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## Exploring the Therapeutic Alliance with Adolescents and Their Caregivers: A Qualitative Approach

Jillian M. Hawks

University of Kentucky, [jmpu224@uky.edu](mailto:jmpu224@uky.edu)

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Jillian M. Hawks, Student

Dr. Ronald Werner-Wilson, Major Professor

Dr. Hyungsoo Kim, Director of Graduate Studies

EXPLORING THE THERAPEUTIC ALLIANCE WITH  
ADOLESCENTS AND THEIR CAREGIVERS:  
A QUALITATIVE APPROACH

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DISSERTATION

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A dissertation submitted in partial fulfillment of the  
requirements for the degree of Doctor of Philosophy in the  
College of Agriculture  
at the University of Kentucky

By

Jillian M. Hawks

Lexington, Kentucky

Director: Ronald Werner-Wilson, Professor of Family Sciences

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## ABSTRACT OF DISSERTATION

### EXPLORING THE THERAPEUTIC ALLIANCE WITH ADOLESCENTS AND THEIR CAREGIVERS: A QUALITATIVE APPROACH

The therapeutic alliance is largely recognized as an important component of the therapeutic process. For clients of all ages, the therapeutic alliance has been associated with positive outcomes and increased engagement in therapy (Bachelor, 2013; Bhola, & Kapur, 2013; Liber et al., 2010). However, very few studies have explored the complex process of fostering the therapeutic alliance with adolescent clients, while also maintaining a positive therapeutic relationship with the adolescent's caregivers. The present study attempted to fill the gap in the literature through qualitatively exploring therapists' perspectives of the therapeutic alliance with adolescents and their caregivers.

In order to discover the essence of therapists' experiences of the therapeutic alliance with adolescents and their caregivers, a phenomenological research design was employed. Nine therapists were interviewed about their experiences of the therapeutic alliance with adolescents and their caregivers. The interviews were transcribed and analyzed, and various themes and subthemes were revealed. The themes were divided into three sections: (1) conceptualizing the therapeutic alliance, (2) therapeutic alliance with adolescents, and (3) therapeutic alliance with caregivers. Two themes emerged within the 'conceptualizing the therapeutic alliance' section: (1) trust, and (2) foundation of therapy. Two themes and various subthemes emerged within the 'therapeutic alliance with adolescents' section. The first theme describes the obstacles that therapists face when attempting to build the alliance with adolescent clients, and contained three subthemes: (1) viewed as an authority figure, (2) resistance to therapy, and (3) differences in SES. The second theme describes the strategies that therapists use to develop the therapeutic alliance and contains three subthemes: (1) discuss interests, (2) honor their voice, and (3) describe limits of confidentiality. Two themes were unveiled within the 'therapeutic alliance with caregivers' section: (1) obstacles, and (2) strategies. The 'obstacles' theme describes barriers that therapists face when constructing the alliance with caregivers of adolescent clients, and contains two subthemes: (1) fear of triangulation, and (2) caregivers' expectations. The 'strategies' theme contains four subthemes: (1) empathy, (2) give caregivers an active role, (3) collaborative approach,

and (4) establish clear boundaries. Clinical implications, recommendations for future research, and limitations of the study are discussed.

**KEYWORDS:** Therapeutic Alliance, Adolescence, Parents, Therapy Process, Qualitative

Jillian Hawks

September 25, 2015

EXPLORING THE THERAPEUTIC ALLIANCE WITH  
ADOLESCENTS AND THEIR CAREGIVERS:  
A QUALITATIVE APPROACH

By

Jillian M. Hawks

Ronald Werner-Wilson  
Director of Dissertation

Hyungsoo Kim  
Director of Graduate Studies

September 25, 2015

## DEDICATION

### *To My Little Family*

It is only natural that I dedicate my dissertation to the people I love most, my little family. William, Colin, and Baby Grace are the loves of my life, and are the sources of my inspiration. I dedicate this dissertation to you, and hope that it can serve as a reminder of the importance of hard work, and the passion that can lead you to accomplish your dreams. I love you forever!

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always hold a special place in my heart, and I look forward to continuing our friendship for many years. I cannot express how thankful I am for your mentorship!

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## CHAPTER 1

### INTRODUCTION

#### **Background of the Therapeutic Alliance**

The therapeutic alliance is largely recognized as an important component of the therapeutic process. For clients of all ages, the therapeutic alliance has been associated with positive outcomes and increased engagement in therapy (Bachelor, 2013; Bhola, & Kapur, 2013; Liber et al., 2010). However, very few studies have explored the complex process of fostering the therapeutic alliance with adolescent clients, while also maintaining a positive therapeutic relationship with the adolescents' caregivers. Instead, most of the research that has been conducted on the therapeutic alliance with adolescents has utilized samples that include both children and adolescents (e.g., Campbell, & Simmonds, 2011), therefore ignoring the unique differences between the two developmental groups. Although research has not thoroughly studied the therapeutic alliance in the context of adolescent therapy process, clinicians often face the task of simultaneously developing positive relationships with their adolescent clients and the adolescent's caregivers. Because clinicians are often faced with the task of simultaneously developing the therapeutic alliance with adolescent clients and their caregivers, it is imperative to further explore the therapeutic alliance in order to better understand how to strengthen the therapeutic alliance, and therefore improve therapeutic outcomes.

In order to study the therapeutic alliance, it is important to define the concept. The therapeutic alliance, also referred to as the working alliance or the therapeutic relationship, can be described as the relationship between the therapist and the client. Bordin (1979) conceptualized the working alliance as maintaining three components: the



agreement upon goals, the assignment of tasks, and the development of bonds. Bordin (1979) explains that the successful completion of the three components of the therapeutic alliance will result in a strong alliance between the therapist and the client. Because a strong therapeutic alliance is associated with enhanced outcomes and increased engagement in therapy (Bachelor, 2013; Bhola, & Kapur, 2013; Liber et al., 2010), it is important for therapists to successfully address each component of the therapeutic alliance.

While Bordin's (1979) conceptualization of the therapeutic alliance may seem straightforward, it can be a daunting challenge for therapists to adequately establish goals, assign effective tasks, and create a strong bond with their clients. When working with adolescent clients, however, the challenge is further intensified. Not only are therapists expected to successfully address the three components of the therapeutic alliance with their clients, they also strive to create positive relationships with their clients' caregivers. Although it can be difficult to establish positive alliances with both adolescent clients and their caregivers, it is beneficial for clinicians to foster relationships with adolescents' caregivers. Through developing a therapeutic alliance with adolescents' caregivers, clinicians can increase the likelihood of continued engagement in therapy (Gatta et al., 2009; Robbins et al., 2006), and can incorporate a systemic approach to their treatment of adolescent clients (Loar, 2001).

Although there are many benefits to fostering a therapeutic alliance with both adolescents and their caregivers, clinicians can also face many potential obstacles when establishing the therapeutic alliance with both parties. For example, when clinicians are trying to maintain trust and confidentiality with their adolescent clients, it may seem

paradoxical to also strive for open communication with the adolescents' caregivers. The current literature does not sufficiently address the concept of the therapeutic alliance in the context of adolescent therapy. As a result, the strategies that clinicians may use to overcome obstacles and develop the alliance with adolescent clients and their caregivers are largely unknown.

### **Statement of the Problem**

Because the therapeutic alliance with adolescent clients and their caregivers has received insufficient attention in the literature, it is unclear as to how therapists simultaneously develop therapeutic alliances with adolescent clients and their caregivers. Furthermore, the obstacles clinicians may face when attempting to establish the therapeutic alliance with adolescent clients are largely unknown. Therefore, therapists do not have resources in the literature to better understand how to develop strong alliances with adolescent clients and their caregivers. Therapists may feel unprepared when they face obstacles in establishing a therapeutic alliance with adolescent clients, and may be unsure as to how to overcome these obstacles. As a result, therapeutic outcomes may suffer for adolescent clients. Therefore, more research needs to be conducted in order to understand therapists' perceptions of the development of the therapeutic alliance with adolescent clients and their caregivers.

### **Significance of the Study**

The therapeutic alliance has been associated with positive outcomes and increased engagement in therapy (Bachelor, 2013; Bhola, & Kapur, 2013; Liber et al., 2010), and therefore, is an important topic for clinicians and researchers to explore. It is important to understand how therapists develop the therapeutic alliance and what obstacles exist when

attempting to establish the alliance simultaneously with adolescent clients and their caregivers. While some research has been conducted to explore the therapeutic alliance with adults and children, very few studies have focused solely on the period of adolescence (Bhola, & Kapur, 2013; Levin, Henderson, & Ehrenreich-May, 2012). The studies that do explore the therapeutic alliance during adolescence tend to focus on adolescent clients' perspective of the alliance (Bhola, & Kapur, 2013; Everall, & Paulson, 2002; Garcia, & Weisz, 2002; Gatta, Spoto, Svanellini, Lai, Toldo, Testa, & Battistella, 2012). As a result, the therapists' perspective of the therapeutic alliance is often overlooked. However, therapists can provide valuable information regarding the therapeutic alliance based on their experiences of working with numerous adolescent clients. While adolescents can provide information regarding their experience of the therapeutic alliance, therapists can formulate their perspectives of the therapeutic alliance from many experiences with adolescent clients. Furthermore, therapists can offer useful information on the development of the therapeutic alliance with adolescent clients and their caregivers. Through including therapists' perspectives when studying the alliance, the obstacles faced by clinicians and the strategies used for the development of the alliance can be better understood. Therefore, it is important to acknowledge the therapists' expertise and experiences of the therapeutic alliance in order to more fully understand the process of the therapeutic alliance with adolescent clients. As a result, this study uniquely contributes to the literature through exploring therapists' perspectives of the therapeutic alliance with adolescent clients and their caregivers.

## **Introduction to Dissertation**

The purpose of the present study is to qualitatively explore therapists' experiences of establishing the therapeutic alliance simultaneously with adolescent clients and their caregivers. Throughout the exploration of the therapeutic alliance with adolescent clients, the current study examined therapists' strategies for developing the alliance with adolescents and their caregivers, and will describe obstacles that clinicians face when attempting to establish the therapeutic alliance with adolescent clients and their caregivers. The present study utilized open-ended questions throughout interviews with therapists in order to explore the phenomenon of the therapeutic alliance with adolescent clients and their caregivers. After the interviews were conducted, I interpreted the lived experiences of therapists in order to better understand the therapeutic alliance. The intent of this study was to provide clinicians and researchers with information on the therapeutic alliance with adolescent clients and their caregivers in order to help clinicians enhance therapeutic outcomes for their clients.

This dissertation utilizes the traditional, five-chapter format. The first chapter serves as an introduction to the dissertation, and provides background information on the therapeutic alliance. Additionally, the first chapter also highlights the significance of the study, the rationale for qualitatively exploring the therapeutic alliance, and the research questions that guided the study. Chapter two provides a detailed literature review. The literature review includes relevant literature relating to the therapeutic alliance, obstacles in establishing the therapeutic alliance, possible strategies for enhancing the therapeutic alliance, and adolescent development. Chapter three describes the methodology that was utilized in order to explore the therapeutic alliance with adolescent clients and their

caregivers. The protocol for interviews, strategies for ensuring validity, and the method for analyzing the data are described. The fourth chapter outlines the results of the study, and provides rich, thick descriptions of the clinicians' experiences of the therapeutic alliance with adolescent clients and their caregivers. Finally, chapter five provides a discussion of the results of the study. The discussion provides a thoughtful analysis of the results of the study in order to help the reader understand the essence of the therapeutic alliance with adolescents and their caregivers.

### **Qualitative Rationale**

Qualitative research methodology is valuable for collecting rich, deep data that helps researchers to reveal the essence of a topic (Creswell, 2007). Qualitative research strategies helped me to convey the essence of participants' experiences of the therapeutic alliance with adolescent clients and their caregivers. Because the therapeutic alliance with adolescent clients is under-researched and relatively little is known about therapists' strategies for negotiating the alliance with adolescents and their caregivers, qualitative research methods are especially appropriate for the exploration of the phenomenon. Through the qualitative study of the therapeutic alliance, I was equipped to collect rich data that help to inform the readers on therapists' perspectives of the therapeutic alliance with adolescent clients and their caregivers.

Qualitative research strategies allowed for open-ended interviews with therapists that enabled me to collect rich, thick data. After the collection of interview data, I identified themes, or recurring ideas within the data, that helped to identify significant areas of interest within the phenomenon of the therapeutic alliance with adolescent clients and their caregivers. After the collection of data and the identification of significant

themes, I provided quotes from the data in order to illustrate the themes and convey the essence of the therapists' perspectives. Because I played a key role in both the collection and the analysis of the data, it is important to note that my biases could have influenced the results of the present study. As a result, I actively participated in strategies to ensure validity (e.g., clarifying researcher bias, peer review, external audits, rich, thick descriptions).

The present study utilized the phenomenological framework in order to explore the therapeutic alliance with adolescent clients and their parents. The goal of a phenomenology is to convey the essence of a phenomenon to readers through the use of qualitative research strategies (Creswell, 2007). Therefore, the phenomenological study of the therapeutic alliance assisted me in unveiling the essence of the therapeutic alliance with adolescent clients and their caregivers. Because the aim of this dissertation was to explore therapists' experiences of the therapeutic alliance with adolescent clients and their caregivers, the phenomenological framework is appropriate for the successful exploration of the therapeutic alliance with adolescents and their caregivers.

### **Statement of Purpose**

The purpose of this dissertation is to understand the essence of the therapeutic alliance with adolescent clients and their caregivers. Three core areas of the therapeutic alliance will be explored throughout the study: (1) therapists' beliefs relating to the therapeutic alliance with adolescents and their caregivers, (2) strategies used to develop and maintain the therapeutic alliance with adolescents and their caregivers, and (3) potential obstacles that therapists face when attempting to establish the therapeutic alliance with adolescent clients and their caregivers. Through the exploration of the

therapeutic alliance with adolescent clients and their parents, this study intended to shed light on the therapeutic alliance in order to provide clinicians with resources in the literature to help them develop and maintain the therapeutic alliance with adolescent clients and their caregivers.

### **Research Questions**

Central research question: How do therapists experience the therapeutic alliance with adolescent clients and their caregivers?

Sub Questions:

- How do therapists conceptualize the therapeutic alliance with adolescent clients and their caregivers?
- What strategies are most helpful in establishing the therapeutic alliance with adolescent clients?
- What obstacles exist when attempting to develop the therapeutic alliance with adolescent clients?
- What strategies are most helpful in establishing the therapeutic alliance with the caregivers of adolescent clients?
- What obstacles exist when attempting to develop the therapeutic alliance with the caregivers of adolescent clients?

### **Definition of Terms**

For the purposes of this dissertation, the following definitions are utilized.

**1. Adolescence:** A stage of human development between childhood and adulthood marked by the beginning of puberty and ending with social changes as the adolescent is expected to accept adult roles and responsibilities (Dahl, 2004).

**2. Therapeutic Alliance:** The relationship between the therapist and the client that is determined by three components: the agreement upon goals, the assignment of tasks, and the development of bonds (Bordin, 1979).

**3. Phenomenology:** A qualitative research methodology in which the purpose is to understand the essence of an experience (Creswell, 2007)



## CHAPTER 2

### REVIEW OF THE LITERATURE

#### **Theoretical Framework**

**Therapeutic Alliance.** In order to understand the concept of the therapeutic alliance, the pan-theoretical framework developed by Bordin (1979) will be applied to the present study. The therapeutic alliance (also called the working alliance) refers to the relationship between the therapist and the client. Bordin describes the working alliance as the most influential component of the change process. Furthermore, Bordin explains that the therapeutic alliance encompasses all theoretical approaches, and is a universally applicable concept within the therapeutic process. Bordin claims that all theoretical orientations have explicit or implicit ideas of the therapeutic alliance, but that different theories may assign various roles to the therapist and the client in relation to the development and maintenance of the therapeutic alliance. Regardless of the theoretical orientation, Bordin explains that the effectiveness of therapy is related to the strength of the alliance. Therefore, the therapeutic alliance is central to the therapy process.

