the association between alliance with therapist and treatment efficacy depended on the amount of parent reported adolescent disclosure about therapy. Following Aiken & West (1991) all variables were standardized (mean = 0, standard deviation = 1) to allow for ease of interpretation of the results. In step 1, alliance with therapist and adolescent disclosure was entered. The interaction variable (alliance X disclosure) was entered in step 2. Results indicated that greater alliance with therapist was statistically associated with more treatment efficacy (see Table 5 for β and ΔR^2). Disclosure was not significantly related to treatment efficacy, but indicated a practical association; there was a small effect size for disclosure on treatment efficacy. The R^2 change was statistically significant, suggesting that the effect of therapist alliance on treatment efficacy was dependent on the level of parent reported adolescent disclosure.

Table 5

Hierarchical Regression Analysis for Therapeutic Alliance on Treatment Efficacy

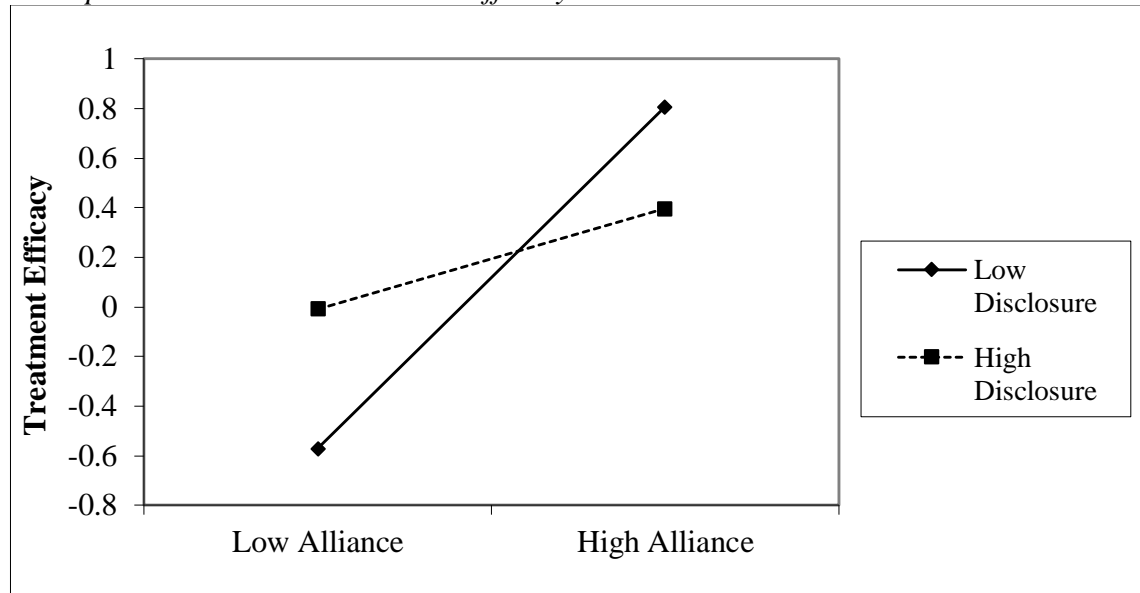
	Treatment Efficacy	
	β	ΔR^2
Step 1		.21*
Therapeutic Alliance	.436**	
Disclosure	.067	
Step 2		.09*
Therapeutic Alliance x Disclosure	-.300*	

Note. N= 38

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

Figure 1

Therapeutic Alliance on Treatment Efficacy with Disclosure as a Moderator



Follow-up analyses were performed to probe significant interactions (see Figure 7).

Simple slopes for the association between alliance and satisfaction with therapist were tested for low (-1SD below the mean) moderate (mean = 0), and high (+1 SD above the mean) levels of disclosure. Two of the three tests (low and moderate) for simple slopes were statistically significant and revealed that for low and moderate alliance, high disclosure acted as a buffer for treatment efficacy. That is, parents with low and moderate alliance but high disclosure reported high levels of treatment efficacy than parents with low and moderate alliance and low disclosure. There was no effect of disclosure on parents that reported high alliance.

Warmth, Disclosure, and Treatment Efficacy. A multiple regression model was tested to investigate whether the association between parental warmth and satisfaction with therapy depended on the amount of parent reported adolescent disclosure about therapy. Following Aiken & West (1991) all variables were standardized (mean = 0, standard deviation = 1) to allow for ease of interpretation of the results. In step 1, warmth and adolescent disclosure was entered.

The interaction variable (warmth X disclosure) was entered in step 2. Warmth and disclosure were not significantly associated with treatment efficacy (see Table 6 for β and ΔR^2). While the regression was not significant, effect sizes indicate positive trends. There was a small effect size for warmth and disclosure on treatment efficacy, accounting for over twelve percent of the variance in step 1. The associations between warmth and treatment efficacy, and the association between disclosure and treatment efficacy, were both approaching a moderate effect size. This suggests that warmth and disclosure are both practically and positively associated with treatment efficacy, but the association between warmth and treatment efficacy is not moderated by disclosure.

Table 6

Warmth on Treatment Efficacy Moderated by Disclosure

	Treatment Efficacy	
	β	ΔR^2
Step 1		.128
Warmth	.242	
Disclosure	.243	
Step 2		.01
Warmth x Disclosure	-.104	

Note. N= 38

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

Closeness, Disclosure, and Treatment Efficacy. A multiple regression model was tested to investigate whether the association between parent-adolescent closeness and satisfaction with therapy depended on the amount of parent reported adolescent disclosure about therapy. Following Aiken & West (1991) all variables were standardized (mean = 1, standard deviation = 1) to allow for ease of interpretation of the results. In step 1, closeness and adolescent disclosure was entered. The interaction variable (closeness X disclosure) was entered in step 2. Closeness

and disclosure were not significantly associated with treatment efficacy (see Table 7 for β and ΔR^2). While the regression was not significant, closeness and disclosure showed a practical positive association; the positive correlation between closeness and disclosure showed a small effect on treatment efficacy accounting for over thirteen percent of the variance in step 1, with both variables closeness and disclosure approaching a moderate effect size on treatment efficacy (as previously indicated, lower scores of closeness indicate higher perceived closeness) This suggests that closeness and disclosure are associated with treatment efficacy, but the association between closeness and treatment efficacy is not moderated by disclosure.