According to Bordin (1979), the therapeutic alliance is comprised of three interdependent components: the agreement on goals, the assignment of tasks, and the development of bonds. The agreement on goals refers to the mutual agreement between the therapist and the client that identifies the major goals of the therapeutic process. Bordin (1979) asserts that the agreement on goals is a major component of the therapeutic alliance and should not be discounted as a minor detail of the therapeutic process. Because the agreement on goals indicates a mutual agreement, it solidifies the union between the therapist and the client. Instead of working separately toward different goals,

the client and the therapist have joined forces to work together towards a common goal. As a result, the agreement on goals is a significant component of the therapeutic alliance.

The second component of the therapeutic alliance is the assignment of tasks. The assignment of tasks entails both implicit and explicit interventions and assignments for clients. According to Bordin (1979), the effectiveness of tasks is dependent upon the therapist's ability to assign tasks that are appropriately matched to the client's perception of their situation and their willingness to change. As a result, the clinician must have an accurate understanding of the client's perceptual world in order to effectively utilize interventions and assign tasks that will help the client to achieve their goals. Therefore, the assignment of tasks is also viewed as a critical component of the therapeutic alliance.

The final factor of the therapeutic alliance is the development of bonds. This component refers to the human experience of the relationship between the therapist and client. While all types of relationships experience the development of bonds, some relationships form deeper bonds than other types of relationships. In order for a deep bond to be established, a basic level of trust must be apparent. In addition, when the focus of the relationship is directed toward an individual's inner experience, a deeper level of trust and attachment are fostered. Therefore, therapeutic relationships that incorporate trust, a focus on the client's inner experience, and a development of attachment tend to be characterized by a deeper bond, and a stronger therapeutic alliance.

Since Bordin's (1979) initial work, several studies have applied his conceptualization of the therapeutic alliance. An overwhelming amount of research has demonstrated that the therapeutic alliance is a robust predictor of client outcomes (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Flückiger, Del Re, Wampold,

Symonds, & Horvath, 2012; Martin, Garske, & Davis, 2000). However, less research has been conducted on the alliance with children and adolescents, and even fewer studies have examined the role of the alliance with adolescents and their caregivers. Campbell, & Simmonds (2011) applied Bordin's theory to therapists' perspectives of the working alliance with children and adolescents. After conducting interviews with therapists regarding the therapeutic alliance, the following themes emerged from the interview data: alliance bond, parental alliance, therapist resources, and therapist self-awareness and well-being. The themes demonstrated partial support for Bordin's conceptualization of the therapeutic alliance. For example, the alliance bond theme has clear connections to Bordin's identification of the third component of the therapeutic alliance, the development of bonds. The alliance bond theme and the development of bonds component of the therapeutic alliance both reflect an emotional connection between the therapist and the client. However, the remaining themes are not directly relevant to Bordin's conceptualization of the therapeutic alliance. For example, the parental alliance theme indicates that it is important for therapists to form an alliance with the parents of children and adolescent clients in order to formulate an alliance with the primary client. However, Bordin's work focused primarily on working with adult clients, and therefore did not acknowledge the role of the caregiver in working with children and adolescents. As a result of Campbell & Simmonds (2011) research, Bordin's conceptualization of the therapeutic alliance was challenged, especially in relation to the therapeutic alliance with children and adolescent clients. However, the results presented by Campbell & Simmonds (2011) do not indicate whether differences exist between adolescent and child clients. As a result, it is important for future research to examine the therapeutic alliance

with children and adolescent clients separately in order to determine whether differences exist between the two developmental groups.

In addition to the study conducted by Campbell & Simmonds (2011), Diamond, Diamond, & Liddle (2000) also applied Bordin's theoretical framework of the therapeutic alliance to clinical work with the parents of adolescent clients. The authors provide guidelines to therapists for generating the therapeutic alliance with adolescents' parents. Specifically, the authors explain that it is helpful for therapists to meet with parents for a minimum of one session in order to develop the therapeutic alliance. During the session, the authors explain that the first component of Bordin's model, the goal phase, should entail defining the parent-adolescent relationship as a central focus of the therapeutic process. The second component of the therapeutic alliance, the task phase, should involve the therapist helping to prepare parents to learn more effective ways of communicating with their child. Finally, therapists should display empathy and understanding towards parents during the bond phase. In addition to the specific guidelines that the authors recommend for each of the three components of Bordin's model, the authors also explain that all three phases can occur sequentially within one session with a parent. Furthermore, the authors claim that the session with the parent can form the foundation for improvements within the parent-adolescent relationship. While Bordin's conceptualization of the therapeutic alliance has been applied to various research studies, there are currently no empirical studies that examine the way in which the therapeutic alliance is developed with adolescent clients and their caregivers. In order to more fully understand the role of the therapeutic alliance with adolescent clients and their parents, family systems theory will also be applied to the present study.

**Family Systems.** In addition to Bordin's theoretical conceptualization of the therapeutic alliance, the present study is also influenced by family systems theory. In its most basic form, family systems theory suggests that individuals can only be understood within the context of the greater system (Smith, Hamon, Ingoldsby, & Miller, 2009). Furthermore, family systems theory claims that the whole system is greater than the sum of its parts; therefore indicating that the family system must be considered instead of focusing solely on each individual family member in order to capture the truth of the phenomenon (Smith et al., 2009).

The assumption that the whole is greater than the sum of the parts leads to a second assumption of family systems theory. Family systems theorists believe that the locus of pathology is a system dysfunction, and is not simply located within one individual (Smith et al., 2009). This assumption of family systems theory requires a paradigm shift of incorporating an interpersonal perspective, instead of maintaining an intrapsychic perspective that is characteristic of most psychology theories (Smith et al., 2009). Because the interpersonal perspective views all behavior as interactive with the greater system, symptomatic behavior is seen as representing a dysfunctional system, as opposed to a dysfunctional individual (Smith et al., 2009). As a result, family systems theory encourages researchers and clinicians to broaden their scope and to acknowledge the greater system instead of focusing solely on one identified patient.

Family systems theory has influenced the researcher to adopt a systemic approach throughout the development of the present study. The systemic influence on the researcher (as well as the desire to understand the therapeutic alliance with adolescent clients and their caregivers) has led to the development of the primary research question:

How do therapists experience the therapeutic alliance with adolescent clients and their caregivers? Instead of focusing solely on adolescent clients, the researcher will attempt to capture the essence of the therapeutic alliance through including components of the adolescent's greater system. As a result, caregivers influence on the therapeutic alliance will be acknowledged throughout the course of the study. Research participants will be asked questions about their experiences of the therapeutic alliance with both adolescent clients and adolescents' caregivers. Through acknowledging the greater system of the adolescent client and including the caregivers' role into the research methodology, the systemic approach of the present study adds depth to the understanding of the therapeutic alliance with adolescent clients and their caregivers. In order to continue to frame the present study, the current literature regarding the therapeutic alliance will be explored in the following section.

### **Therapeutic Alliance**

The therapeutic alliance has been consistently associated with positive outcomes. For example, several meta-analyses have identified the therapeutic alliance as a robust predictor of treatment outcomes (Del Re et al., 2012; Flückiger et al., 2012; Martin et al., 2000). Furthermore, meta-analyses have failed to identify consistent moderating and mediating variables in relation to the therapeutic alliance (Flückiger et al., 2012; Martin et al., 2000), therefore emphasizing the influential power of the therapeutic alliance on the change process. In support of Bordin's (1979) pan-theoretical conceptualization of the therapeutic alliance, several meta-analyses have identified the therapeutic alliance as a predictor of positive outcomes regardless of the therapist's theoretical orientation (Flückiger, 2012; Horvath, & Symonds, 1991). Therefore, the therapeutic alliance has

been consistently associated with positive outcomes for therapists practicing from a variety of theoretical backgrounds.

In addition to the research from meta-analyses, the therapeutic alliance has also been associated with positive outcomes for adolescents (Bhola, & Kapur, 2013) and children (Liber et al., 2010). For example, Bhola & Kapur (2013) examined the therapeutic alliance from the perspectives of adolescent girls, and found that stronger therapeutic alliances were associated with reductions in internalizing problems. In addition, their results also indicated that the development of the therapeutic alliance is not a stable, gradual growth, but can rise sharply at various points throughout the therapeutic process. For example, the researchers assessed the alliance at sessions three, six, and nine by collecting self-report data from the adolescent girls. The results indicated that the alliance was relatively stable between sessions three and six, but that the adolescents rated the alliance significantly higher by the ninth session. As a result, it may be especially important for therapists to take their time building the therapeutic alliance, and to acknowledge that a strong alliance may not be formed with adolescent clients within the first several sessions. Instead, it is important for therapists to continue to build the therapeutic alliance with adolescent clients throughout the therapy process in order to establish a strong alliance and improve outcomes.

In addition to the association between the therapeutic alliance and therapy outcomes for adolescent clients, research has also explored client characteristics that predict the formation of a strong therapeutic alliance. While the majority of research focuses on outcome research and the ways in which therapists can increase the therapeutic alliance, Levin, Henderson, & Ehrenreich-May (2012) examined adolescent

client's contribution to the therapeutic alliance through identifying possible individual variables that predict the therapeutic alliance. The results indicated that adolescents' perceptions of their interpersonal relationships predicted their ratings of the alliance. In addition, the adolescents' symptom severity also predicted ratings of the therapeutic alliance. Finally, therapists perceived weaker alliances early in therapy with adolescents who were depressed as compared to adolescents with anxiety but no depression. This article presents useful information because it is one of the only studies that examine client characteristics that predict the therapeutic alliance. As a result, it is important to recognize that adolescent clients can have individual variables (e.g., their perception of their interpersonal relationships) that affect the development of the therapeutic alliance, and that therapists are not in complete control of the formation of the therapeutic alliance. Instead, both adolescent clients and therapists contribute to the development and maintenance of the therapeutic alliance.

In addition to research that has associated adolescent positive outcomes with the therapeutic alliance, researchers have also explored adolescents' perceptions of the therapeutic alliance. Everall and Paulson (2002) conducted qualitative interviews with adolescent clients in order to better understand adolescents' perceptions of the therapeutic alliance. Adolescents were interviewed utilizing semi-structured interviews. The results revealed three themes: therapeutic environment, uniqueness of the therapeutic relationship, and therapist characteristics. Based on the results of the study, adolescents' perception of a strong alliance was characterized by viewing their therapist as accepting, supportive, and trustworthy. In addition, the adolescents' perception of their therapist also influenced the adolescents' evaluation of the therapeutic tasks and goals. These results



clearly connect to Bordin's (1979) conceptualization of the therapeutic alliance, as evidenced by the apparent interacting roles of the three components of the therapeutic alliance: goals, tasks, and bond. While it is imperative to explore the role of the therapeutic alliance in the therapeutic process with adolescents, it is also important to recognize the role of adolescents' caregivers throughout the therapeutic process. As a result, the therapeutic alliance will be explored in the context of adolescents' caregivers in the following section.

**Therapeutic Alliance and Adolescents' Caregivers.** Adolescents' caregivers play an important role throughout the therapy process, even when the adolescent is being seen by a therapist on an individual basis. The caregivers can fulfill both practical and therapeutic purposes. Practically, caregivers must provide consent for the initiation of therapy, they often pay for the therapy process, and they tend to provide the adolescent with transportation to and from therapy sessions. As a result, caregivers play a pivotal role in the initiation and continued attendance of therapy sessions. In addition to the practical aspects of caregivers' involvement in therapy, caregivers can also play active roles in the therapy process. For example, caregivers can offer unique insight into the adolescent's world that the therapist may not have access to without the caregivers' help. Therapists can incorporate caregivers' perspectives into the therapy process in order to enhance treatment and improve therapeutic outcomes. In addition, the incorporation of caregivers into the therapy room may provide a beneficial systemic approach to therapy. Clearly, adolescents' caregivers can play a major role throughout the therapeutic process. As a result, it is important for therapists to build therapeutic alliances with adolescents'

caregivers in order to effectively design and implement treatment that will best meet the adolescents' needs (Diamond, Diamond, & Liddle, 2000).

While relatively little research has been conducted on the therapeutic alliance with adolescent clients, even fewer studies have examined the therapeutic alliance with children's and adolescents' caregivers. Gatta et al. (2009) found that stronger alliances between parents and therapists were associated with higher therapeutic compliance and positive outcomes for child clients. In addition, the results provided by Gatta et al. (2012) indicated that therapeutic compliance was a critical variable when predicting outcomes for both children and adolescents, and that the parents' alliances with therapists was a significant factor that influenced therapeutic compliance. Furthermore, an additional study found that adolescent clients and their parents who prematurely terminated therapy tended to report weaker therapeutic alliances than adolescents and parents who completed the therapeutic process (Robbins et al., 2006). The results of these studies all emphasize the role of the caregiver in "therapeutic compliance", which can partially be defined as the attendance of therapy sessions, and continued engagement of therapy sessions. While the therapeutic alliance can play a pivotal role in the therapeutic process, it is important to acknowledge the hurdles that may prevent clinicians from establishing a strong therapeutic alliance with adolescents and their caregivers. As a result, the following section will explore possible obstacles that clinicians may face when attempting to form an alliance with adolescents and their caregivers.

**Obstacles in Establishing the Therapeutic Alliance.** Although clinicians may face many obstacles in forming therapeutic alliances with adolescent clients and their caregivers, the current literature does not adequately reflect the possible difficulties that

therapists encounter when working with adolescents. However, possible obstacles to forming strong therapeutic alliances include blurred boundaries in identifying the primary client, recognizing appropriate times to share information with caregivers, navigating the relationships when the needs of the adolescent and the caregiver conflict, and establishing trust and confidentiality with adolescent clients while also maintaining communication with caregivers. However, the current literature that explores these topics in the mental health field is almost nonexistent, and is limited to the medical field. For example, research in the medical field has recognized the ethical dilemmas that arise when physicians attempt to maintain the confidentiality of their adolescent patients while also developing relationships with the adolescents' caregivers. More specifically, several studies have identified an internal struggle in physicians when attempting to maintain adolescent patients' confidentiality while also communicating with the patients' parents (Helitzer, Sussman, Urquieta de Hernandez, & Kong, 2011; Tebb, 2011). For example, Helitzer et al. (2011) conducted in-depth interviews with 37 physicians in order to explore possible barriers that physicians face when attempting to maintain an adolescent's privacy while also communicating with the adolescent's parents. Results indicated both individual and structural barriers to maintaining confidentiality for adolescent clients while also maintaining relationships with adolescents' parents. The identified barriers included parents' lack of knowledge regarding their child's risk behaviors, physicians' time constraints, the physicians' concerns for maintaining confidentiality with the child, and legal requirements that limit communication with parents. This study provides useful information for understanding the obstacles that may arise from various sources (e.g., caregivers' perspectives, clinicians' time constraints, and

the legal system) when clinicians are attempting to respect adolescents' privacy while also maintaining a relationship with the adolescent's caregivers.