Table 7

<i>Closeness on Treatment Efficacy Moderated by Disclosure</i>		
	Treatment Efficacy	
	β	ΔR^2
Step 1		0.14
Closeness	-0.26	
Disclosure	0.24	
Step 2		0.07
Closeness x Disclosure	0.26	

Note. N= 38

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

CHAPTER V

Discussion

One out of every five adolescents ages thirteen to eighteen experience mental illness each year (Kessler et al., 2005). Despite the prevalence and harmful impacts of mental illness, many adolescents do not receive appropriate treatment or do not continue treatment (U.S. Public Health Service, 2000; National Institute of Mental Health, 1999). This is concerning because adolescents are particularly vulnerable to negative impacts of mental illness. As symptoms are emerging, they are also in the process of negotiating significant developmental changes, most notably the task of identity formation and increased autonomy in relation to parents (Fleming et al., 2010; Keijsers & Poulin, 2013). Thus, adolescents with a mental illness are pulling away from parents in a time when they likely need increased parental support to both access treatment and negotiate developmental tasks. Since adolescents typically do not overtly seek help (Oetzel & Scherer, 2003), parental knowledge and perceptions of the adolescent's mental illness become central to whether and how the adolescent receives treatment. However, how parents are forming these perceptions of their adolescents' psychotherapy is empirically unexplored. Since the main source of parental knowledge of adolescents' lives is through direct and spontaneous disclosures, it is likely that a parent's perception of his or her adolescent's therapy comes from adolescent disclosure. Thus, this study examined associations among parental perceptions of their adolescent's disclosure about therapy, parental perceptions of the parent-therapist alliance, parental perceptions of treatment efficacy, parent-reported warmth and parent-adolescent closeness to better understand the interplay between parental perceptions of treatment and the parent-adolescent relationship.

Preliminary analyses examined the means and correlations among all the variables presented in the study. The first research question examined whether parental perceptions of their adolescent's therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age, adolescent gender, and parent gender. Due to small cell sizes, only adolescent age and parent gender were examined. The second research question examined parent-therapist alliance, parent-reported closeness, and parent-reported parenting warmth on parental perceptions of treatment efficacy, and if these associations are moderated by parental perceptions of disclosure.

Key Findings for Preliminary Correlations

Preliminary analyses examined correlations among the variables, which included perceived therapy disclosure, treatment efficacy, treatment alliance, parental warmth, parent-adolescent closeness, general therapy beliefs, and parent-therapist interactions. Treatment efficacy was significantly positively correlated with treatment alliance. This correlational finding was expected as it reflects the broader literature, which indicates that therapeutic alliance is the most important indicator of efficacy beliefs and treatment outcomes, across all treatment modalities (Shirk & Karver 2003, 2011). Parents' general beliefs about therapy were also positively correlated with both therapeutic alliance and parent-therapist interaction; parents who had more positive therapy beliefs in general also had positive perceptions of the parent-therapist alliance and indicated more frequent interactions with the therapist. This also was expected and reflects the literature, which indicates that parents' general beliefs about therapy predict their engagement in their youth's treatment (Bonner & Everett, 1986; Gustafson et al., 1994) and indicates that parents with negative perceptions of therapy in general are more likely to terminate treatment early (Day & Reznikoff, 1980; Kazin et al., 1997). Additionally, parent-therapist

interaction was significantly associated with adolescent disclosures such that parents who reported more frequent interactions with the therapist also reported more adolescent disclosures. This is the first study known to date to examine associations among adolescent therapy disclosures and parental perceptions of therapy and therapist. Although there is a variety of literature examining parental roles in adolescent psychotherapy treatment and much literature on parent-adolescent communication and relationships, this is the first known study to integrate these concepts to understand the interplay that occurs between parents' therapy perceptions and the parent-adolescent relationship. Thus, the emergence of correlations among adolescent therapy disclosures and frequency of parent-therapist interactions indicates that an interplay does occur between how parents communicate with adolescents and how parents participate in that adolescent's therapy. While no previous research has been done to support this association, this finding makes sense based on what is known about parental involvement in adolescent therapy; parents who are more engaged in the therapy and interact more with the therapist likely have more positive perceptions of the therapy (Nevas & Farber, 2011), and thus might receive more disclosures from adolescents or might become more willing to interact with the therapist when their adolescent is engaging them with disclosures.

Other correlations among variables were not statistically significant, but effect sizes indicate this was likely due to small sample size and that associations were trending in the expected direction. All correlations among variables suggested small effect sizes approaching moderate effect sizes, with the exception of the association between disclosure and general beliefs and between disclosure and closeness, which showed no effect. This indicates that the examined variables are likely associated, despite the lack of statistical significance. For example, disclosure and treatment efficacy, disclosure and alliance, and disclosure and warmth were

trending towards a positive correlation, which is not surprising given the literature indicating associations between disclosure and parenting warmth (Darling et al., 2009), as well as literature indicating that more parental engagement in therapy is associated with treatment efficacy (Nevas & Farber, 2011). This suggests that adolescent disclosures are one mechanism in which parents can be engaged in adolescent therapy, even as more privacy and autonomy is granted during adolescent by both the therapist and parent. In addition, the associations among warmth and closeness and among closeness and disclosure were trending toward a positive association. These trends support the literature indicating that warmth, disclosure, and closeness are interrelated factors in the parent-adolescent relationship, and that more warmth and closeness are associated with more disclosures (Vieno et al., 2009). Although small sample size limited significant interactions, effect sizes indicate that the examined variables are interrelated concepts that should be explored further.

Key Findings for Research Question 1

The first research question asked whether parental perceptions of their adolescent's therapy disclosures, parent-reported closeness, and parent-reported warmth differ as a function of adolescent age, adolescent gender, and parent gender. The first key finding for this research question indicated no differences in disclosure as a function of adolescent age or parent gender. Hypothesis B predicted that perceived disclosure would be higher for daughters and mothers and older teenagers (15-18) and lower for males and younger teenagers (12-14). Adolescent gender could not be analyzed due to small cell sizes, so the hypothesized differences by adolescent age could not be examined. The hypothesis regarding differences by adolescent age and parent gender was not statistically supported. Although it was expected that older teenagers, on average, would disclose more than younger adolescents, no differences in perceived disclosure rates were

found by parent gender or adolescent age. Additionally, on average, parents perceived only moderate disclosures about therapy, suggesting that parents' knowledge about adolescents' therapy via disclosure is limited, and this remains consistent throughout adolescence.

This finding is inconsistent with the current literature, which indicates that parent-adolescent communication exhibits decreases during early adolescence, but increases during late adolescence (Keijsers & Poulin, 2013; Smetana et al., 2006). Keijsers and Poulin (2013) found decreases in communication during early adolescence (12-14) and increases in communication during late adolescence (17-19). Smetana and colleagues (2006) found that 12th graders disclosed more about peers to parents than 9th graders. The absence of an increase in disclosure during late adolescence might be related to the type of disclosure examined in the current study, as well as population demographics. While previous studies examined adolescent disclosure on topics such as school work, personal issues, and peers (Smetana et al., 2006), the present study examined disclosures about therapy in a sample of adolescents, most of whom had a mental illness diagnosis. Thus, these findings might contradict current literature due to the way in which mental illness moderates perceived disclosures. Literature suggests that symptoms of mental illness are associated with adolescent nondisclosures to parents, such as depression (Keijsers et al., 2010; Smetana et al., 2006), increased behavioral struggles (Crouter et al., 2005; Keijsers et al., 2010), and less self-control and self-concept (Frijns et al., 2005). The impact of these symptoms, and the subsequent struggle to negotiate the task of increased autonomy and communication with parents, might be related to the finding that there were no changes in parental of disclosure related to adolescent age.