The medical literature has also examined caregivers' perceptions of the communication process with physicians when their adolescent children are receiving treatment. Many studies have indicated that caregivers have a desire to be involved in their adolescent children's treatment (Duncan, Vandeleur, Derks, & Sawyer, 2011; Sasse, Aroni, Sawyer, & Duncan, 2013). Sasse et al. (2013) conducted semi-structured interviews with 17 Australian parents of adolescent patients. The results indicated that parents maintained a wide range of views about adolescents' confidentiality with doctors. However, many parents expressed concern about not being involved in their child's healthcare. Furthermore, parental views of confidentiality for adolescents were dependent upon two factors: the way in which they perceived their role as a parent, and how they viewed their child's doctor. As a result, it can be helpful for clinicians to understand how their adolescent clients' caregivers view their role as a caregiver in order to fully understand how the caregivers views their role in the therapy process. Additionally, it can be helpful for clinicians to spend time with the adolescent's caregivers in order for the caregivers to develop trust with the clinician. As caregivers learn to trust the therapist, they may feel more comfortable allowing the adolescent to share private information with the therapist.

In addition to the research conducted by Sasse et al. (2013), Duncan et al. (2011) also explored parents' perspectives of confidentiality between doctors and adolescent patients. The researchers surveyed 86 parents who had an adolescent child that attended a medical clinic. The results indicated that parents wanted to be informed about their

children's care, even if their adolescent children did not want them to be included in the treatment process. As a result of the competing views among caregivers and adolescents, many clinicians may struggle with the amount of information to share with caregivers in an attempt to maintain trust and confidentiality with adolescent patients. While many of these issues may present challenges to clinicians, very little research reflects the difficulties that therapists might encounter when working with adolescents in the mental health setting. As a result, the present study attempted to fill the gap in the literature through examining the possible obstacles that therapists encounter when working with adolescents, and exploring the strategies that therapists employ to successfully form strong therapeutic alliances with adolescent clients and their caregivers. In order to more fully understand the therapeutic alliance in the context of adolescence, adolescent development will be discussed in the following section.

### **Adolescent Development and the Therapeutic Alliance**

**Adolescent Development.** Adolescence is an important transitional period between childhood and adulthood (Grotevant, 1998). The physical changes of puberty initiate the stage of adolescence, but the culture and societal norms help to shape the experience of adolescence (Grotevant, 1998). Although adolescence is considered to be a time of transition, it is a unique stage that requires specific attention from researchers and clinicians (Grotevant, 1998). Because the developmental period of adolescence is characterized by unique differences that distinguish it from childhood and adulthood, the period of adolescence demands its own study (Grotevant, 1998). Not only is adolescence a time of physical change reflected by puberty, but it also maintains several unique social and relational features as adolescents prepare to accept the roles and expectations of

adulthood (Dahl, 2004). For example, adolescence maintains three core areas of developmental change: physical and sexual maturation, change in status from a child to an adult, and enhanced reasoning capabilities (Hill & Monks, 1977; Grotevant, 1998),

The first primary area of change during adolescence refers to the physical changes of adolescence (Grotevant, 1998). The pubertal changes initiate the period of adolescence, and enables adolescents to reproduce. Some of the physical changes of puberty include the development of reproductive organs, growth in height, change in the tone of voice for boys, menarche for girls, and the development of breast tissue for girls. The physical changes of puberty also present important psychological processes for adolescents (Grotevant, 1998). For example, early physical development for boys and average physical development for girls is associated with easier adjustment to adolescence (Grotevant, 1998). Conversely, late development for boys and early development for girls has been associated with difficulty adjusting to adolescence (Grotevant, 1998; Brooks-Gunn, Petersen, & Eichorn, 1985). As a result, it is important to recognize that puberty presents important implications for the adolescent's psychological and social well-being, as well as their physical well-being.

The second core area of change within adolescence is the transition from childhood to adulthood (Grotevant, 1998). This change refers to the social implications of puberty, and can be greatly influenced by societal norms and expectations. For example, the transition could be completed quickly through the participation in an initiation rite, or gradually through the slow acquisition of adult privileges (Grotevant, 1998). By the end of the transition, the individuals are considered to be adults within their society (Grotevant, 1998).

The third and final primary change within adolescence describes the cognitive changes that gradually take place throughout adolescence (Grotevant, 1998). The cognitive changes can include the adolescent's quest to explore their own identity, as well as the development of hypothetic-deductive reasoning (Grotevant, 1998). Although the potential for cognitive growth is considered universal, it is important to note that the environment of the adolescent can influence their cognitive development (Grotevant, 1998). As a result, some adolescents may experience cognitive growth, whereas the environments of other adolescents may stifle the potential for cognitive development.

**Caregiver-Child Relationship.** The three primary changes of adolescence present major implications for adolescents' relationships. Because adolescence is a transitional period, many relational transformations take place during adolescence (Grotevant, 1998). For example, as adolescents gain autonomy, they begin to transform their relationships with their caregivers. In general, adolescents tend to spend less time with their caregivers as compared to the childhood years (Grotevant, 1998). Adolescents tend to feel more emotional distance from their caregivers, and experience increased conflict and decreased closeness after the onset of puberty (Steinberg, 1981; Grotevant, 1998). Research suggests that children's emotional autonomy increases between fifth to ninth grades, and that the increased levels of emotional autonomy are linked to decreased dependence on caregivers and increased reliance on peers (Steinberg, & Silverberg, 1986; Grotevant, 1998).

While a general trend of decreased dependence upon caregivers exists within adolescence, the caregiver-child relationship remains an important source of support throughout adolescence (Grotevant, 1998). Papini, Roggman, and Anderson (1991)

conducted research to explore the distancing process between adolescents and their parents. The results indicated that attachment levels tend to decrease after puberty, but that greater levels of attachment to both parents predicted lower levels of depression and anxiety for both adolescent boys and girls. Therefore, the parent-adolescent relationship can serve as a buffer against potential negative consequences (e.g., isolation, depression, etc.) of increased autonomy during adolescence.

Adolescents also recognize the importance of the caregiver-adolescent relationship, even in the midst of increased reliance upon peers. Lempers and Clark-Lempers (1992) conducted a study to explore the functional importance of varying relationships during adolescence. In order to assess the importance of each relationship, the researchers asked adolescents to rate their relationships with their parents, best friend, siblings, and teachers on various scales of relationship functionality. All of the participants (n = 330) perceived their relationships with both their mothers and fathers as highly important relationships for affection, instrumental aid, and reliability. The adolescents also described the parent relationship as highly conflictual. Although the adolescents reported high levels of conflict within the parent-adolescent relationship, they also described the relationship as reliable, important for affection, and a source of help with daily activities. As a result, it is important to recognize the caregiver-adolescent relationship as an important source of support during adolescence.

As noted above, adolescents tend to experience increased levels of conflict with their caregivers (Grotevant, 1998; Steinberg, 1981; Lempers, & Clark-Lempers, 1992). Current research has identified a number of contributing factors that influence the increased conflict levels within parent-adolescent relationships. For example, parents and



adolescents tend to hold different expectations of behaviors and the appropriate timing for new behaviors (Collins et al., 1997; Grotevant, 1998). Parents' and adolescents' expectations tend to be more mismatched during early adolescence, which is also the time of greatest conflict (Collins et al., 1997; Grotevant, 1998). In addition to the conflicting expectations of parents and adolescents, adolescents' increased levels of autonomy can also contribute to the conflict within the parent-adolescent relationship (Smetana, 1989). As adolescents exert their newfound autonomy, parents may feel as though the family system is being threatened (Smetana, 1989; Grotevant, 1998). As a result, adolescents and caregivers begin to experience higher levels of conflict (Smetana, 1989; Grotevant, 1998).

In addition to the increased levels of conflict, the caregiver-adolescent relationship transforms in other ways as well. For example, many important gender differences exist throughout parent-adolescent relationships. Youniss and Smollar (1985) conducted research to explore gender differences within dyadic parent-adolescent relationships and discovered many significant findings (Grotevant, 1998). Adolescent girls tended to perceive their fathers as strict authority figures, and reported feeling distant and withdrawn from their fathers. However, adolescent boys viewed their fathers as knowledgeable sources of advice, and spent more time with their fathers as compared to girls. Adolescent males reported interacting with their fathers in a variety of contexts, including conversation, recreation, and work activities. Differences also existed between girls' and boys' relationships with their mothers. Adolescent girls reported feeling as though their relationships with their mothers met both their material and emotional needs. They described their relationships as balanced with both authority and equality, and

intimacy and conflict. Adolescent males characterized their relationships with their mothers as helpful, loving, honest, and trustworthy. Additionally, males reported viewing their mothers as confidants for both personal and practical matters. Regardless of the gender of the adolescent, it is important to note that most adolescents recognize the significance of their relationships with their caregivers (Lempers, & Clark-Lempers, 1992).

Because the caregiver-child relationship plays a major role during adolescence, it is important to explore the role of the parent-adolescent relationship throughout the therapeutic process. Many clinicians and researchers highlight the importance of incorporating caregivers throughout the therapeutic process with adolescents and children (Novick, & Novick, 2005; Novick, & Novick, 2013). For example, Novick and Novick (2005) claim that caregivers play a crucial role in therapy with adolescents, and that the caregiver-child relationship should be strengthened throughout therapy in order to create long-lasting change (Novick, & Novick, 2005). Furthermore, the authors explain that therapists and caregivers should form a strong alliance in order to support adolescents' development and to enhance therapeutic outcomes (Novick, & Novick, 2005).

While researchers and clinicians often encourage the collaboration between therapists and caregivers (Novick, & Novick, 2005; Novick, & Novick, 2013), the current literature does not offer concrete methods for establishing the therapeutic alliance between therapists and caregivers of adolescent clients. Furthermore, the potential obstacles clinicians may face when attempting to establish an alliance with the caregivers of an adolescent client are unknown. As a result, the present study attempted to address the gap in the research through exploring therapists' perceptions of the therapeutic

alliance with adolescent clients and their caregivers. The following section will explore the role of peer relationships in adolescent development, and the relationship between the therapeutic alliance and adolescents' peer relationships.

**Peer Relationships.** As noted above, peer relationships become more important as children progress into adolescence. Adolescence is often characterized as a period of identity formation (Erikson, 1980). As adolescents attempt to establish their own identity, they tend to place more importance on their relationships with peers (Brown, 1990; Petersen, 1988; Wigfield, Byrnes, & Eccles, 2006). Adolescents' peer relationships can serve as an exploratory tool for adolescents to discover life outside of their family unit, and to begin to establish more independence while they participate in the identity formation process (Erikson, 1980; Steinberg, 1990).

Adolescents' peer groups aid their identity exploration in a number of ways. Brown, Mory, & Kinney (1994) conducted research to examine the developmental transformation of friendships during adolescents (Grotevant, 1998). Their results indicated that adolescents utilize interactions with their peer groups to enhance their own identity formation and autonomy in three main ways. First, the stereotypes associated with each peer group (e.g., jocks) help adolescents to understand alternative social identities. Secondly, peer groups help adolescents to understand that relationships between certain individuals are more likely than relationships among others. Finally, interactions in peer groups help adolescents to understand that relationships can be structured in various ways and that closeness and longevity can vary between relationships. Clearly, adolescents' peer relationships can serve a number of functions,

including identity formation, expression of autonomy, and learning about interacting with different types of people.

Adolescents' enhanced focus on peer relationships presents interesting implications for the therapeutic alliance. For example, several studies have identified adolescents' interpersonal relationships as a key factor for influencing the way in which adolescents' view the therapeutic alliance (Levin, Henderson, & Ehrenreich-May, 2012; Garner, Godley, & Funk, 2008). Levin, Henderson, and Ehrenreich-May (2012) found that adolescents' perception of the therapeutic alliance was predicted by their conceptualization of their interpersonal relationships with peers. Therefore, adolescents' positive perceptions of their peer relationships as strong and healthy predicted more positive ratings of the therapeutic alliance. Similarly, Garner, Godley, and Funk (2008) found that adolescents who reported high levels of social support were more likely to experience a strong therapeutic alliance. As a result, it is important to understand that adolescents' peer relationships can influence the way in which adolescent clients perceive the therapeutic alliance.

Adolescents' increased focus on peer relationships can also influence their willingness to seek help from professionals (Raviv, Raviv, Vago-Gefen, & Fink, 2009; Sheffield, Fiorenza, & Sofronoff, 2004). For example, adolescents' perception of greater peer social support is associated with willingness to seek help from friends, and less willingness to seek help from professionals for mental health problems (Sheffield et al., 2004). Similarly, Raviv et al. (2009) explored adolescents' attitudes toward seeking help for mental health problems. The results indicated that adolescents are more willing to refer themselves and their peers to a friend for help as compared to a mental health

professional. Furthermore, adolescents were also more likely to refer their peers to a professional than they were themselves. These studies highlight the importance of peer relationships during adolescence, and the way in which the therapeutic relationship is affected by adolescents' friendships

CHAPTER 3  
METHODOLOGY

**Overview of Methodology and Research Design**

The present study utilized a phenomenological research design. The phenomenological design was used to inductively understand therapists' experiences of establishing and maintaining the therapeutic alliance with adolescent clients and their caregivers. In-depth interviews were conducted in order to gather data from mental health therapists. The interview questions probed the topics of the therapeutic alliance with adolescent clients and their caregivers, and the challenges that therapists face when attempting to establish and maintain the therapeutic alliance with adolescent clients. Through the use of a phenomenology, the lived experiences of therapists were reduced to a rich, thick description of the essence of their experiences of the therapeutic alliance with adolescents and their caregivers (Creswell, 2007). The following sections provide a detailed description of the qualitative tradition, the role of the researcher, the sampling methods, data collection procedures, data analysis, and the strategies for validation that were used throughout the present study.

**Qualitative Tradition**

The goal of a phenomenological study is to describe the meaning of several individuals' lived experiences of a phenomenon (Creswell, 2007). The researcher attempts to reduce individual participants' experiences of a phenomenon to a description of the essence of the event (Creswell, 2007). In order to conduct a phenomenological study, qualitative researchers must first identify a phenomenon (e.g., the therapeutic alliance; Creswell, 2007). Next, the researcher collects data from individuals who have

experienced the phenomenon (Creswell, 2007). Finally, the data must be analyzed in order to develop a description of the essence of the phenomenon (Creswell, 2007).

The present study utilized the psychological (or transcendental) approach to phenomenology. The psychological approach focuses on describing the experiences of participants in order to convey the essence of the phenomenon (Creswell, 2007; Moustakas, 1994). Additionally, the psychological approach encourages qualitative researchers to participate in bracketing, which requires researchers to describe their own experiences that might influence the study (the results of the bracketing process can be found in the following section, “Researcher as Instrument”). Furthermore, the psychological approach to phenomenology requires researchers to provide both textural and structural descriptions of the essence of the phenomenon. As a result, the present study will provide rich, thick descriptions that describe the “what” participants experienced, and the “how” of participants’ experiences. Through the use of rich, thick descriptions, detailed narrative of the interviews (including verbatim quotes) will be provided.

The psychological approach to phenomenology outlines several steps for the completion of a phenomenological study (Creswell, 2007; Moustakas, 1994). The following steps were developed by Moustakas (1994), and are recommended for phenomenologies (Creswell, 2007):

- 1) Determine if phenomenology is an appropriate fit for the research question.

The phenomenological design may be an appropriate fit if the research is intended to describe several individuals’ common experiences of a phenomenon (Creswell, 2007).

- 2) Identify a specific phenomenon for the focus of the study.
- 3) The researcher recognizes the assumptions of phenomenology. The researcher participates in the bracketing process (Creswell, 2007).
- 4) Data is collected from participants who have experienced the identified phenomenon. Data collection is often consisted of in-depth interviews (Creswell, 2007).
- 5) Participants are asked two core questions: What have you experienced?, and How have you experienced the phenomenon? These questions will lead to the textural and structural descriptions of the phenomenon (Creswell, 2007).
- 6) Complete data analysis steps. First, identify significant statements in the data (Creswell, 2007). Next, organize the significant statements into broader categories, or themes.
- 7) Write a textural (“what” was experienced) and structural (“how” it was experience) description of the phenomenon (Creswell, 2007).
- 8) Combine the textural and structural descriptions to formulate a comprehensive description of the essence of the phenomenon.

Because the goal of the present study was to describe a group of individuals’ common experiences (e.g., therapists’ experiences of the therapeutic alliance with adolescent clients and their caregivers), a phenomenological design was a good fit for the research question. Therefore, the present study adhered to the guidelines set forth by the psychological approach to phenomenological studies (Creswell, 2007; Moustakas, 1994). The methodology of the present study will be discussed in detail in the following sections.



### **Researcher as Instrument.**

Qualitative researchers are often the key instrument in data collection. The researcher acts as the data collection instrument through collecting the data themselves, often through the use of interviews during face-to-face interactions with the research participants (Creswell, 2007). It is important to note the personal experiences and biases of the researcher in order to have a clear understanding of the impact of the researcher throughout the study. The process of exposing personal situations and biases that may influence the research exploration is referred to as bracketing (Creswell, 2007). As the qualitative researcher and the key instrument in the present study, I will disclose my own interests and experiences that may influence my bias.

My initial interest in researching the adolescent population stems from my personal experience of interacting with adolescents. Throughout my adult life, I have had many enjoyable experiences with adolescents. Currently, I have two adolescent siblings and two adolescent nieces whom I love dearly and look forward to seeing. Additionally, I have worked with adolescents in youth group settings at a local church. My interactions with adolescents have been both challenging and rewarding, as well as fun and entertaining. While I enjoy the company of adolescents, I am continually bombarded with negative messages regarding adolescents in both research and media contexts. For example, much of the research on adolescence focuses on delinquency and negative outcomes (Brunelle, Tremblay, Blanchette-Martin, Gendron, & Tessier, 2014; Fair Worthen, 2012), while the media often portrays adolescents as unruly villains with negative attitudes. My personal experiences have led me to question the truth of these

stereotypes, and have sparked an interest in pursuing research with the adolescent population.

In addition to my personal experiences, my professional work has also influenced my beliefs and expectations that might bias the present study. Most notably, I work as a marriage and family therapy associate. I have worked in several settings with adolescent clients, including private practice, clinical work at a middle school, an inpatient psychiatric facility, a Veterans Affairs family counseling office, and a university family counseling center. Throughout my clinical experiences with adolescents, I have culminated a passion for working with the adolescent population that has encouraged my research interest in the topic of the therapeutic alliance with adolescent clients.

Furthermore, I have formulated certain beliefs regarding clinical work with adolescents.

For example, I believe that the adolescent population maintains unique characteristics that make working with adolescents fundamentally different from working with children or adults. For example, I believe that developmental characteristics and the juxtaposition between autonomy and dependence results in unique attributes of the adolescent population. Additionally, I also believe that it is beneficial for therapists to have a working relationship with both the adolescent client and their parent(s). The passion I have for working with adolescents and my belief set that guides my clinical work may influence the present study. For example, the primary research question was developed from my own interests and beliefs. Because I enjoy working with adolescents and I believe that parents can influence the therapeutic process, I constructed the current study. As a result, the way I ask participants the interview questions or the way I interpret participants' responses may be biased by my personal beliefs and experiences.

In addition to my personal experiences of working with adolescent clients, my clinical training and educational background may also influence the present study. Throughout my undergraduate and graduate work, I have been trained to incorporate a systemic approach when viewing social phenomena. Because of the systemic nature of my educational training, I often attempt to acknowledge the greater system when working as a marriage and family therapist and a researcher. As a result, it is possible that the systemic training I have received will influence the present study. For example, throughout the present study I will attempt to explore the therapeutic alliance with both adolescent clients and their parents. Because I hope to research the role of the therapeutic alliance with the parent as well as with the adolescent client, I will be incorporating a systemic approach to the present study.

Finally, it is important to note that it is possible that I will have a preexisting professional relationship with some of the research participants. Because I have worked with some of the possible participants in a past professional setting, a level of rapport was established prior to the initial interviews. Our previous interactions could encourage the participants to trust me, and therefore share more information during the interviews. However, it is possible that our prior relationship may intimidate the participants and prevent them from openly discussing their experiences of the therapeutic alliance. As a result, it is important for the reader to understand the nature of the relationship between the researcher and the participants in order to understand the context of the data collection process and the validity of the results.

While my experiences and beliefs have the potential to bias the present study, several strategies were utilized in order to minimize the effects of the bias. The strategies

for validation include peer review, rich, thick description, clarifying researcher bias, and external audits, and will be discussed in further detail below.

### **Data Collection Procedures**

**Sampling.** The present study utilized criterion, convenience, and snowball sampling strategies to recruit participants. Participants were eligible for the study if they met the following criterion: (1) are active mental health clinicians, and (2) have experience conducting mental health counseling with adolescent clients and their caretakers. Participants were recruited through contacting mental health clinical offices in the greater Lexington area and through professional associations' email list serves. Additionally, I also contacted clinicians who have had previous professional relationships with me in order to recruit participants. Emails were sent to clinical offices and the professional associations email list serves. In addition, phone calls were also placed to mental health clinical offices in the greater Lexington area. Finally, snowball sampling strategies were utilized by providing participants the opportunity to identify additional clinicians who may be interested in participating in the study.

The general guidelines for phenomenological studies recommend a sample size of 5 to 25 participants (Polkinghorne, 1989; Creswell, 2007). The current study interviewed nine participants, and therefore fell within the recommended guidelines for phenomenological research (Polkinghorne, 1989; Creswell, 2007). All nine participants were marriage and family therapists, and had experience working with adolescent clients and their caregivers. The participants practiced from a variety of theoretical orientations, and worked in various professional settings with a broad range of clientele. The

participants ranged in age from 25-28 years old, were Caucasian, and were mostly female. A brief demographic description of the sample can be found in Table 1.

**Informed Consent.** The informed consent (see Appendix A) was approved by the Institutional Review Board (IRB) prior to the recruitment of participants. The IRB reviewed the informed consent in order to ensure the ethical treatment of all research participants. After receiving approval from the IRB, I reviewed the informed consent verbally with each participant. Additionally, the participants received a copy of the informed consent to read and sign.

The informed consent contained several sections: the purpose of the study, the procedures of the study, the benefits and possible risks of participating in the study, confidentiality and privacy information, and the participant's right to discontinue the study at any time without penalty. A copy of the informed consent can be found in Appendix A.

**In-depth Interviews.** Semi-structured, in-depth interviews were conducted with each participant. The goal of the interviews was to gather data in order to qualitatively explore the essence of the participants' experiences of the therapeutic alliance with adolescent clients and their caregivers. The interviews were focused on three core topics: (1) therapists' beliefs relating to the therapeutic alliance with adolescents and their caregivers, (2) potential obstacles that therapists face when attempting to establish the therapeutic alliance with adolescent clients and their caregivers, and (3) strategies used to develop and maintain the therapeutic alliance with adolescents and their caregivers. In order to explore the three primary areas of focus, the following questions were used as a guide throughout the interview process:

Central research question: How do therapists experience the therapeutic alliance with adolescent clients and their caregivers?

Sub Questions:

- How do therapists conceptualize the therapeutic alliance with adolescent clients and their caregivers?
- What strategies are most helpful in establishing the therapeutic alliance with adolescent clients?
- What obstacles exist when attempting to develop the therapeutic alliance with adolescent clients?
- What strategies are most helpful in establishing the therapeutic alliance with the caregivers of adolescent clients?
- What obstacles exist when attempting to develop the therapeutic alliance with the caregivers of adolescent clients?

The interviews were scheduled at the research participants' convenience. As a result, the locations of the interviews varied. The interviews took place at a private practice therapy office and over the telephone in order to accommodate participants who do not live in the greater Lexington area. I attempted to assess each interview location for appropriateness in order to ensure comfort and privacy for the participant, and an adequate environment for data collection (e.g., appropriate noise levels). The interviews were audio recorded in order to collect the data. Additional field notes were also written throughout the interviews. The interviews lasted approximately one to two hours with each participant. The interviews were transcribed in order to prepare the data for analysis.

## **Data Analysis**

The data analysis procedure followed the recommendations outlined by Creswell (2007) for phenomenological analysis. The first step of analysis involved bracketing, where the primary researcher disclosed her own experiences that might influence the present study in order for the reader to be able to interpret the data with minimal bias. The reader can find the bracketed information above within the “Researcher as Instrument” section.

The second step of data analysis involved the development of a list of significant statements. As a result, I read the transcribed interviews and identified significant statements that relate to the phenomenon of the therapeutic alliance. The process of identifying significant statements and treating each statement as an equal piece of data is referred to as the horizontalization of the data.

The third step of data analysis involved grouping the significant statements into larger categories. The larger categories of data are referred to as “meaning units” or themes.

In order to complete the fourth step of data analysis, I wrote a description of “what” the participants experienced relating to the phenomenon. This is referred to as a “textural description”, and includes raw data to illustrate the “what” of the phenomenon.

The fifth step of data analysis involved writing a “structural description”, which provides a description of “how” the participants experienced the phenomenon of the therapeutic alliance with adolescent clients and their caregivers. The structural description provides information regarding the setting and context of the phenomenon.

The final step of data analysis required me to formulate a composite description of the phenomenon by including both textural and structural descriptions of the phenomenon. The final description conveys the essence of the participants' experiences of the therapeutic alliance.

**Strategies for Validating Findings.** When conducting qualitative research, it is important to implement strategies to ensure validation, or accuracy, of the findings. Creswell (2007) highlights eight validation strategies, and recommends that researchers engage in a minimum of two strategies in order to assess the accuracy of the findings. The present study utilized four validation strategies:

*Peer Review.* Peer review, or debriefing, involves an external audit of the research procedures and analysis. I identified a fellow doctoral student in order to serve as the peer review. The peer encouraged me to remain honest through asking questions about the methods, the interpretation, and the meanings of the findings. The peer review was an ongoing process that occurred throughout the course of the study. I met with the peer prior to data collection in order to help familiarize them with the study and to practice the interview in order to enhance the data collection process.

After the collection and transcription of data was complete, the communication with the peer increased in frequency to approximately one meeting per week. The peer played a greater role throughout data analysis in order to encourage me to provide a clear and accurate illustration of the results. The peer helped to review the themes, and provided feedback throughout the data analysis process.

*Clarifying Research Bias.* Clarifying researcher bias encourages the researcher to outline their own biases and assumptions that might influence the study. This strategy is



especially important for qualitative research because the researcher is often the primary tool for data collection, and therefore has the ability to influence the study. Through participating in this validation strategy, the researcher provides information to the reader in order for them to learn more about the researcher and how their beliefs and assumptions might influence the study. After the researcher clarifies their own bias, the reader can then interpret the results with a better understanding of how the researcher might have influenced the study. I conducted this strategy throughout the bracketing process, and it can be found in the “Researcher as Instrument” section.

*Rich, Thick Description.* Rich, thick descriptions of the data involve providing detailed descriptions of the interviews and the phenomenon. I provided rich, thick descriptions through providing verbatim quotes from the interviews. The quotes add interest and depth to the study, and help the reader to more fully understand the essence of the therapeutic alliance with adolescent clients and their parents. Additionally, the rich, thick descriptions enable readers to determine the transferability of the results. Through providing both textural and structural descriptions of the phenomenon, I utilized rich, thick descriptions as a validation strategy.

*External Audits.* The final validation strategy required me to engage with an external consultant to assess the methods and findings of the study. In order to complete the external audit, I gathered the professional opinions of the dissertation committee members. The external audits occurred at two core sessions. First, the external audit occurred during the dissertation proposal meeting. The committee had the opportunity to provide feedback and help me to strengthen the study. A second external audit occurred at the time of the dissertation defense. The committee will analyze the results and

discussion, and will assist me in strengthening the weaknesses of the study. In addition to the two formal external audits, the dissertation chair and committee members were also available throughout the course of the study in order to provide feedback and ensure the accuracy of the findings. Through the incorporation of external audits, I was held accountable to the true essence of the phenomenon.

Table 1  
Demographic Summary of Sample

<b>Name</b>	<b>Gender</b>	<b>Age</b>	<b>Theoretical Orientation</b>	<b>Type of Practice</b>	<b>Ethnicity</b>	<b>Religious Affiliation</b>
Emma	Female	26	CBT	Crisis center; non-profit	Caucasian	Christian
Grace	Female	26	Experiential; CBT	School-based	Caucasian	Catholic
Jane	Female	26	Experiential	University clinic	Caucasian	N/A
Joe	Male	26	Experiential; Structural	University clinic	Caucasian	Christian
Julia	Female	28	Trauma systems therapy	In-home; School-based	Caucasian	Christian
Kate	Female	28	Symbolic experiential	University clinic	Caucasian	N/A
Leah	Female	28	Postmodern	Intake; Crisis assessment	Caucasian	Spiritual
Lily	Female	25	Bowenian Family Therapy	University clinic	Caucasian	N/A
Paige	Female	26	Eclectic; Collaborative	Private practice	Caucasian	Christian

## CHAPTER 4

### FINDINGS

#### **General Overview**

The purpose of this study was to discover the essence of therapists' experiences of simultaneously establishing the therapeutic alliance with adolescent clients and their caregivers. In order to explore therapists' experiences of the therapeutic alliance with adolescents and their caregivers, nine therapists were interviewed (demographic information can be found in Table 1). After the completion of the interviews, the interviews were transcribed and analyzed. Additionally, several strategies for validation were also utilized in order to ensure accuracy of the findings. Firstly, I attempted to clarify my bias through the process of bracketing (see Chapter 3), which provides information in order for the reader to understand how the researcher's bias can influence the study. I also engaged with a fellow doctoral student in order to complete a peer review of the study's methodology and findings. The peer review involved ongoing communication between the peer and me throughout the design of the study and the analysis of the data. The peer attempted to hold me accountable to the essence of the participants' experiences. Additionally, I participated in external audits with the dissertation committee. I arranged two formal external audits. The first audit occurred at the proposal meeting, during which the committee provided feedback regarding the methodology and design of the study. The second audit occurred at the dissertation defense, and will provide the committee the opportunity to assess the findings and interpretation of the findings of the study. I also engaged in ongoing communication with the chair of the committee in order to solicit additional guidance and to help ensure accuracy of the findings. Finally, rich, thick descriptions were utilized in order to provide

detailed, raw data to help the reader understand the essence of the participants' experiences.

Throughout the remainder of this chapter, the findings will be presented. In order to provide an accurate description of the participants' experiences, rich, thick descriptions utilizing participants' quotes will be provided. Through providing both textural and structural descriptions of the data, as well as rich, thick descriptions, the researcher attempted to convey the essence of therapists' experiences of the therapeutic alliance with adolescents and their caregivers.

The findings of the study will be presented in three core sections: (1) conceptualizing the therapeutic alliance, (2) the therapeutic alliance with adolescents, and (3) the therapeutic alliance with caregivers. A visual representation of the findings can be found in Figure 1. The following segment will provide a brief overview of each section.

### **Overview of Emerging Themes by Section**

**Conceptualizing the Therapeutic Alliance.** The first section describes the participants' conceptualization of the therapeutic alliance. Throughout the interviews, two themes emerged in relation to the definition of the therapeutic alliance: (1) trust, and (2) foundation of therapy. Throughout this section, rich, thick descriptions will be used in order to describe the participants' definition and conceptualization of the therapeutic alliance.

**Therapeutic Alliance with Adolescents.** The second section will outline the participants' experiences of the therapeutic alliance with adolescent clients. This section contains multiple themes and subthemes. The first theme describes the obstacles therapists face when attempting to establish the alliance with adolescent clients.