The second key finding for the first research question indicated a significant interaction between parent gender and adolescent age on closeness. The interaction between adolescent age

and parent gender on closeness was only significant for fathers such that fathers reported more closeness with older adolescents than younger adolescents. There was no difference in mothers' reports of closeness based on adolescent age. This finding indicates that differences occur between mothers' and fathers' perceptions of relational closeness with their adolescent. This key finding partially supports the hypothesis that perceived closeness would be higher for daughters and mothers and older teenagers (15-18) and lower for males and younger teenagers (12-14). While adolescent gender could not be analyzed due to small cell sizes, it was found that perceived closeness was higher for older adolescents than younger adolescents. However, differences in perceived closeness based on adolescent age were dependent on parent gender, and only mattered for fathers.

This finding is consistent with the literature, which indicates differences in parent-child closeness as a function of adolescent age (Fleming et al., 2010; Keijsers & Poulin, 2013; Marceau et al., 2014; McGue et al., 2005; Steinberg & Morris, 2001). Research suggests that during early to middle adolescence, parent-child conflict increases while perceptions of warmth and closeness decrease (Fleming et al., 2010; Marceau et al., 2014; McGue et al., 2005). However, the parent-adolescent relationship tends to shift into a state of cohesion, decreased conflict, and increased communication in late adolescence (Keijsers & Poulin, 2013; Steinberg & Morris, 2001). It was not expected, however, that these differences would be perceived by fathers but not by mothers.

Gender differences in parent-perceived ratings of closeness are an important finding in the discussion on adolescent relationships, as the majority of the literature has focused only on mother's reports. Hawley and Garland (2008) had 88.5% mothers and only 11.5% fathers. Nock, Phil, and Kazin (2001) surveyed 91.4% biological mothers and 4.5% adoptive or stepmothers in

their work on parental expectations of therapy. Keijsers and Poulin (2013) did not differentiate between mothers and fathers. Since there is a lack of data on fathers' perceptions, the current finding suggests that parent gender differences do matter and should be more closely considered in understanding variables such as perceived closeness and disclosures in the parent-adolescent relationship.

Key Findings for Research Question 2

Research question 2 asked if there was a relationship between therapeutic alliance, warmth, and closeness on treatment efficacy, and if disclosure moderates this relationship. Hypothesis A for question 2 predicted that parents' perceptions of alliance will positively predict treatment efficacy, and this effect will be moderated by disclosure, with more disclosure related to higher perception of treatment efficacy. Findings supported this hypothesis. Results indicated that greater perceptions of therapeutic alliance were associated with greater perceptions of treatment efficacy, and this effect was dependent on the level of parent-reported adolescent disclosure. For parents with low to moderate therapeutic alliance, high disclosure acted as a buffer, and increased the positive association between therapeutic alliance and treatment efficacy.

The positive correlation between therapeutic alliance and treatment efficacy was expected and strongly supported by the current literature. Across the literature on psychotherapy, therapeutic alliance is indicated as one of the most important factors in outcomes of treatment and perceptions of treatment efficacy. Two extensive meta-analyses by Shirk and Karver (2003, 2011) found that therapeutic alliance is consistently associated with perceptions of therapeutic outcomes, and that therapeutic alliance was a stronger predictor of treatment efficacy beliefs than treatment modality. Additionally, Nevas and Farber (2001) found that parental alliance with the

therapist was associated with treatment outcomes with child populations, and Hawley and Garland (2008) found that parent-therapist alliance and parental “buy-in” was associated with treatment efficacy and outcomes in adolescent populations. Conversely, parents of children and adolescents who did not perceive a strong alliance with the therapist prematurely terminate treatment and have low perceptions of treatment efficacy (Garcia & Weisz, 2002).

While the association between therapeutic alliance and efficacy perceptions is well-established, the current finding adds the importance of adolescent disclosures on this association. Not only are positive perceptions of therapeutic alliance associated with positive perceptions of treatment efficacy, but this association is moderated by parent-perceived disclosure, with high levels of disclosure associated with moderate to high levels of treatment efficacy when parental perceptions of therapeutic alliance is low. This indicates that parental perceptions of adolescent’s therapy disclosures impacts perceptions of therapy, but only for parents who have low therapeutic alliance ratings. This finding makes sense. Parental perceptions of treatment efficacy depend on parent-therapist alliance; that is, it is dependent on their personal interactions with the therapist, and thus should be less dependent on what adolescents disclose. Parents who do not engage with the therapist are not privy to the therapeutic process and thus have no external information about how the treatment is going. However, parents who do not engage with the therapist but have adolescents who disclose about the therapy process may have access to similar information about therapy or the process which allows the parent to think that treatment is working. This suggests that parents judge treatment efficacy not just from the perspective of the therapist, but from the adolescent as well, when there is not a strong therapeutic alliance. While the current literature indicates the clear importance of parents’ views of therapy and therapist in determining treatment longevity and outcomes (Garcia & Weisz, 2002; Nevas & Farber, 2001)

this finding suggests that adolescent disclosures can help facilitate positive treatment beliefs for parents who do not engage with the therapist. In this way, adolescent disclosures and perceptions of the therapist can have a significant impact on treatment outcomes. Thus, the treatment efficacy beliefs of parents who do not have a strong alliance with the therapist are impacted by adolescent therapy disclosures, which are likely the main source of parental knowledge about the therapy.

This is an important finding that begins to illustrate how parents might be receiving information and subsequently developing their perceptions about their adolescent's therapy, and how adolescent disclosure and parental perceptions of treatment have a bidirectional influence on each other. This is particularly important when considering how impactful parental perceptions are in how adolescents access and engage in treatment. Current literature indicates that parents are the most influential person in determining if and how adolescents receive psychotherapy, with 90.9% of adolescents reporting that a parent impacted their decision to begin psychotherapy (Wahlin & Deane, 2012). For adolescents already in therapy, parental perceptions are associated with engagement in treatment, longevity of treatment, and treatment outcomes (Bonner & Everett, 1986; Armbruster & Kazdin, 1994; Nock et al., 2001; Nevas & Farber, 2001; Staudt, 2007). Literature clearly indicates the importance of parental perceptions in whether and how adolescents receive treatment, and show the association between parent-therapist alliance and treatment efficacy, but the present finding suggests that the way in which parents receive information about therapy from adolescents' impacts these perceptions of therapy. Since parental perceptions are clearly impactful, and these perceptions are moderated by adolescent disclosure, this finding suggests that adolescent disclosures are an important factor in examining how parents are forming their perceptions of therapy, which subsequently influences their adolescents' treatment and psychosocial health. This finding is especially important for parents

who do not have strong alliances with the therapist. Although positive therapeutic alliance typically predicts positive treatment efficacy beliefs, parents can still have positive perceptions of treatment efficacy even without a strong alliance with the therapist when they perceive high rates of adolescent disclosures.

The relationship between perceptions of alliance, treatment efficacy, and disclosure may suggest a few concepts about parents' perceptions of therapy and therapist and disclosures, and the interactions among the variables. One possibility is that parents who perceive more disclosures feel that they "know" what's going on in their adolescent's therapy, and thus have more positive perceptions of the therapy. This could be related to parents feeling included in the therapeutic process. Parents who feel they know more about the therapy might feel better able to assist their adolescent prepare for therapy sessions, process after therapy sessions, and apply what they are practicing in therapy outside of sessions. This involvement of parents, in turn, might be assisting the adolescent's therapeutic process by facilitating positive change outside of sessions. As a result, parents perceive the therapy as helpful and effective.