Subthemes within the obstacles theme include: (1) viewed as an authoritative figure, (2) resistance to therapy process, and (3) differences in socioeconomic status. In addition to the first theme that describes obstacles, a second theme also emerged: strategies to build the alliance. This theme describes strategies that therapists use to establish the therapeutic alliance with adolescent clients. Three subthemes emerged within the strategies theme: (1) discuss interests, (2) honor the adolescents' voice, and (3) describe limits of confidentiality. In order to accurately describe the therapists' experiences of the therapeutic alliance with adolescent clients, rich, thick descriptions will be provided.

**Therapeutic Alliance with Caregivers.** The final section of the findings chapter will describe therapists' experiences of the therapeutic alliance with adolescents' caregivers. This section is comprised of two core themes: obstacles faced when establishing the alliance, and the strategies used to build the alliance. The obstacles theme contains two subthemes: (1) fear of triangulation, and (2) caregivers' expectations. The strategies theme contains four subthemes: (1) empathy, (2) give caregivers an active role, (3) collaborative approach, and (4) establish clear boundaries. Quotes from participants' interviews will be provided in order to clearly illustrate the essence of therapists' experiences of the therapeutic alliance with adolescents' caregivers.

### **Conceptualizing the Therapeutic Alliance**

Each research participant was given the opportunity to describe their conceptualization of the therapeutic alliance. Based on the participants' responses, two subthemes emerged from their descriptions of the therapeutic alliance: trust and the idea that the alliance is the foundation of the therapy process. The following sections will

explore the participants' definition of the therapeutic alliance through focusing on their responses related to trust and the foundation of therapy.

**Trust.** When I asked the participants about their conceptualization of the therapeutic alliance, all nine therapists described trust as a defining characteristic of the therapeutic alliance. Furthermore, the participants explained that trust was an important attribute of the therapeutic alliance for both adolescent clients and their caregivers.

For example, Emma described the therapeutic alliance as “the relationship between client and therapist, and how well the client trusts the therapist and feels that they can talk openly with them.” She continues by explaining the beneficial consequences of establishing trust and a strong therapeutic alliance with clients, “they will be more open to talking to you about issues that they feel like they can trust you with, things that they tell you and that you’re not going to go tell anybody, and in the future they can come to you if they are having a really big concern with something.”

Similarly, Jane explains that trust is an important characteristic that defines the strength of the therapeutic alliance, “My definition of the therapeutic alliance, I guess mainly I would describe that as the type of relationship or connection you have with your clients as to how comfortable and how much trust there is between you and your client.” Jane also explains that trust has a reciprocal property, and the therapist’s ability to trust the client can also influence the therapeutic alliance:

I think that a lot of it is the trust the client has with the therapist, but I think it’s a little bit the other way around. I think that depending on how much the therapist can trust that they are safe to say the things that they feel need to be said and how

much they want to self-disclose, how comfortable they feel to do that, I do think that it goes both ways between the therapist and the client.

Leah also emphasized the importance of trust within the therapeutic alliance. However, she explains that developing the alliance is not limited to the identified patient, but should also be fostered with the client's system:

The biggest part for me that pops into my head is it's a bond between the therapist and the clients that they are working with. And it's often, especially with family therapy, it's not just with the identified patient or the client, it's with everybody who is in the room with you establishing a bond that's primarily made up of trust. You want your client to trust you.

Paige explains that trust is a vital part of the therapeutic alliance. She describes trust as a prerequisite for accomplishing the goals of therapy, "If you don't trust your therapist that they really, you know, have your best interest in mind or that they're going to challenge you even when you need to be challenged, it's not going to be as effective."

**Foundation of Therapy.** In addition to believing that trust is a defining characteristic of the therapeutic alliance, most of the participants described the belief that the therapeutic alliance is the foundation of therapy. Five of the nine therapists that were interviewed explicitly described the therapeutic alliance as the foundation of the therapy process and necessary for therapeutic outcomes.



For example, Paige explains that the therapeutic alliance is defined by trust, and acts as the foundation of therapy, “I view the alliance as the foundation, you know, and so for me the foundation of therapy is trust.” She continues to discuss the importance of the therapeutic alliance, and explains that the alliance is a prerequisite for future therapy work, “I think there’s multiple components to that, but I think the biggest one for me is that foundation of trust and then off of that, you know, things like okay, they’re going to challenge me, they’re going to support me.”

Similarly, Jane also describes the therapeutic alliance as the foundation of the therapy process. She explains that clients cannot accomplish change or the goals of therapy without feeling an alliance with their therapist:

I think it’s absolutely necessary. I think that for me at least it’s kind of like the main core piece of therapy. I don’t think I can do, I do most of the time if therapy quickly kind of drops off or doesn’t work out or the client drops out I think a lot of that has to do with the alliance. I think it’s kind of the foundational building block that you have to have before you can really do anything else. I think a lot of change, no matter what it is or what type of whatever else you are doing is not going to work as well if you don’t have that alliance with your client.

Grace also describes the therapeutic alliance as the basis of therapy. She explains that the alliance is the most important component throughout the therapy process, and is necessary for successful interventions. Furthermore, Grace also explains that she focuses

on building the therapeutic alliance every session, because of its importance to the therapy process:

In my opinion, the therapeutic alliance is the most important thing above any kind of training or intervention you could learn because if you can't engage the client then no intervention you could teach them would go anywhere, so I think it's the most important thing and that's the thing that I primarily focus on when I'm working with clients. I think it's the most important thing throughout the whole therapy process, so it's the first thing I work on and I work on it every single session, engaging them and making them feel comfortable and forming a relationship with them.

Kate also emphasizes the importance of the therapeutic alliance. She describes the alliance as the foundation for therapeutic change, "I personally think it's most important... I feel like I've spent months developing an alliance with kids who have different attachment needs before really diving into the content of their traumas or things like that. So I really consider it to be the basis of where therapeutic change is."

### **Therapeutic Alliance with Adolescents**

In order to understand the essence of therapists' experiences of the therapeutic alliance with adolescents, each participant was asked questions regarding their experiences of the alliance with adolescent clients. As a result, two core themes emerged: obstacles faced when establishing the alliance, and strategies used to build the alliance.

### **Obstacles Faced when Establishing Alliance.**

Participants reported multiple obstacles they have faced when attempting to develop the therapeutic alliance with adolescent clients. After completing data analysis, three subthemes emerged: (1) being viewed as an authority figure, (2) resistance to therapy, and (3) differences in SES.

**Viewed as an Authority Figure.** When the participants were asked about barriers they encountered when attempting to establish the therapeutic alliance with adolescent clients, all nine therapists reported that adolescents' view of therapists as an authority figure can act as an obstacle. Participants described their position as an adult as an automatic barrier when they attempt to develop an alliance with adolescent clients.

Leah explained that adolescent clients often associate therapists with their parents. She described the association between therapists and an adult figure as one of the most difficult obstacles to overcome when attempting to establish the therapeutic alliance:

For me the big challenge with adolescents is that automatically, even before they come in the room they often associate you with the parents, with being an adult who is going to sit there and tell them what to do or what they are doing wrong and not give them a voice. So the hardest part with adolescents for me is trying to set that assumption aside or get them to set that assumption aside before we get too far into the assessment process or the therapy process.

Kate also discussed her attempt to overcome adolescents' view of her as an authority figure, "I'm not just another adult who is here to tell you what to do, because a

lot of other adults don't get to know them on a deeper level, so they don't understand, they don't have the opportunity to understand, but hopefully therapists do." Similarly, Paige described her status as an adult as an obstacle to overcome, "I'm an adult and yes, I'm an authority figure just kind of based on how your parents have presented you to me or whatever it is, like I can't ignore the fact that there is that difference there but, you know, I ultimately want to convey to them, we're the ones working together." Jane also discussed her attempt at distinguishing herself from other adults in order to develop the therapeutic alliance with adolescent clients, "I'm not going to be the person to tell you like whatever you're doing is wrong. I'm a real person. You need to trust me. I'm not going to be like some other adults in your life are."

In addition to the association between parents and therapists, Julia explains that therapists can be viewed as authority figures because of their connection to the larger system (e.g., case managers, schools, etc.):

No matter what you do, you are seen as an authority figure, especially at the beginning. And the clients that I worked with in some respects because the referral was through a case manager, they saw me as an extension of a state agency. Not so much the clients that I work with at the school setting. But the school is considered an authority figure, so there is that.

**Resistance to Therapy.** In addition to adolescents' tendency to view therapists as an authority figure, the participants also identified adolescents' resistance to therapy as a possible obstacle when establishing the therapeutic alliance. Five of the nine participants

explained that some adolescents express resistance to therapy, often times because it was not their choice to attend therapy.

For example, Jane described her experiences of working with adolescent clients who express resistance to the therapy process, “Gosh! The ones that are coming in with the mindset, ‘I refuse to talk to you, I’m going to crap on you today. I’m going to sit here and stare at the wall and not say anything to you’, those ones are fun. Of course they don’t want to be there in the first place.” Julia also reported experiences of working with adolescent clients who resist the therapy process, and her struggle to develop the alliance with some adolescent clients, “Sometimes adolescents are just difficult. Sometimes they are very mean. Sometimes they are very rude.”

Similarly, Grace described her own struggles to develop the alliance with adolescents who are not engaged in the therapy process and who may not want to participate in therapy:

There are those really difficult kids sometimes that you just can’t seem to crack, and can’t seem to find something to be interested in. You have those awkward silences where you’re just sitting with them. That’s something that I’m trying to work on because I’m a really talkative person obviously, and that is really hard for me to sit with the silence, but I’m working on that and just being in the moment, even though it’s difficult. And then the ones that do not want to be there at all and they are being made to come to therapy, that’s really hard because they don’t want it.

**Differences in SES.** The final obstacle that emerged from the data describes the difficulty therapists experience when attempting to establish the therapeutic alliance with adolescent clients from different socioeconomic statuses. Seven of the nine participants reported that differences in SES between the therapist and the client can form a barrier when trying to establish the therapeutic alliance.

Emma explained that the clients' view of the therapist's socioeconomic status can negatively influence the alliance, "I think it also depends on SES of the client. I just see it as a huge thing with forming an alliance because if the client feels like I'm above them I guess, I feel like that can hinder a relationship." Conversely, Leah described her own biases relating to lower SES as a possible obstacle when trying to form an alliance, "I have a judgment, but I have to be aware of it. And recognize it so that it is not harming the client, but those were my automatic thoughts, my automatic bias."

In addition to general differences in SES, multiple participants discussed their professional appearance as an initial obstacle when working with adolescent clients from lower SES backgrounds. For example, Julia described her appearance and vernacular as possible obstacles to overcome when working with adolescent clients:

SES the way that we have, like presenting myself as a professional, but I think that again, it's just something that they had to learn. They had to get to know me because I'm not going to not dress professionally. I'm not going to go get a car that's not, you know, I'm not going to change those things and some of them are kind of like my job makes me wear dress pants. Sorry. Just like you had some of the schools in the area have uniforms so the kids have to wear khakis. I'm like,

just like you have to wear khakis to school, I have to wear these pants to work. Trust me I'd rather be in jeans. It was just like having that conversation when they would say like, you look really nice. I'd be like it's annoying. And having that, so that it wasn't you know, how we respond to that if it came up to kind of taking that opportunity to dispel whatever myth they were holding. The way I was dressed or the way I was behaving or you know my vocabulary. I'm like if you don't know a word that I said how do you think I learned them? Somebody had to explain it to me. So if I say something and you don't understand be like 'Julia, what did you just say?', and I'll rephrase it.

Grace also explained that differences in SES can pose obstacles because it can take more effort to understand and identify with clients:

Lower income is a very different population. I wasn't raised in a lower income and so they experience things a lot differently than what I did. It's a population that you really have to learn to understand to work well with. .... It's just, it's a different population. It can be stressful in the sense that a lot of things revolve around money and that gets very frustrating at times, but that's a big part of their lives a lot of the time and it's a big stressor for them and it's also, I couldn't sit down with them and say, let's read this research article. This is why I'm doing this with you. You know, just breaking things down on their level, very concrete, pretty much like I'm going to get in and get out, let's do this. I'm not gonna amp anything up a lot or try to give the research basis on everything but at the same

time, it is very rewarding in the sense that they are so appreciative of the things that you do. Most of the families I work with really appreciate me and are thankful for things that I do for them because I'm helping them with really big problems, so I think that there's a lot of differences in that population.

### **Strategies to Build Alliance.**

Participants described various strategies they use to develop the therapeutic alliance with adolescent clients. After data analysis was completed, three subthemes emerged: (1) discuss interests, (2) honor the adolescent client's voice, and (3) describe the limits of confidentiality. The following sections will describe each subtheme in detail.

**Discuss Interests.** When participants were asked about strategies they use to develop the alliance with adolescents, all nine participants reported that they try to discuss the adolescents' interests in order to foster the therapeutic alliance.

Lily explains that she tries to discover adolescent clients' interests in order to develop a bond with them, "I think that it definitely involves asking them what their interests are.... Yeah, so like for example, I have clients who, they like watching YouTube videos. And so I would I incorporate that into therapy session, or maybe we would watch favorite ones, as long as it was appropriate to watch them." Similarly, Emma describes her strategy of discussing adolescents' interests and sharing her own interests in order to help show that she cares about her clients, "So I would say that at first just letting them know that you're going to share information with them so that way they can feel comfortable sharing information back to you is my main thing, but definitely looking at



interests they have and trying to align with them, so that they feel like that we care about them.”

Grace also describes her attempts at discussing adolescents’ interests in order to develop the therapeutic alliance:

If I can’t relate to them in some way, they aren’t going to go with me anywhere, so I really just take that first session to really find out what they’re interested in and then I hone in on that, and if I can engage them in that way then they will do a lot more with me and that relationship starts forming...I’ve talked about Iggy, the musician, numerous times. I’ve seen her in concert, so that got me a huge in with one girl, and The Walking Dead. That’s a TV show one of my kids likes, so we’ll compare characters to real life situations or things that we can work on.

Minecraft. I don’t like Minecraft at all. I pretend like I know what they’re talking about because that’s one thing I really don’t want to research a lot on, so just anything I can pick up on, sports, I mean, I just look for it and really just hone in on those kind of things. : I’d say in the beginning when I’m trying to like kind of get them engaged with me, I’ll talk about it a lot, but it is always throughout.

Jane reports that she spends more time discussing interests and hobbies with adolescent clients as compared to adults. She explains that adolescent clients take more time to feel comfortable talking, and discussing interests can be a way to help them feel comfortable talking about other topics:

I've been thinking about it, I spend more time with adolescents asking questions about like them and what they like to do more than like any other group. Like what shows do they watch, what are their friends like, what do they do for fun? I think I spend more time asking those kinds of questions. Just to get at like their personality and what they do for fun. Just to get them like comfortable and talking about some of the things they are more comfortable with.

Similarly, Jane also described an increased importance of discussing interests with adolescent clients as compared to adults. She explained that adolescents often require more discussion about common interests before they can discuss more intimate conversations, "I would always just try and find the common interest ... trying to find a common interest that we could talk about because you don't dive right into tell me your deepest and darkest fears in therapy with anybody, let alone an adolescent. So I try to always find some point of connection."

Joe described his struggle to connect with adolescents based on their interests, but also explained that it is an important intervention that can help to build the alliance: "I think it's sometimes hard to relate to the things like hobbies or interests or ways of thinking about the world that adolescents have. But at the same time it's important to try to build that connection."

**Honor Their Voice.** This subtheme describes therapists' attempt to give adolescents a voice, and to respect their feelings and opinions. Several participants explained that adolescents' voices are often not valued by other adults, and therefore it is especially important to honor adolescents' narrative in order to develop the therapeutic

alliance. Six of nine participants described the importance of giving adolescent clients a voice throughout the therapeutic process.