Conversely, adolescents might disclose more to parents *after* parents convey positive perceptions of treatment efficacy. Research indicates that adolescents are more willing to spontaneously disclose to parents when they feel their disclosures will be met with receptivity, warmth, and acceptance (Darling et al., 2009; Smetana et al., 2006; Vieno et al., 2009). When parents convey that they believe that the treatment is "working," adolescents may disclose more about the therapy because they expect their parents to respond positively and accepting towards disclosures.

The relationship between disclosures and treatment efficacy is likely bidirectional. Adolescents feel their therapy disclosures will be accepted by parents who have positive

perceptions of the therapy. In response to disclosures, parents feel they know more about the therapy and are able to assist in the treatment at home. This parental involvement contributes to more positive beliefs about treatment efficacy, and facilitates even more disclosures. While this exploratory study studied associations rather than cause-effect relationships, these findings indicate that when parents feel their adolescent is communicating about therapy, they believe the therapy is “working” even when they do not perceive a positive therapeutic alliance.

Neither hypothesis B, which predicted that parenting warmth would positively predict treatment efficacy, and this effect would be moderated by disclosure, or hypothesis C, which predicted parent-adolescent closeness would positively predict treatment efficacy and this effect would be moderated by disclosure was not statistically supported. Both parenting warmth and parent-adolescent closeness should have predicted treatment efficacy with disclosure moderating the effect, with high amounts of disclosure associated with high perceptions of treatment efficacy. Since closeness and warmth were correlated with disclosures, higher levels of warmth and closeness should predict higher levels of disclosure, and disclosure should have contributed to higher treatment efficacy. While these associations were not statistically significant, effect sizes for both regressions indicated positive trends in the expected direction, such that higher amounts of both closeness and warmth showed trends toward positive perceptions of treatment efficacy. It is likely that these associations were not significant due to small sample size. Further analysis with a larger sample size is needed to better understand these trends, especially with disclosure as a moderating factor.

Strengths of the current study

Three strengths of the present study were anonymity, reliability of the measures, and examination of both mothers and fathers' perceptions of adolescents. A strength of this study was anonymous participation via an online survey format. The survey did not collect names, email addresses, mailing addresses, IP addresses, or any other identifying information, so there was no way for the researcher to know who completed a survey. Additionally the online format of this survey likely created a deeper sense of anonymity and distance between the participant and researcher (Joinson, 1999). The ensured anonymity of the study, coupled with the online survey format, likely allowed for honest disclosures by respondents which may not have been shared in a face to face style interview or a questionnaire taken in a room with a researcher (Fawcett & Buhle, 1995). These factors particularly strengthened this study due to issues of social desirability for parents responding to questions about their relationship with their adolescent and perceptions of their psychotherapy, as these topics are likely to produce emotions and social expectations for parents.

This study used measures that had previously determined empirical reliability, indicating consistency and stability of results. The Nature of Disclosures About Therapy Inventory, the Revised Satisfaction with Therapy and Therapist Scale, the Therapeutic Alliance Scales for Caregivers and Parents (TASCP), the Relationship Closeness Inventory, and the Parenting-style Questionnaire all had previously-determined reliability. In addition, all scales showed reliability when used in the current study.

Another strength of this study is the examination of both mothers and fathers, and the subsequent finding that differences in adolescent closeness perceptions were found for fathers but not for mothers. Parental gender differences in adolescent relationships is a gap in the current literature that this study aimed to fill. This study indicates that there are differences between

fathers' and mothers' perceptions of relational closeness with their adolescent. This problematizes studies which do not account for parental gender differences. In future studies, fathers and mothers need to be differentiated and compared to examine other potential differences in perceptions of the adolescent relationship.

Limitations and Future Directions

Sample size. One significant limitation of this study is its small sample size (N = 42) due to slow response rate. The population, which was very specific due to eligibility criteria, was difficult to reach and did not have clear sampling frame. Due to the time-limited nature of the current study, I did not have enough time to increase sample size. Despite consistent trends in the data indicated by small to moderate effect sizes, most findings were not statistically significant due to small sample size. In addition, the first research question was modified as a result of small cell sizes; the sample was not large enough to examine adolescent gender differences or parent-adolescent gender combinations on closeness, warmth, and disclosure and thus the first research question could only be partially addressed.

Due to slow response rate because of the hard to reach sample, several changes were made to exclusion criteria during the study. While this was necessary to generate more responses, it also was a limitation. Criteria were expanded to include parents who have ever had an adolescent attend therapy after difficulties recruiting parents of adolescents who are currently or recently in outpatient psychotherapy. There are potential issues in accuracy of recall for parents whose adolescent was in therapy several years ago, which could impact accuracy of responses.

To address this limitation, an area for future work is replicating the current study to a large sample in order to examine if trends in the data produce significant effects and to examine

effects based on adolescent-parent gender combinations that could not be analyzed in the current study. Findings indicated differences in perceived closeness between mothers and fathers, and these gender differences should be more closely examined in future work, particularly due to continued lack of research these differences between mothers and fathers.

Generalizability. The sample itself is also not representative of the larger population and unable to be generalized beyond white middle class highly educated families. The use of convenience sampling via social media sites, emailing personal contacts, and snowball sampling limited the diversity of the sample, and reflects demographic factors of the researcher and researcher's contacts. This is problematic in being unable to reach a more diverse body of experiences and perspectives. To address this limitation, an area for future study would be extending the present study to a randomized sample reflecting a larger, more diverse sample which could be generalized. However, achieving a diverse sample has been difficult across the literature due to difficult accessing a population without a sampling frame, such as parents of adolescents in psychotherapy.

Sampling bias. Another limitation of this study was sampling bias. Parents of adolescents who terminated treatment in less than six sessions were not eligible to participate in this study. Excluding those who terminated treatment before six weeks might have left out negative experiences and perceptions about therapy and therapists. Parents who responded to this study, in general, had very positive beliefs about therapy in general showing that those with negative perceptions of therapy likely did not respond. While this sampling bias might have impacted the range of responses in this study, the exclusion was necessary to ensure that parents could adequately answer questions about their adolescent's therapy and therapist based on a long enough duration of treatment.

Another sampling bias was that it excluded parents whose adolescents attended other types of therapeutic treatment besides outpatient therapy. Involvement in consistent outpatient psychotherapy likely indicates a certain level of financial stability (i.e. having consistent health insurance, able to afford transportation to and from appointments) and a certain level of parental involvement (i.e. consistently driving the adolescent to appointments, re-applying for health insurance), and belief about what therapy should entail. Parents taking the time to respond to this survey also inherently indicated some level of involvement and interest in their adolescent's treatment. Thus, results in this study might be confounded in these variables related to parental demographics and inherent level of involvement, and may be missing responses from parents less involved in the treatment process.

To address these issues of sampling bias, future work should expand research to include a greater variety of experiences. A future area for exploration would be expanding this study to parents of adolescents in different types of treatment in order to examine perceptions of alliance, treatment efficacy, and disclosure across treatment types. In addition, the relationship between perceived disclosure, alliance, and treatment efficacy could be examined in parents who terminated their adolescent's therapy early.

Method. A limitation of this study's methodology was its reliance on parent perceptions. This study was unable to triangulate responses of parent, adolescent, and therapist, and thus results rely solely on the subjective experiences of the parent. While the perspective of the parent was chosen for this study due to the evident importance of parental perceptions in the adolescent's therapeutic process based on the current literature, it offers a limited understanding of this topic's complexity and effects might be due to shared method variance rather than true associations between the measures.

Another problem with using solely parental perceptions is the possibility of social desirability bias. Parents might be likely to answer scales based on socially acceptable standards about what it means to be a “good parent.” This type of bias might particularly impact scales relating to parent-adolescent parenting style warmth, and involvement in their adolescent’s treatment. Parents who do not feel close to their child might not answer accurately in fear that their parenting would be judged. Ensuring anonymity and using an online format addressed this limitation, but results indicated that parents reported very high levels of parenting warmth and thus results may have been impacted by social desirability bias.

A future direction to address these methodological limitations would be replicating the current study, with the addition of therapist and adolescent perceptions. This would strengthen the design of the study by obtaining comprehensive reports that would not rely solely on parental perceptions. Furthermore, future studies should examine perceptions of both parents of the adolescent (when available). This study indicated differences in the way fathers perceive relational closeness with adolescents compared to mothers, and these gender differences need to be further explored, as most of the current literature leaves fathers out completely.

Implications for Social Work

This study has important implications for the field of clinical social work, particularly for clinicians who work with adolescents and parents. Although no significant differences in perceived disclosures were found as a function of adolescent age or parent gender, it is informative that parents, on average, are perceiving only moderate disclosures from adolescents about therapy, and that this rate of disclosure remains constant throughout adolescence. For therapists, this suggests that parents might feel that they know relatively little about the therapy sessions because they do not perceive frequent disclosures from adolescents.

Since parents are influential in adolescent treatment, it is important for therapists to understand the amount of communication that occurs between adolescent and parent. - Adolescents in outpatient psychotherapy are only in session for a very short duration of time per week. This means that a significant amount of the therapeutic work, such as therapy “homework,” processing daily events, and practicing new ways of relating and coping, are worked on outside of sessions. After a session ends, parents are responsible for facilitating this therapeutic work. However, if it is assumed by the therapist that adolescents are communicating these needs to their parent on their own, the therapy might be less effective because parents are removed from the process. Therapists working with adolescents should be facilitating the involvement of parents, while also maintaining the confidentiality and autonomy of the adolescent client. This balance can be achieved when the adolescent is able to autonomously and spontaneously disclose to parents about therapy.

It is also important for therapists working with adolescents to facilitate the involvement of both parents (when available). The current study indicates differences in how mothers and fathers perceive relational closeness with their adolescent, with fathers perceiving more closeness with older adolescents than younger adolescents while mothers are not perceiving a change between ages. For therapists working with adolescents, this indicates that parental perceptions of the adolescent could differ between parents, and both parents should be involved in the therapeutic process for more comprehensive parental involvement. If the therapist is communicating with one primary parent, but the adolescent feels closer to the other parent, then this could hinder the therapeutic process by leaving an important person out of the process.

Differences as a function of parent gender also have implications for parents with an adolescent in therapy. On average, fathers might perceive differences in relational closeness that

mothers do not. While more work needs to be done to further understand patterns of therapy disclosures, relational closeness, and parental perceptions of therapy, differences in closeness may also relate to differences in how adolescents chose to disclose to parents about therapy. Nonetheless, this study does suggest that there are differences between the perceptions of mothers and fathers regarding closeness, and involving both parents might facilitate more adolescent disclosures depending on age and gender.

The finding that disclosure moderates the association between parent-therapist alliance and treatment efficacy also has implications for clinical social work with adolescents. This implies that therapists who work with adolescents should not underestimate the importance of the parent-therapist alliance in adolescent therapy, as it is associated with how effective parents perceive the therapy. Thus, clinicians should work toward developing an alliance not only with the adolescent client but the client's parents as well. This could be a difficult balance, as adolescent therapists also strive to grant increasing autonomy and privacy to adolescent clients to facilitate healthy and age-appropriate psychosocial development. However, it is clear that positive parental perceptions of the parent-therapist alliance are correlated to positive perceptions of treatment efficacy and parental "buy-in" to the therapeutic process, and thus a strong predictor of treatment adherence.

Additionally, parent perceptions of adolescent disclosures moderate treatment efficacy beliefs such that high disclosure is associated with moderate to high treatment efficacy when parent perceptions of therapeutic alliance is low to moderate. For parents and therapists who do not have a strong alliance, this implies that parental perceptions of therapy are, on some level, influenced by adolescent disclosures. While the parent-therapist alliance is clearly important and beneficial, parents can still believe that the therapy is "working" even when they do not perceive

a positive relationship with the therapist *if* they perceive disclosures from the adolescent.

Whether it is the positive efficacy beliefs facilitating adolescent disclosures, or the disclosures facilitating positive beliefs of treatment efficacy, parents who perceive more disclosures believe the therapy is effective, and when parents think the therapy is “working” they are more likely to keep their adolescent in treatment. For parents, this suggests that conveying a warm, accepting, and receptive attitude towards the therapy can help facilitate more spontaneous adolescent disclosures in a way that does not threaten their sense of autonomy. For therapists working with adolescents, this suggests that assisting parents in being receptive to disclosures is a way to facilitate parent-adolescent communication without jeopardizing the trust, the therapeutic alliance, or the autonomy of the adolescent client. It also suggests that therapists who do not have a positive relationship with parents can still work effectively with parents and still facilitate positive beliefs about the treatment if the adolescent is communicating to the parent.

Conclusion

Mental illness is a prevalent issue in the adolescent population, with many symptoms first manifesting during the adolescent years. Adolescents can be particularly vulnerable to the negative impacts of mental illness due to the developmental struggles that also occur during these years, such as grappling with the task of identity consolidation and achieving increased autonomy (Erikson, 1950). Due to these vulnerabilities, parents become crucial to their psychosocial wellbeing and can buffer many of the negative impacts of mental illness and life stressors (Fan & Chen, 2001; Jeynes, 2003; Quach et al., 2013). One way parents can help is by accessing psychotherapy and staying engaged in the process. While it is known how central parents are in the therapeutic process, how parents form their perceptions has been empirically ignored. This study sought to explore the associations between parental perceptions of therapy

and therapist, and how they are impacted by variables relating to the parent-adolescent relationship, operating under the understanding that one of parents' main sources of knowledge about the therapy is direct disclosures from the adolescent.