Joe explained that he tries to value adolescent clients' voice in order to help develop the therapeutic alliance, "I also want to make sure that adolescents know that I'm hearing them because I think that is really important to a lot of adolescents is to be heard and to have their voice, to see that their voice matters to someone else, and I think that will help to create therapeutic alliance." Similarly, Leah attempts to differentiate herself from adolescents' caregivers in order to show adolescents that they are respected, "I'm not just there to get them to do what their parents want them to do, that I'm also there for them and to give them a voice and to help them feel heard ... So showing that I'm not just going to take the parents' word as truth. I'm going to try to listen to everybody."

Paige explains that it is important for her to give adolescent clients a voice, especially towards the beginning of the therapy process. She describes her explicit attempt to give adolescents an opportunity to speak for themselves, instead of relying solely on what their caregivers have communicated:

I really want to make it a point that my client is comfortable, and I think that by doing that, kind of having that approach of tell me about yourself, tell me what you want, I've heard things about you, but I want to hear it from you, being very open about that, I think that's another thing that I try to employ and that's usually actually, if I'm thinking about a formula of how I go about my sessions like that would be, you know, step one, that informed consent with the parents, step two

would be the first few sessions with an adolescent and giving them that opportunity to introduce themselves to me essentially.

**Describe Limits of Confidentiality.** Many participants explained that it is especially important to describe the limits of confidentiality to adolescent clients because of the communication that occurs with caregivers. Participants explained that adolescent clients are often concerned about what information will be shared with their caregivers; and a breach of confidentiality could cause a break in trust and the therapeutic alliance. As a result, several participants described the importance of describing the limits of confidentiality in order to prevent disturbances in the therapeutic alliance. Five of the nine participants explicitly discussed the strategy of discussing the limits of confidentiality with adolescent clients in order to protect the therapeutic alliance.

For example, Julia explained that she has an explicit conversation with adolescent clients about their right to confidentiality and the circumstances in which she would share information with their caregivers:

I'm never going to tell an adolescent that I won't share information with their parent. I feel like that puts you in a bind and can put you in a potentially dangerous situation if they disclose reckless behaviors and you need the parent to be somebody who is monitoring them. For example, I have worked with a lot of adolescent boys with substance abuse problems and if they tell me that they are going out at all hours of the night and engaging in illegal activity whether it's stealing, using drugs, being with people who have stolen vehicles, those types of

activities, I can't keep that from their parent. So I'm up front with them, 'listen, I'm not going to tell your parent word for word everything that we talk about. I'm going to tell you before I tell your parents something', and what I most often try to do is empower the adolescent to tell their parents.

Grace also describes her attempt to clearly communicate the limits of adolescents' confidentiality rights in order to prevent disturbances in the therapeutic alliance when she must communicate information with outside sources:

That's when I kind of use the time to remind them, because as soon as I open a file, as soon as I do an intake, I give them a spiel on 'I'm a mandated reporter. This is what confidentiality is, but there are limits to confidentiality', and I go through all of those limits and I talk to them about it and have them ask questions, all those things, so from doing that then I always want to have that conversation with them. 'Remember the first time you met me and what did I tell you, and this is the hardest part about my job', and I kind of, you know, just give them time to talk about that, but I actually just had a conversation like that this morning with a kid that was furious with me because I made a report and that's hard, you know, but it's something we face a lot.

Jane describes her attempt to discuss the limits of confidentiality as a way to empower adolescent clients. She explains that she tries to give the adolescent some power in the decision to share information with their caregivers:

I want the adolescent to know kind of what the expectations are when I'm meeting with the parent. Like what level of like confidentiality is, transparency is, what their comfortable like going over these are the topics that you will be comfortable talking about and these are the ones you are not and then having even like a plan for if there is an issue that comes up with one of your uncomfortable topics, this is what I'm going to do if I do really need to talk to them, kind of just like laying it all out on the table. And giving them a little bit of power in deciding how that's going to be handled.

In addition to discussing the limits of confidentiality in order to prevent breaks in the therapeutic alliance, some therapists described highlighting the benefits of confidentiality in order to encourage open communication from the adolescent. For example, Emma described confidentiality to adolescent clients in order to help adolescents feel comfortable sharing information with her:

I make sure that I explain confidentiality very well to them as what we say in the session stays in the session, and I only tell parents things that are necessary, like if they would be hurting themselves or someone else. There are some things that I don't have to tell the parent and they don't have to worry about that or that I'll tell anybody else. I just make sure I go over confidentiality with them and that they can trust me and what they say in there stays in there.

## **Therapeutic Alliance with Caregivers of Adolescents**

In order to explore therapists' experiences of simultaneously building the therapeutic alliance with adolescents and their caregivers, participants were asked questions about their experiences of the therapeutic alliance with caregivers of adolescent clients. After the data was analyzed, two core themes emerged: obstacles faced when establishing the alliance, and strategies used to build the alliance.

### **Obstacles Faced when Establishing Alliance.**

Participants described various obstacles they have encountered when attempting to build the therapeutic alliance with caregivers. After data analysis was completed, two subthemes emerged that described obstacles that participants faced when establishing the alliance with the caregivers of adolescents: fear of triangulation, and caregivers' expectations.

**Fear of Triangulation.** Several participants described feeling a fear of triangulation when working with both adolescent clients and their caregivers. Participants reported often feeling stuck between the adolescent and the caregiver, or feeling as though the adolescent or the caregiver was attempting to have the therapist value one voice over another voice. Participants described the fear of triangulation as an obstacle to establishing the therapeutic alliance with caregivers.

For example, Joe described his view of potential triangulation as an obstacle when he works with adolescents and their caregivers, "And another obstacle I would say is just that a lot of times if I'm doing therapy with an adolescent, the whole form of the therapy is one big triangle, and that's just like a habitual place where you need to be and so that's

something that I have to either restructure or rethink or find some way to exist within and still do my work. Yeah, it's being stuck between the adolescent and the parents."

Jan also reported feeling that the possibility of triangulation is an obstacle to overcome when attempting to establish the alliance with caregivers, "Generally I think that is such a tough place to be in and like we always talk about you know like the therapist is going to stay neutral, and not be triangulated, so that is the ultimate thing, to be put in the middle." Similarly, Leah described feeling triangulated when working with adolescents and their caregivers:

I often start to feel that [caregivers] are trying to get me on their side and so not only am I trying to get the adolescent to put that assumption aside, I have to also reinforce to the parents that I'm there for all parties and not just to do what the parents want me to do. That I'm there as a separate entity to try to figure out what actually is best for the entire family.

Emma described her attempt at avoiding triangulation through meeting separately with caregivers and adolescents:

Sometimes I do individual sessions with the parents, the adolescent knows that I'm meeting with them, but the adolescent isn't sitting there the whole time trying to figure out if they're watching me, siding with one or siding with them, so I'll sometimes make individual appointments so that parents can come in and talk to



me and for the parents' sake it looks like I'm aligning more with them than for the kids' sake, but sometimes I'm just appeasing the parent.

**Caregivers' Expectations.** Several participants reported caregivers' unrealistic expectations as an obstacle to developing the therapeutic alliance. Six of the nine participants described caregivers' expectations of the therapist and therapeutic outcomes as potential obstacles to overcome when trying to establish the therapeutic alliance.

For example, Joe explained that some caregivers have rigid expectations that may not be appropriate for the therapeutic process: "I do feel stuck between the adolescent's desire and the parent's desired outcome. And the parents' expectation of what a therapist is and what a therapist should and shouldn't do. Almost like that, kind of like a commercialist mentality of I'm going to bring you my broken car and I want you to fix it." Similarly, Paige also described her experiences of working with caregivers who assume therapists will comply with their expectations of therapy:

I will say I don't appreciate parents who, and I've had several of these, who expect me just to do the dirty work for them, like 'okay this is what I want my kid to do, make it happen'. I don't like that at all, so I find that it's a lot rougher of a start with that type of parent because I tell them like, I'm sorry, that's not my job, that's not what I'm here to do. I'm not here to be like, you know, a cloned version of you but in a different body, a different voice, so I would say in those situations to build the alliance with them it's pretty much like this is how it's going to go and I need you to be respectful of that. If they agree with that then we can work

off of that, but if they don't then, you know, it's rough, and those are the people that usually end up stop bringing their kids at some point, you know.

In addition to some caregivers' expectations that therapists should follow their instructions, participants also reported that caregivers' expectation that therapy will not work can act as an obstacle to engaging caregivers and establishing the therapeutic alliance. For example, Julia explained that some caregivers have experienced the therapy process with their adolescent before, and are reluctant to believing in its efficacy:

More of a fear that nothing is going to be different. Okay, so we're going to try this and it's not going to change again. So, I think there is a certain amount of well if the adolescent's behavior doesn't change, it doesn't change. And seeing therapy as another failed attempt to get their kid on the right path. I mean, honestly I didn't always have positive outcomes.

Grace also described caregivers who have lost hope that therapy can be effective with their adolescent. She explains that she has to try to overcome caregivers' negative expectations in order to engage the caregiver and establish the alliance:

They can get pretty jaded sometimes. And I'm just really blunt a lot of time and I'm like, 'well is what you got going for you right now working for you?' And, they're usually like, 'no', and I'm like, 'so can we give it a go again? I'm a different person, let's try it. This is a different time in your life. Let's not just like

cross out everything’, because most of the time when you go diving in you realize they haven’t fully completed the intervention or they haven’t done it the correct way or maybe it wasn’t implemented at the best time, so I just kinda tell them, you know, ‘if you don’t like the way things are going right now all we can do is try something different. You gotta try something again.’

### **Strategies to Build Alliance.**

Participants reported several strategies they utilize in order to build the therapeutic alliance with caregivers. After data analysis was complete, four subthemes emerged that captured the experiences of the participants’ strategies to build the alliance with caregivers: (1) empathy, (2) give caregivers an active role, (3) collaborative approach, and (4) establish clear boundaries. The following sections will explore the subthemes in detail.

**Empathy.** Several participants reported using empathy to establish the therapeutic alliance with caregivers. Participants described empathy as a strategy that can be employed to foster an alliance with caregivers. Five of the nine participants reported utilizing empathy to develop the therapeutic alliance with caregivers of adolescent clients.

Leah describes empathy as a useful tool for fostering the therapeutic alliance with adolescent clients, “You can still offer empathy, you can still express interest in what’s going on and the idea that we’re a team together and we’re going to find out something that works.” Emma also expresses empathy towards caregivers in order to build an alliance with them, “I probably have empathy towards the parent, like I really understand

where you're coming from, and that can be frustrating that the child is doing this with the parents. ... But I think using a lot of empathy towards the parent for that situation I think is a good way to develop an alliance.”

Similarly, Joe describes empathy as his core strategy for developing an alliance with caregivers of adolescents, “The one that jumps to mind is bonding with them over the difficulty with being a parent. I mean I’m not a parent, but I know a lot of parents. I’ve worked with a lot of parents and it seems like a fairly difficult job. So I think that’s something that they can probably relate to so yeah, I kind of get with them on that.”

Grace explains that she uses empathy as a way to help connect with caregivers and to empower caregivers in order to establish the therapeutic alliance:

I always validate and validate and validate a million times over, even if it’s something that I don’t agree with or I’m trying to get them to work on, I’ll validate how they feel and just let them know that I hear them, and I think just so many parents feel so defeated by the point of time that they’re seeing me that they’re already so run down, so I really work on empowering them again too.

**Give Caregivers an Active Role.** Many participants described the importance of including caregivers in the therapeutic process, and that giving caregivers an active role can help them to feel included and can help to foster the therapeutic alliance. Six of the nine participants reported that giving caregivers an active role in the therapy process can help to develop the therapeutic alliance.

Paige described her attempt to include caregivers in the therapy process, and explained that including caregivers can present multiple benefits, including an enhanced therapeutic alliance and more information about the adolescent to help achieve therapeutic outcomes:

I always want to make sure that even though they aren't in the room that they feel like they have a voice in the process as well so, you know, I only see what happens in the room. I only hear what the client tell me in the room, but mom and dad are seeing a lot more at home than I'm seeing, so I always want to know and so, you know, I'll invite them to do that, but sometimes too, I just kind of like pull them into the room at the end of the session and leave my client out in the waiting room, the teenager, and just say like just really quickly tell me what's going on, is there anything I need to know about, and I think that by doing that I'm not necessarily having a therapy session with the parent but I'm including them, you know, and on the other side of that too, I'll tell the adolescent like I'm bringing your parent in, don't freak out, I just kind of want get their take on things and like the same way that I give you your space I'm giving your parent their space too, so you gotta respect that. So I would say with parents that's kind of how I go about the alliance.

Kate described her attempts to include caregivers throughout the therapeutic process, "You know even if it's just in the lobby striking up a brief conversation, having a one way street where they can tell me stuff and that I'm not going to disclose. I may

nod my head or just empathize.” Similarly, Grace also described her attempt to give caregivers an active role in the therapeutic process, “I meet with the parents a lot and then no matter what, even if it’s an individual session at my office, the last 10-15 minutes I always end with the parent or start with the parent to kind of see how things are going, always check in.”

**Collaborative Approach.** Therapists also reported utilizing a collaborative approach with caregivers in order to foster the therapeutic alliance with caregivers. Participants described their attempts to develop a teamwork approach with the caregivers in order to help the adolescent clients. Six of the nine participants reported striving for a collaborative approach to therapy in order to help develop the alliance with caregivers.

Jane described her attempt to develop a sense of team work with adolescents’ caregivers in order to foster an alliance and achieve outcomes for adolescents, “We can be each other’s kind of best, not best friends, but best helpers in the situation and this like what we can do. Kind of like forming an alliance. We can work at this together even if we might disagree on how we might get there, our end goal is the same.” Similarly, Leah also highlights the teamwork approach she strives for when working with the caregivers of adolescents,

I definitely think with any type of guardian, I need them to also be on my team or I need them to also support what I’m doing because they’re the ones at the end of the day who are going to say whether or not the client follows through with the treatment or continues with treatment. So I definitely need to also have a bond with them. I need them to trust me.

Leah reported attempting to develop a collaborative approach in order to enhance treatment for the adolescent, and improve the therapeutic alliance with caregivers:

But definitely because I do think for me coming from a collaborative place, it's not completely talking away my own role, taking away my own expert stance, I think it's just understanding that we all have something to offer, and figuring out how then to turn that into one goal or plan that we can all get behind. And that will help the parents feel better.

Some participants described emphasizing the caregivers' expertise in order to develop a collaborative approach and to help foster the alliance with caregivers. For example, Lily reported that she attempts to highlight caregivers' expertise when working with adolescents and their caregivers:

They are always going to be the expert on their child's life, but I think it also like it helps to empower them, hey you know what you're doing and we're just kind of here to provide support in a healthy process. So I guess it empowers the parent that they are the expert, and we're not just there to be like you don't know what you're doing so we're going to parent your kid, so it empowers it to them.

Similarly, Grace also emphasizes the parents' expert role in order to empower them and build the therapeutic alliance. She explains that the collaborative approach can

be developed through recognizing that both the therapist and the caregivers have valuable information to offer to the process:

I always tell parents I'm not an expert, I'm just a person that went to school for this and I know some tools that might help you, but you have to use those. You are the expert of your family, I am not. You are the person in control of this, you're in charge. This is your family. I'm not the expert of your family. I just know some tools that might help your family.

Julia also describes the importance of developing a collaborative approach with caregivers, and recognizes the important role that they play in their adolescent's lives. She acknowledges that caregivers can help to enhance therapeutic outcomes, and she describes honoring their role in order to develop the alliance and create a collaborative approach:

First of all let them know that they are supported. Like you've been doing this for a really long time and I'm brand new to this situation. So kind of giving them back the expert role. You are the expert on your family. You've been seeing what's been going on with your child. You care about them and you love them more than I can ever imagine even though I care about and vested in your welfare, you care about them in a way I can never know, so help me understand.