Findings indicated that parental perceptions of disclosures, treatment efficacy, therapeutic alliance, parenting warmth, parent-adolescent closeness, general therapy beliefs, and involvement with the therapist were meaningfully related to each other, which strong associations between therapeutic alliance and treatment efficacy. In addition, differences in perceptions of relational closeness between mothers and fathers emerged, indicating a need to more closely examine parent gender differences. Furthermore, therapeutic alliance predicted treatment efficacy, and this relationship was moderated by perceptions of adolescent disclosures. Taken together, findings uphold the association between treatment efficacy and alliance perceptions, and suggest that adolescent disclosures moderate this association; for low and moderate alliance, high disclosure acted as a buffer for treatment efficacy; parents that reported high disclosure but low alliance report high treatment efficacy. This suggests that adolescent disclosure is a mechanism that facilitates positive perceptions of treatment efficacy, and a way parents can stay engaged in the treatment and know about the therapy, even without a strong alliance with the therapist

Findings have meaningful implications for social work. Treating adolescents with a mental illness involves a careful balance of facilitating adolescent autonomy while also involving parents, who are crucial to the therapeutic process but are often removed from the therapy. Findings suggest that parents can still have positive perceptions of treatment efficacy and stay engaged in treatment, even when parent-therapist perceptions are not high if adolescents are disclosing. In this way, clinicians can support and facilitate communication about therapy

between parent and adolescent, which can help maintain the delicate balance between engaging the parent in the treatment process while supporting the autonomous development of the adolescent.

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Appendix A

Human Subjects Review Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

January 28, 2015

Kara Maltese

Dear Kara,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Shannon Audley-Piotrowski, Research Advisor

Appendix B

Protocol Change Request: Amendment One



RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following approved research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Parental Perceptions of Parent-Therapist Alliance and Adolescent Self-Disclosure on the Perceived Efficacy of Adolescent Psychotherapy Treatment
Kara Maltese
Shannon Audley-Plotrowski

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

- 1. I would like to expand participant recruitment methods by adding the following:
- Using Reddit, specifically SampleSize Subreddit, to post a link to my survey
- Using online discussion forums to post a link to my study:
- http://www.depressionforums.org/forums/topic/600-teens-and-mental-health/
- http://www.healthyplace.com/forum/support-community-sp-1476618279/parenting-forum-chat/
- http://www.netmums.com/coffeehouse/tweens-teens-581/
- Using the following websites to host a link to my study:
- http://www.onlinepsychresearch.co.uk/
- http://psych.hanover.edu/research/exponnet_submit.html
- http://www.psychforums.com/surveys-studies/
- http://www.psychstudies.co.uk/index.php?P=About
- https://www.callforparticipants.com/

I understand that these proposed changes in protocol will be reviewed by the Committee.
I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: [Handwritten Signature]
Name of Researcher (PLEASE PRINT): Kara Maltese Date: 3/2/15

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at L.Wyman@smith.edu or to Lilly Hall Room 115.

***Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.

Appendix C

HSR Approval Letter for Amendment One



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 3, 2015

Kara Maltese

Dear Kara,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Shannon Audley-Piotrowski, Research Advisor

Appendix D

Protocol Change Request: Amendment Two



RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following approved research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Parental Perceptions of Parent-Therapist Alliance and Adolescent Self-Disclosure on the Perceived Efficacy of Adolescent Psychotherapy Treatment
Kara Maltese
Shannon Audley-Piotrowski

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

- 1. In my original HSR document, I indicated that I would be asking several screening questions at the beginning of my survey to determine eligibility. One of these questions asks "Does your child have a mental health diagnosis?" and if the participant answers "No," they are screened out of the study. I would like to change this question to one that does not screen participants out of the study, thus making "having a teenager with a mental health diagnosis" not an inclusion criterion.
2. I would like to add the attached flyer as a recruitment method. This flyer was in my initial HSR document (Attachment C) t, but it was removed because I was not granted permission to put a flyer in the outpatient clinics I was intending on using for recruitment. Instead, I will use this flyer to post in public spaces, such as local coffee houses, grocery stores, and public bulletin boards.

These changes are both in response to low survey completion, and the need to increase sample size.

- I understand that these proposed changes in protocol will be reviewed by the Committee.
I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: [Handwritten Signature]
Name of Researcher (PLEASE PRINT): Kara Maltese Date: 3/18/15

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at L.Wyman@smith.edu or to Lilly Hall Room 115.

***Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.

Appendix E
Recruitment Flyer

RESEARCH STUDY:

Exploring parent views of their adolescent's psychotherapy, and how adolescents discuss therapy with their parents

WHO IS ELIGIBLE?


Parents of adolescents (ages 12-18) who are in, or who have been in psychotherapy

WHAT WILL YOU DO

Take a brief (about 45 minutes) anonymous, online survey

WHAT WILL YOU GET?

After completing the survey, you can choose to be entered into a drawing for a \$20 coffee shop gift card!



SMITH COLLEGE

SCHOOL FOR SOCIAL WORK

If you have any questions or are interested in participating, please contact:
Kara Maltese at kmaltese@smith.edu

simply access this link to the survey:
https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN

<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>
<p>REARCH STUDY: Parent perceptions of adolescent therapy</p> <p>EMAIL: kmaltese@smith.edu</p> <p>https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2aRDMN</p>

Appendix F

HSR Approval Letter for Amendment Two (recruitment flyer)



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 19, 2015

Kara Maltese

Dear Kara,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Shannon Audley-Piotrowski, Research Advisor

Appendix G

Protocol Change Request Form for Amendment Three



RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Parental Perceptions of Parent-Therapist Alliance and Adolescent Self-Disclosure on the Perceived Efficacy of Adolescent Psychotherapy Treatment
Kara Maltese
Shannon Audley-Piotrowski

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. I would like to expand participant recruitment methods by adding the following:
 - Using Mechanical Turk to recruit participants
2. I would like to change my inclusion criteria regarding amount of time since the adolescent has been in therapy. Currently the question asks "Has your adolescent been in therapy in the last three years?" I would like to change the question to "How many years has it been since your adolescent has been in therapy?" with choices being 0-3, 4-6, 7 or more. I am requesting this change because many potential participants have been screened out as a result of this exclusion criteria. Since I have not been approved to advertise the study in any outpatient clinics, I have not been able to recruit enough eligible participants who currently have teenagers in therapy.

- I understand that these proposed changes in protocol will be reviewed by the Committee.
- I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
- I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: Kara Maltese

Name of Researcher (PLEASE PRINT): Kara Maltese Date: 3/29/15

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*

Appendix H

HSR Approval Letter for Amendment Three



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 31, 2015

Kara Maltese

Dear Kara,

I have reviewed your amendments and they look fine. These amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Shannon Audley-Piotrowski, Research Advisor

Appendix I

Eligibility Criteria Questions (original)

Please answer the following questions to determine if you are eligible to participate in this study.