**Establish Clear Boundaries.** Several participants identified the importance of establishing clear boundaries with caregivers in order to develop the therapeutic alliance. Participants described clear boundaries as a prerequisite for the therapeutic alliance with caregivers. Five of the nine participants reported the strategy of establishing clear boundaries to foster the therapeutic alliance with caregivers.

For example, Jane explained that it is important to discuss expectations and set clear boundaries in order to have an accurate understanding of the therapist's and caregivers' roles in the therapy process:

I feel like once I've got ground rules for the parents then I can really start building the relationship with them. I think that when it comes to actually forming with the parent and with them I think a lot of it's still like that transparency and like giving, like finding out what their expectations are and being real to think about how much I can fit into them. I think a lot of it is just that being like honest and real and like laying my cards out on the table. This is what we're going to get with me and we can kind of negotiate that and then once that's established we can kind of build up from there, like that's the main, again that foundational piece of building the alliance with the parents.

Julia also described the importance of establishing clear boundaries with caregivers in order to develop the therapeutic alliance, "The most important thing is being up front with them about what that relationship is going to look like and I personally learned that as a therapist through trial and error." Paige also reported her attempt to

establish clear boundaries with caregivers at the beginning of the therapy process, “The way that I do that is similar with that first session of the informed consent of like this is the role that I take, this is what I do with your child, this is what I do with you, and now we can move forward.”

Joe explained the importance of establishing clear boundaries for the development of the alliance, as well as the achievement of therapeutic outcomes:

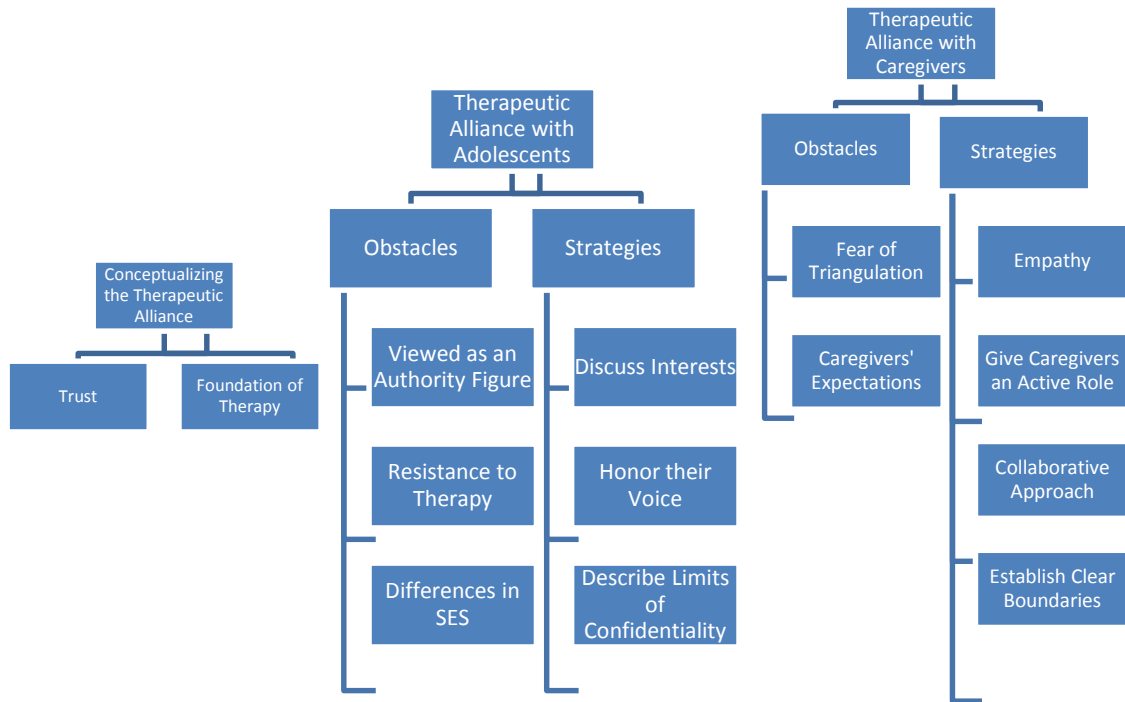
Strategies I’ve used are being very up front at the beginning about how I work with families. In families with kids, I probably just won’t be seeing the kid or adolescent and just talking individually about where the problem is. The way that I see problems as systemic or located within a family and so I want to work with the whole family or to create some kind of lasting change. Being apparent about that sets the structure of I’m not going to get triangulated and I think also it sets more lasting change because the adolescent and the parent can change together then it’s something that just might last longer. It might be more meaningful. Clarifying expectations so that both the adolescent and parent know that I’m not for or against, well I’m for both of them. I’m for the family. But there’s not like one party that I’m trying to win over or be more, I’m not trying to hear one voice louder than another.

## **Summary**

The findings of this study attempted to convey the essence of the participants’ experiences of the therapeutic alliance with adolescents and their caregivers. The three

core sections of the findings chapter (conceptualizing the therapeutic alliance, the therapeutic alliance with adolescents, and the therapeutic alliance with caregivers) provided rich, thick descriptions to illustrate participants' beliefs regarding the therapeutic alliance, obstacles faced by therapists when attempting to build the therapeutic alliance, and strategies used by therapists to build the alliance with adolescents and their caregivers. The findings present important implications for therapists and client outcomes. The following chapter will provide a detailed discussion of the findings, and will outline clinical implications, recommendations for future research, and limitations of the current study.

Figure 1: Findings



## CHAPTER 5

### DISCUSSION

The purpose of the present study was to qualitatively explore therapists' experiences of the therapeutic alliance with adolescents and their caregivers. Because the therapeutic alliance is associated with positive outcomes for clients (Bachelor, 2013; Bhole, & Kapur, 2013; Liber et al., 2010), it is imperative for therapists to strive for the development of a strong alliance with their clients. However, very little research exists that examines the therapeutic alliance with adolescents and their caregivers. The present study attempted to fill the gap in the literature through discovering the essence of therapists' experiences of the therapeutic alliance with adolescents and their caregivers. Chapter 4 revealed several interesting findings relating to therapists' experiences of the therapeutic alliance. This chapter will discuss the findings in relation to current research, and will explore the clinical implications of the findings.

#### **Theoretical Conceptualization of the Therapeutic Alliance**

In order to frame the study, Bordin's (1979) pan-theoretical conceptualization of the therapeutic alliance was utilized. Bordin claimed that the therapeutic alliance was comprised of three core components: (1) the agreement upon goals, (2) the assignment of tasks, and (3) the creation of a strong bond. The first component, the agreement upon goals, requires the therapist and client to work together to identify a common goal for therapy. The second component, the assignment of tasks, involves the therapist identifying specific interventions that will successfully help the client to achieve the goals of therapy. The final component, the creation of a strong bond, refers to the emotional bond between the therapist and the client.

Because the conceptualization of the therapeutic alliance is critical to the way in which therapists experience the therapeutic alliance, all participants were asked to define the therapeutic alliance. The findings revealed that the participants emphasized trust and emotional security as defining characteristics of the therapeutic alliance. “Trust” was identified as a theme within the ‘Conceptualization of the Therapeutic Alliance’ section, and highlighted the importance of trust within the relationship between the therapist and client(s). Furthermore, the participants largely discussed the therapeutic alliance in terms of an emotional bond between the therapist and the client(s). Therefore, the findings appeared to strongly support the third component of Bordin’s conceptualization of the therapeutic alliance: the creation of a strong bond.

While the findings of the study strongly support the third component of Bordin’s conceptualization of the therapeutic alliance, less support was given to Bordin’s first and second components of the alliance: (1) the agreement upon goals, and (2) the assignment of tasks. When Bordin (1979) described the agreement upon goals component, he highlighted the collaborative nature of working with the client to identify goals for the therapy process. Similarly, the findings revealed that ‘Collaborative Approach’ was a theme within the strategies for building the alliance with caregivers of adolescents section. While the participants did emphasize the importance of fostering a collaborative approach when working with the caregivers of adolescent clients, the theme did not explicitly refer to the establishment of goals. Additionally, none of the findings described the agreement upon goals as a component of the participants’ experiences of the therapeutic alliance. As a result, little support was found for the ‘agreement upon goals’ component of Bordin’s conceptualization of the therapeutic alliance.

The second component of Bordin's (1979) conceptualization, the assignment of tasks, describes the therapist's responsibility to identify interventions to help the client achieve their therapeutic goals. While the findings revealed several strategies for the development of the alliance with clients, the participants did not describe the assignment of tasks as a critical component of the therapeutic alliance. Furthermore, none of the findings describe the importance of assigning specific interventions in order to help the client achieve their goals in relation to the development of the therapeutic alliance. Therefore, no support was given for Bordin's assignment of tasks component of the therapeutic alliance.

While the present study did not find support for the agreement upon goals and the assignment of tasks components of Bordin's conceptualization, previous research has demonstrated that goals and tasks can be effective predictors of therapy outcomes (Greer, 1980; Adams, Piercy, & Jurich, 1991). For example, clients who collaborate with their therapist to establish goals have reported improved therapeutic outcomes as compared to clients who did not establish goals with their therapist (Greer, 1980; La Ferriere, & Calsyn, 1978; Smith, 1976). Similarly, research has also associated specific tasks and interventions with positive client outcomes (Adams, Piercy, & Jurich, 1991). Although research has associated the establishment of goals and the assignment of tasks with positive client outcomes, it is possible that therapists perceive goals and tasks as external processes from the therapeutic alliance. Instead of including goals and tasks within their conceptualization of the therapeutic alliance, the participants of the study emphasized the emotional bond component of the alliance.

## **Alliance and Adolescents**

It is important to discuss the findings of the study in relation to the current research. As a result, this section will examine the findings of the study in the context of the current research on the therapeutic alliance with adolescent clients. One of the core foundational pieces of research that motivated the current study was the association between the therapeutic alliance and treatment outcomes. For example, several meta-analyses have identified the alliance as a predictor of treatment outcomes (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Martin, Garske, & Davis, 2000). The present study also found support for the central role the therapeutic alliance plays within the therapeutic process. One of the central themes that emerged within the ‘Conceptualizing the Therapeutic Alliance’ section was the ‘Foundation of Therapy’ theme. This theme described participants’ beliefs that the therapeutic alliance was critical for the successful completion of treatment outcomes. The majority of the participants identified the therapeutic alliance as an integral part of therapy that acts as a prerequisite for the fulfillment of therapeutic goals. As a result, the findings of the present study provide qualitative data that supports the current research on the therapeutic alliance and treatment outcomes.

In addition to the research on the relationship between the therapeutic alliance and treatment outcomes, research has also been conducted to examine adolescents’ perceptions of the therapeutic alliance. For example, Everall and Paulson (2002) conducted a qualitative research study that found that adolescents’ perception of a strong alliance was characterized by viewing their therapist as supportive and trustworthy.



Similarly, the present study found that therapists also tend to view the alliance as being characterized by trust. The ‘Trust’ theme emerged within the ‘Conceptualizing the Alliance’ section, and described therapists’ perception of the therapeutic alliance as largely characterized by trust. As a result, it is important to acknowledge that both adolescents and therapists view trust as an important characteristic of the therapeutic alliance. In order for therapists to develop a strong alliance with adolescent clients, it is especially important to develop a sense of trust within the therapeutic alliance.

**Obstacles.** While adolescent clients and therapists maintain similar perceptions of the therapeutic alliance, the findings of the present study revealed that therapists may face unique obstacles when attempting to develop the alliance with adolescents. Three subthemes emerged that described the participants’ experiences of obstacles within the development of the therapeutic alliance with adolescents: (1) viewed as an authority figure, (2) resistance to therapy process, and (3) differences in SES. The first theme described the participants’ belief that they had to attempt to overcome their status as an authority figure in order to encourage adolescent clients to feel comfortable, and to develop the alliance. Participants explained that some adolescent clients were distrustful toward adults, and that the therapist had to convince the clients that they were trustworthy and different from other authority figures in order to develop the alliance. It can be helpful to examine this obstacle in the context of adolescent development in order to more fully understand clinicians’ experiences of being viewed as an authority figure by adolescents. During adolescence, individuals tend to experience increases in emotional autonomy, and often begin to shift from dependence upon caregivers to reliance upon peers (Steinberg, & Silverberg, 1986; Grotevant, 1998). As a result, it may be

developmentally normative for adolescents to resist connection with adults. Therefore, therapists' role as an adult and an authority figure may present a unique obstacle to the development of the therapeutic alliance. The 'viewed as an authority figure' theme presents important information for clinicians who work with adolescents. Through understanding specific obstacles that clinicians face when working with adolescent clients, interventions can be developed to help therapists overcome obstacles and improve outcomes. However, the 'viewed as an authority figure' obstacle is not present in the current literature. Therefore, this finding presents especially useful information for clinicians who work with adolescent clients.

Clinicians may also face resistance to the therapy process when working with adolescent clients. The present study identified adolescents' resistance to therapy process as a common obstacle to the development of the alliance faced by therapists who work with adolescent clients. While this specific obstacle is not found within the literature, research does recognize developmental processes that can help inform the participants' experiences of adolescents who express resistance to therapy process. For example, because adolescents tend to experience increases in emotional autonomy (Grotevant, 1998), it may be difficult for them to negotiate their newfound autonomy with the vulnerability that is often required in therapy. Therefore, adolescents may present more resistance to therapy and the therapeutic alliance with therapists than other developmental groups (e.g., adults, children).

The final obstacle that was revealed throughout the findings section described the participants' perception of differences in socioeconomic status as a potential obstacle within the development of the therapeutic alliance with adolescents. Several participants

described differences in SES as an obstacle that can make it difficult for clients to relate to their therapist. Participants reported specific scenarios that can heighten the differences in SES obstacle, including the way in which the therapist dresses and their experiences growing up. While differences in SES was a common obstacle faced by the participants who worked primarily with lower income populations, the therapists explained that it was often unavoidable. Because agencies often maintain dress codes and rules for professional conduct, therapists may be unable to avoid adolescent clients' first impression of the therapists as not relatable. As a result, differences in SES can serve as an obstacle to the development of the therapeutic alliance. However, the differences in SES obstacle is not represented in the current literature. Therefore, the findings of the present study provide especially useful information for clinicians who work with adolescent clients from various SES backgrounds.

**Strategies.** In order to understand how to develop the therapeutic alliance with adolescent clients, the participants were asked to describe strategies they use to build the therapeutic alliance with adolescent clients. The findings revealed three strategies used to develop the alliance with adolescents: (1) discuss interests, (2) honor the adolescents' voice, and (3) describe limits of confidentiality. While there is a wealth of current research that highlights the importance of the therapeutic alliance for achieving positive outcomes, virtually no research exists that provides strategies for therapists to build the alliance with adolescents. Because research has not previously focused on strategies for the development of the therapeutic alliance, the findings of the current study are not present within the current literature. As a result, the discussion of the strategies for the

development of the alliance will focus on clinical implications for therapists who work with adolescent clients.

All of the participants described the ‘discuss interests’ strategy as a useful tool for developing the alliance with adolescents. The participants explained that discussing common interests with adolescents can be an effective tool for establishing a relationship and helping the client to feel comfortable before discussing more sensitive topics of conversation. This strategy could also be utilized to overcome some of the identified obstacles to establishing the alliance. For example, the participants reported that being viewed as an authority figure by adolescents can serve as an obstacle when trying to develop the alliance. However, therapists can attempt to discuss common interests with adolescent clients in order to illustrate the similarities between the therapist and the client, and to help establish the alliance. Through identifying common interests, therapists can help adolescents to relate to the therapist more easily, and can lessen the adolescents’ perception of the therapist as an authority figure. In addition, participants also recognized differences in SES as a potential obstacle to developing the therapeutic alliance. Discussing common interests could be a strategy used by therapists to help diminish the difference in SES obstacle. For example, as therapists emphasize common interests between themselves and the client, the adolescent may be able to more easily relate to the therapist. Instead of focusing solely on differences in SES between the client and the therapist, the client would be able to recognize similarities between themselves and the therapist. As a result, discussing common interests can help to form the foundation for a relationship between the client and the therapist, and can serve as an effective tool for the development of the therapeutic alliance between adolescents and therapists.