1. Are you a parent of an adolescent between the ages of twelve and eighteen? YES NO
2. Has your adolescent ever attended outpatient psychotherapy? YES NO
3. Has your adolescent attended outpatient psychotherapy within the last three years? YES NO
4. Is your child currently in outpatient therapy? YES NO
5. My adolescent has attended psychotherapy for 6 weeks or more. YES NO
5. Does your child have a mental health diagnoses? YES NO
6. Please indicate your adolescent's most current diagnosis. Choose all that apply:

- Attention Deficit Hyperactivity Disorder
- Adjustment Disorder
- Anorexia Nervosa
- Anxiety Disorder
- Bipolar Disorder
- Bulimia
- Conduct Disorder
- Depressive Disorder
- Psychotic Disorder
- Posttraumatic Stress Disorder
- Panic Disorder
- Schizophrenia
- Substance Abuse
- Oppositional Defiant Disorder
- Reactive Attachment Disorder
- Other:

Appendix J

Amended Eligibility Criteria Questions

1. Are you (or have you been) a parent of an adolescent between the ages of twelve and eighteen? YES NO
2. Has your adolescent ever attended outpatient psychotherapy? YES NO
3. Is your adolescent currently in outpatient psychotherapy? YES NO
4. If your adolescent is not currently in psychotherapy, how long has it been since they have attended therapy?
 0-3 years 3-7 years 7 or more years
5. Has your adolescent attended psychotherapy for 6 weeks or more? YES NO
6. Does your child have a mental health diagnosis? YES NO
7. Please indicate your adolescent's most current diagnosis. Choose all that apply:

- Attention Deficit Hyperactivity Disorder
- Adjustment Disorder
- Anorexia Nervosa
- Anxiety Disorder
- Bipolar Disorder
- Bulimia
- Conduct Disorder
- Depressive Disorder
- Psychotic Disorder
- Posttraumatic Stress Disorder
- Panic Disorder
- Schizophrenia
- Substance Abuse
- Oppositional Defiant Disorder
- Reactive Attachment Disorder
- Other:

Appendix K

Informed Consent

Consent to Participate in a Research Study Smith College School for Social Work • Northampton, MA

.....
Title of Study: Parental perceptions of parent-therapist alliance and adolescent self-disclosure on the perceived efficacy of adolescent psychotherapy treatment

Investigator(s):

Kara Maltese, MSW Candidate
Smith College School for Social Work
Phone: (XXX) XXX-XXXX
Email: kmaltese@smith.edu

.....

Introduction

- You are being asked to be in a research study of parents' perceptions relating to their adolescent's psychotherapy.
- You were selected as a possible participant because you are a parent of an adolescent who is either currently in psychotherapy, or who has been in psychotherapy in the last three years. In addition, your adolescent has a psychiatric diagnosis and has attended therapy for at least six weeks.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to learn more about parental perceptions of what adolescents discuss about therapy, and how perceived discussions might relate to parents' perceptions of their adolescent's therapy and therapist. One research question looks at what factors relate to how adolescents talk about their therapy with their parents. The second research question considers how perceived discussions about therapy relate to parental perceptions of their relationship with the therapist and the effectiveness of the therapy.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- Once you have answered some preliminary questions to determine eligibility for this study, you will be asked to complete a questionnaire that will be accessed via Qualtrics, an online survey program. You will respond to statements using scales to rate the degree to which you agree or disagree with each statement. These statements will relate to your relationship with your adolescent, your perceptions of your child's therapy and therapist, and how your child talks about his or her therapy with you. Then you will be asked several personal information questions

(such as gender, education level, and prior experience with therapy). Your one-time involvement in this study will take approximately forty-five minutes.

Risks/Discomforts of Being in this Study

- There are no reasonable foreseeable (or expected) risks for participation in this study. While this study poses no expected risks, the questionnaire will require reflection on the experiences of you and your adolescent, so there is a small risk that participation will cause emotional discomfort. If any discomfort arises during your participation, you will be able to skip any question you do not want to answer. You will have the choice to withdrawal your participation at any point.

Benefits of Being in the Study

- The benefits of participation include the opportunity to reflect on your experiences with your adolescent's therapy and gain insight into these experiences, the opportunity to express your opinions, and knowing that your participating could be contributing to increasing knowledge and research regarding adolescent psychotherapy and parent-adolescent relationships.
- The benefits to social work and society include increasing knowledge about how parents feel about their adolescent's therapy and how to best involve parents in adolescent therapy.

Confidentiality

- This study is anonymous. No identifying information will be collected, including names, email addresses, or other information. Qualtrics will not record IP addresses, and responses will be password-protected and encrypted to ensure privacy and confidentiality of data. Once the data are collected, it will only be accessed by me, my research advisor, and the data analyst. Data will be kept in a secured location for three years of the completion of the study as required by Federal guidelines. After that, data will be destroyed. All survey information will be securely retained and hosted on a third party (Qualtrics) server and not on a Smith server.

Payments/gift

- You will not receive any financial payment for your participation. However, participants who complete a survey will be given the opportunity to enter into a drawing for a \$20 gift card to a coffee shop. To enter the drawing, you must voluntarily enter an email address at the end of the survey to be notified if you win. If you voluntarily enter the drawing, anonymity will only be compromised to the extent that I may know your name or email address. I will not be able to connect your name to any information you provided in the study, so your responses will remain confidential.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researchers of this study or Smith College or the agency where you and your adolescent may be receiving psychotherapy. or (agency where may be receiving psychotherapy). Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 1st, 2015. After that

date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

● You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Kara Maltese, at kmaltese@smith.edu or by telephone at XXX-XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

BY CHECKING “I AGREE” AND CLICKING “NEXT” YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION, THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

- I AGREE
- I DO NOT AGREE

Next

Appendix L

Survey Instrument

The Disclosure About Therapy Inventory (DATI)

Nature of Disclosures about Therapy

Please indicate to what extent you experience the following statements in relation to how your adolescent discloses to you about his/her therapy, with 1 being “Not At All”, 4 being “Somewhat,” and 7 being “To a Great Extent.”

SCALE: 1= Not at all; 4=Somewhat; 7= To a great extent

1. Overall, how self-disclosing is your adolescent to you about his/her therapy?
2. *My adolescent withholds certain details about his/her therapy from me.
3. My adolescent speaks generally/abstractly about his/her therapy sessions with me.
4. My adolescent speaks in detail about his/her therapy sessions.
5. My adolescent discusses his/her therapist’s reactions to things he/she says in session.
6. My adolescent discusses the positive feelings he/she has for his/her therapist.
7. My adolescent discusses the negative feelings he/she has for his/her therapist.
8. My adolescent solicits help from me in applying what he/she has learned in therapy.
9. My adolescent solicits help from me in preparing for his/her next session.
10. My adolescent solicits help from me on his/her “therapy homework”

Revised Satisfaction with Therapy and Therapist Scale

Please rate your agreement with each of the following statements about your adolescent's therapy and therapist using the following scale: 1 = Strongly disagree 2 = disagree 3 = neutral 4 = agree 5 = strongly agree.

1. I am satisfied with the quality of the therapy my adolescent received.
2. The therapist listened to what I was trying to get across
3. My adolescent's needs were met by the program
4. The therapist provided an adequate explanation regarding my adolescent's therapy
5. I would recommend the program to a friend.
6. The therapist was not negative or critical towards my adolescent.
7. My adolescent would return to the clinic if he/she needed more help
8. The therapist was friendly and warm towards my adolescent.
9. My adolescent is now able to deal more effectively with my problems
10. My adolescent felt free to express myself
11. My adolescent was able to focus on what was of real concern to him/her.
12. The therapist seemed to understand what my adolescent was thinking and feeling.

For the following question, please choose one of the following options which best indicates your experience with the helpfulness of your adolescent's therapy.

13. How much did this treatment help with the specific problem that led your child to therapy?
 1. Made things a lot better
 2. Made things somewhat better

3. Made no difference
 4. Made things somewhat worse
 5. Made things a lot worse
-

Prescreening question: Please choose the statement most applicable to you:

1. I regularly meet with my adolescent's therapist.
2. I occasionally meet with my adolescent's therapist.
3. I rarely meet with my adolescent's therapist.
4. I never meet with my adolescent's therapist.

**If this statement is selected, the participant will skip the Therapeutic Alliance Scale for Caregivers and Parents (TASCP) and will be directed to the next section.*

Therapeutic Alliance Scales for Caregivers and Parents (TASCP)

Please rate how true you believe each statement is regarding your relationship with your adolescent's therapist. Please use the following scale for this section: 1= not true , 2= true , 3= somewhat true , 4= very much true.

1. I like spending time with my adolescent's therapist.
2. I find it hard to work with my adolescent's therapist on solving problems in our lives.
3. I feel like my adolescent's therapist is on my side and tries to help me.
4. I work with my adolescent's therapist on solving our problems.
5. When I'm with my adolescent's therapist, I want the sessions to end quickly.
6. I look forward to meeting with my adolescent's therapist.
7. I feel like my adolescent's therapist spends too much time working on our problems.

8. I'd rather do other things than meet with my adolescent's therapist.
 9. I use my time with my adolescent's therapist to make changes in our lives.
 10. I like my adolescent's therapist.
 11. I would rather not work on our problems with my adolescent's therapist.
 12. I think my adolescent's therapist and I work well together on dealing with our problems.
-

Child Rearing Practices Report

The following questions look at your relationship with your adolescent. Please read the following statements and rate the degree to which they relate to your relationship with your adolescent who is in therapy on a scale from 1 to 5, with 1 being "not like me at all"; 2 being "not like me"; 3 being "sometimes like me, sometimes not"; 4 being "like me"; and 5 being "very much like me."

1. I often tell my child that I appreciate what he/she tries out or achieves.
2. I believe that praise is more effective than punishment.
3. I respect my child's opinions.
4. I often joke with my child.
5. I talk it over and reason with my child when he/she misbehaves.
6. I am easygoing and relaxed with my child.
7. I often show my child that I love him/her.
8. My child and I have a good relationship.
9. I usually take my child's preferences into account in making plans for the family.

10. I express my affection by hugging and holding my child.
-

Relationship Closeness Inventory

The following questions look at how much you and your child influence each other as a measure of closeness. Please read each statement and rate how much you agree or disagree with each item based on the following scale:

1= Strongly agree 2 3 4 5 6 7= Strongly Disagree

1. My adolescent will influence my future financial security.
 2. My adolescent does not influence everyday things in my life.
 3. My adolescent influences important things in my life.
 4. My adolescent influences the way I feel about myself.
 5. My adolescent does not influence my moods.
 6. My adolescent does not influence the type of career I have.
 7. My adolescent influences and contributes to my overall happiness.
 8. My adolescent influences how I spend my free time.
-

Demographic Questions

Please answer the following demographic questions about yourself.

1. Please select the gender you identify with most.

Female

Male

Transgender

Other (please specify) _____

2. How do you identify racially?

Black or African American

Hispanic, Latino, or Spanish origin
 Asian
 Middle Eastern
 Native American or Alaskan Native
 Pacific Islander
 Mixed Race or Biracial
 White or Caucasian
 Other (please specify) _____

3. Please choose your highest level of education completed
- Doctoral degree
 - Master's degree
 - Bachelor's degree
 - Associate's degree
 - Postsecondary non-degree award
 - Some college, no degree
 - High school diploma, GED, or equivalent
 - Less than high school diploma

4. Please indicate your experience with your own psychotherapy.
- I have never attended my own psychotherapy
 - I have attended my own psychotherapy in the past.
 - I currently attend my own psychotherapy.

5. On a scale from one to five, please indicate the extent to which you agree or disagree with the following statement:

Psychotherapy is an effective and helpful experience.

1	2	3	4	5
Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree

Please answer the following demographic questions related to your adolescent.

6. Please select the gender your adolescent identifies with most.

Female
 Male
 Transgender
 Other (please specify): _____

7. Please identify the age of your adolescent who is/has attended psychotherapy.
- Twelve
 - Thirteen
 - Fourteen

Fifteen
Sixteen
Seventeen
Eighteen

8. What is your adolescent's previous experience in psychotherapy?

This is his/her first experience in psychotherapy

This is not his/her first experience in psychotherapy.

**Please indicate the extent of previous treatment, including the duration of treatment and type of treatment (outpatient, in-home services, school-based counseling, inpatient hospitalization, partial hospitalization/intensive outpatient program (PHP/IOP))*_____

Thank you for participating in this research study. Please click "done" to submit your responses and exit the survey.

[DONE]

Appendix M

Generic Recruitment Email

Dear Friends, Colleagues, and Classmates,

I am working on my master's thesis for Smith College School for Social Work, as many of you are already aware. I am conducting a quantitative research study that explores parents' perceptions of their adolescent's psychotherapy, and what they disclose to parents about their therapy. I am sending this email to ask for your help with recruiting eligible participants for my research study, which involves a brief online and anonymous survey. If you are personally eligible for participation, I invite and encourage you to participate in my study.

I am recruiting parents of adolescents who attend psychotherapy in an outpatient setting. The criteria to participate in this study are the following:

- You are a parent who has an adolescent between the ages of 12 and 18 who attends outpatient psychotherapy, or has attended outpatient psychotherapy in the past
- Your adolescent has attended therapy for a minimum of 6 weeks

Participants will first answer a few general questions to determine eligibility. If you are eligible, you will then be asked to read an informed consent form which will outline the purpose of the study, along with risks and benefits of participating. There are minimal risks associated with this study, and participation is completely anonymous. Participants will be asked to check a box if they agree to participate. Participation in the study will involve completing a brief survey with Likert scales and a short section of questions relating to demographic information. Participation should take no longer than forty-five minutes. Again, participation is anonymous so I will have no way of knowing who participates in my study. If you meet criteria for participating, I encourage you to take my research survey. If you do not meet the criteria, I encourage you to forward this email to any colleagues, classmates, friends, or acquaintances you might know who may be eligible to participate.

By participating in this study, participants can help expand our knowledge of parent-adolescent relationships, how adolescents communicate with parents about their therapy, and what parents think about their adolescent's therapy. Data can provide insightful information to clinicians who work with adolescents in the field in order to improve parent and adolescent engagement in therapy, which has the potential to learn more effective ways of working with adolescents.

Please click on this link to access the survey:

https://qtrial2014az1.az1.qualtrics.com/SE/?SID=SV_7VcOIEITC2sRDMN

If you have any questions about this study or the involvement of participation, please feel free to reply to this email or contact me via phone at (xxx) xxx-xxxx. If you reply to this email with questions, please do not select "Reply All."

Thank you for your time and interest in my research study!

Sincerely,

Kara Maltese

MSW Candidate, Smith College School for Social Work