The second identified strategy for the development of the therapeutic alliance with adolescent clients described participants' efforts to honor adolescent clients' voices. Participants explained that adolescent clients' opinions and experiences are often valued less by adults, and that it is especially important for therapists to honor adolescents' voices in order to develop the therapeutic alliance. This strategy may be especially helpful for overcoming the 'viewed as an authority figure' obstacle. For example, several participants described their desire to differentiate themselves from other adults in their adolescent client's life in order to overcome the adolescent's view of the therapist as an authority figure. Through respecting the adolescent and honoring their voice, the therapist can help to show the adolescent that they care about them, and want to understand their perspective. As a result, honoring the adolescent's voice can help the therapist to distinguish themselves from other adults, and can help to develop the alliance with adolescents through establishing a relationship defined by mutual respect. Therefore, honoring the adolescent's voice is an important strategy for the development of the therapeutic alliance.

The third and final strategy for the development of the alliance with adolescent clients that was revealed throughout the study describes therapists' attempts to clearly define the limits of confidentiality. The participants described this strategy as important for the protection of the alliance, and explained that clearly communicating the limits of confidentiality can help adolescent clients to adjust more easily if the therapist must report an incident to the authorities or adolescent's caregivers. While adolescent clients may feel frustrated when a therapist has to report private information to an outside source, participants explained that adolescents tend to adjust more easily and the alliance

can remain strong if the therapist clearly communicated the limits of confidentiality prior to the report being filed. As a result, this strategy is fairly unique in comparison to the other strategies (discuss interests, and honor the adolescents' voice) because it serves as a proactive strategy for the prevention of damage to the therapeutic alliance. While this strategy for the maintenance of the therapeutic alliance is not explicitly stated in the literature, it can be used to help address issues of confidentiality when working with adolescent clients. For example, studies within the medical literature have identified an internal struggle in physicians when attempting to maintain adolescent patients' confidentiality while also communicating with the patients' caregivers (Helitzer, Sussman, Urquieta de Hernandez, & Kong, 2011; Tebb, 2011). The strategy of clearly communicating the limits of confidentiality may help to ease therapists' (and physicians') experiences of honoring the adolescents' right to privacy while simultaneously maintaining open communication with caregivers. Additionally, discussing the limits of confidentiality with adolescent clients can help to protect the alliance if the therapist must report private information with caregivers or an outside source.

### **Alliance and Caregivers**

The purpose of the present study was to discover the essence of therapists' experiences of the therapeutic alliance with adolescents and their caregivers. While the therapeutic alliance with adolescents' caregivers is not adequately represented in the current literature, it has been associated with positive outcomes for underage clients and higher rates of therapeutic compliance (Gatta et al., 2009; Gatta et al., 2012). As a result, the therapeutic alliance with caregivers is an important area to research. This section will explore therapists' experiences of the therapeutic alliance with adolescents' caregivers.

First, potential obstacles to the development of the alliance with caregivers will be discussed. Next, the strategies used by therapists to develop the therapeutic alliance with adolescents' caregivers will be explored.

**Obstacles.** Two obstacles to the development of the alliance with caregivers emerged throughout the analysis of the data: (1) fear of triangulation, and (2) caregivers' expectations. The 'fear of triangulation' obstacle describes the participants' feelings of anxiety when working with both adolescents and their caregivers, and their fear that they will be caught in the middle between the two competing parties. Participants described situations in which the adolescent and/or the caregivers attempted to encourage the therapist to take sides, and to prioritize the adolescent or the caregiver over the other party. The participants described these situations as particularly harmful to the therapeutic alliance, and as sticky scenarios they hoped to avoid. While very little research has been conducted on the therapeutic alliance with the caregivers of adolescents, the medical research has identified an internal struggle in physicians who work with adolescent patients and their caregivers (Helitzer, Sussman, Urquieta de Hernandez, & Kong, 2011; Tebb, 2011). Similarly, therapists also reported feeling an internal struggle when attempting to negotiate the needs of adolescent clients and their caregivers. As a result, it is important for clinicians and researchers to understand therapists' fear of triangulation when working with adolescents and their caregivers in order to develop strategies to avoid triangulation and develop the therapeutic alliance.

In addition to the fear of triangulation, participants also described caregivers' expectations as a possible obstacle to the development of the therapeutic alliance. Participants explained that some caregivers maintain unrealistic expectations for the

therapy process that can be harmful to the alliance between the therapist and the caregiver. For example, several participants described some caregivers' expectations that therapy should be used to "fix" the adolescent, and that the "fix it" mentality can be a difficult obstacle to overcome when attempting to foster the alliance between the therapist and the caregiver. The therapists explained that they must help the caregiver to adjust their expectations for therapy in order to engage the caregiver and develop the alliance. While this obstacle is absent in the current literature, it was a common experience for the participants. As a result, it is important to understand that caregivers' expectations may serve as an obstacle to the development of the therapeutic alliance with caregivers.

**Strategies.** In order to more fully understand therapists' experiences of the therapeutic alliance with caregivers, the strategies used to develop the therapeutic alliance will be explored in this section. The findings revealed four strategies used by therapists to establish the alliance with adolescents' caregivers: (1) empathy, (2) give caregivers an active role, (3) collaborative approach, and (4) establish clear boundaries. Because the current literature does not describe strategies used by therapists to establish the alliance with adolescents' caregivers, the strategies will be discussed in relation to clinical implications for therapists who work with adolescents and their caregivers.

The first identified strategy used by therapists to develop the therapeutic alliance with caregivers is the use of empathy. The participants described using empathy as a way to connect and identify with the caregivers of adolescents. Several participants described empathizing with the difficult role that many caregivers fill, and highlighted the importance of recognizing caregivers' perspectives when working with adolescent



clients. Participants explained that it is important for therapists to empathize with the caregivers of adolescents in order to help caregivers feel valued and included throughout the therapeutic process. While empathy is largely recognized as an important part of the therapeutic process (Rogers, 1980; Johnson, 2007), it has not been discussed in the context of building the therapeutic alliance with the caregivers of adolescent clients. However, the findings of the present study emphasize the importance of using empathy to build the therapeutic alliance with adolescent clients' caregivers.

In addition to the use of empathy, the participants also identified the importance of giving caregivers an active role in the therapeutic process as a helpful strategy for the development of the therapeutic alliance with caregivers. Participants explained that caregivers often want to be included in the therapy process, and they desire an active role alongside the adolescent. Several participants described specific strategies for giving caregivers an active role. For example, therapists often give caregivers time before, during, or after sessions to hear their perspective and include them throughout the process. Additionally, some therapists described collaborating with caregivers to determine treatment plans. While the participants utilized various interventions to include the caregivers in the process, all the participants agreed that it was important to include caregivers if possible. As a result, it can be useful to give caregivers an active role in order to honor their voice and develop the therapeutic alliance.

Similarly, several participants described the importance of developing a collaborative approach with caregivers in order to establish the therapeutic alliance. While the previous strategy emphasized the importance of giving caregivers an active role in the therapeutic process, the 'collaborative approach' strategy emphasizes a

teamwork approach to therapy. Instead of simply giving caregivers a voice, the collaborative approach strategy encourages therapists to actively work with caregivers to develop goals, methods of treatment, and at-home interventions. The collaborative approach strategy builds a teamwork attitude amongst the adolescent, caregiver, and therapist. Participants explained that the collaborative approach strategy can help to engage caregivers, and foster the therapeutic alliance.

The fourth and final strategy for the development of the therapeutic alliance with caregivers describes therapists' attempt to establish clear boundaries. Participants described this strategy as an effective tool for helping caregivers to understand their role, the therapist's role, and the adolescent's role throughout the therapeutic process. Additionally, participants explained that establishing clear boundaries with caregivers can help to prevent disturbances in the therapeutic alliance. For example, establishing clear boundaries with caregivers at the beginning of the therapeutic process can help to overcome unrealistic expectations, and can therefore prevent disappointments or confusion in the future. As a result, several participants described the importance of establishing clear boundaries with caregivers for the maintenance of the therapeutic alliance.

### **Clinical Implications**

The therapeutic alliance is largely recognized as an important component of the therapeutic process. For clients of all ages, the therapeutic alliance has been associated with positive outcomes and increased engagement in therapy (Bachelor, 2013; Bhola, & Kapur, 2013; Liber et al., 2010). However, very few studies have explored the complex process of fostering the therapeutic alliance with adolescent clients, while also

maintaining a positive therapeutic relationship with the adolescent's caregivers. As a result, the present study attempted to fill the gap in the literature through examining the therapeutic alliance in the context of the therapeutic process with adolescents and their caregivers. The findings of the current study present major clinical implications for therapists who work with adolescent clients and their caregivers. Most importantly, the findings outline obstacles faced by therapists and strategies used by therapists to develop the alliance with adolescents and their caregivers (the previous section describes each obstacle and strategy in detail, and discusses further clinical implications). While more research should be conducted in order to determine the effectiveness of the strategies and the prevalence of the obstacles, the findings of the present study provide useful information for clinicians. More specifically, clinicians who work with adolescents should be aware of the possible obstacles to the development of the therapeutic alliance. The findings of the present study revealed 3 common obstacles: (1) viewed as an authority figure, (2) resistance to therapy process, and (3) differences in socioeconomic status. Additionally, therapists and clients may benefit from learning about strategies that can be used to build the therapeutic alliance with adolescent clients. 3 strategies emerged from the current study: (1) discuss interests, (2) honor the adolescents' voice, and (3) describe the limits of confidentiality.

In addition, the present study provides useful information for the development of the therapeutic alliance with adolescents' caregivers. Because the therapeutic alliance with caregivers has been associated with positive outcomes for clients and higher rates of therapeutic compliance (Gatta et al., 2009; Gatta et al., 2012), it is important for clinicians to foster the therapeutic alliance with caregivers. In order to develop the

alliance with caregivers, it can be helpful to be aware of possible obstacles that therapists might face when working with adolescents' caregivers. The current study identified 2 common obstacles that therapists face when attempting to develop the therapeutic alliance with caregivers: (1) fear of triangulation, and (2) caregivers' expectations. In order to overcome barriers and develop the alliance, clinicians should be aware of strategies that can be used to facilitate the development of the therapeutic alliance with caregivers. The findings of the present study identified 4 strategies that can be used to foster the alliance with caregivers of adolescents: (1) empathy, (2) give caregivers an active role, (3) collaborative approach, and (4) establish clear boundaries. Clinicians may be able to enhance the therapeutic alliance with adolescents and their caregivers through being aware of potential obstacles and understanding helpful strategies for the development of the therapeutic alliance. As a result, the present study maintains major clinical implications for clinicians who work with adolescent clients and their caregivers.

### **Limitations**

The purpose of the present study was to qualitatively explore therapists' experiences of the therapeutic alliance with adolescents and their caregivers. While the study was able to successfully reveal the essence of the participants' experiences of the therapeutic alliance with adolescents and their caregivers, it was not without limitations. First, the sample was not representative of all therapists (see Table 1). The participants were Caucasian, and were mostly female. Additionally, the sample was fairly young in age. While the sample maintained diverse theoretical views and types of practice, there was a lack of diversity within the demographic variables. As a result, it is possible that the findings of the study may vary with a more diverse sample.

Second, the interview process and method for data collection placed limitations on the study. The study utilized semi-structured interviews which allowed for flexibility within each interview. While semi-structured interviews present benefits for the research, they can also impose limitations. For example, follow-up questions can vary from interview to interview. As a result, some participants were asked questions that other participants were not asked. Therefore, each interview was different and generated various results. While I found that the benefits of the semi-structured interviews outweighed the negative consequences, it is important to note that the semi-structured interview format could have resulted in limitations on the current study.

Finally, as the researcher, I acted as the primary tool for data collection and analysis. While this is common for qualitative research, it can present limitations. As a result, several strategies for validation were utilized in order to diminish my biases. For example, I attempted to outline possible biases in order to help the reader interpret the findings through the bracketing process (see chapter 3). Also, I engaged in a peer review with a colleague before data collection, during the analysis of the data, and at the conclusion of the study in order to reduce personal bias. Additionally, external audits were performed by the dissertation committee at the proposal meeting and the dissertation defense. Finally, rich, thick descriptions were used throughout the reporting of the findings in order to help convey the true essence of the participants' experiences. While several strategies for validation were used to help diminish my personal biases, it is possible that the findings of the study were influenced by my opinions and world view. As a result, it is important to note that my role as the primary data collection and analysis tool may impose limitations on the study.

## **Recommendations for Future Research**

The present study presents important findings on therapists' experiences of the therapeutic alliance with adolescents and their caregivers. Prior to the completion of this study, very little research focused on the therapeutic alliance with adolescent clients and their caregivers. As a result, there are several areas for future research. First, the findings of the present study outlined several strategies used by therapists to develop the therapeutic alliance with adolescents and their caregivers. Future research should be conducted to assess the effectiveness of the strategies identified within this study, and other strategies that might be used to foster the therapeutic alliance. Through a more thorough understanding of strategies for the development of the therapeutic alliance, the therapeutic process can be strengthened and client outcomes may be improved.

While the present study focused on the therapeutic alliance with adolescents and their caregivers, the therapeutic alliance has been associated with positive outcomes for clients of all ages (Bachelor, 2013; Bhola, & Kapur, 2013; Liber et al., 2010). However, there is a large gap in the therapeutic alliance literature. Currently, the research has not identified obstacles or strategies for the development of the alliance with various populations. As a result, future research should be conducted with adults, children, and couples in order to better understand the therapeutic alliance in the context of various populations. Through understanding each population's unique needs, therapists may be able to enhance the therapeutic alliance with clients and improve outcomes.

## *Appendix A*

### Consent to Participate in a Research Study

#### **EXPLORING THE THERAPEUTIC ALLIANCE WITH ADOLESCENTS AND THEIR PARENTS: A QUALITATIVE APPROACH**

##### **WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?**

You are being invited to take part in a research study about the therapeutic alliance with adolescent clients and their parents. You are being invited to take part in this research study because you are an active mental health counselor who has worked with adolescent clients within the last year. If you volunteer to take part in this study, you will be one of about 25 people to do so.

##### **WHO IS DOING THE STUDY?**

The person in charge of this study is Jillian Hawks, M.S., a student in the Family Sciences department at the University of Kentucky. She is being guided in this research by Ronald Werner-Wilson, Ph.D. There may be other people on the research team assisting at different times during the study.

##### **WHAT IS THE PURPOSE OF THIS STUDY?**

By doing this study, we hope to learn about the role of the therapeutic alliance in therapy with adolescent clients and their parents.

##### **ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?**

If you are:

- Not 18 years or older
- Not a mental health counselor or therapist
- Have not worked with adolescent clients within the last year

##### **WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?**

The research procedures will be conducted at professional offices or via Skype. The interview will take about one and a half to two hours. The researcher will send you a summary of the interview approximately one to two months after the interview. The review of this summary will take approximately thirty minutes. The researcher will contact you within two weeks of sending the summary to ask questions about the interview summary and the initial interview. This will take approximately thirty minutes. The total amount of time you will be asked to volunteer for this study is between two and two and a half over the next two months.

### **WHAT WILL YOU BE ASKED TO DO?**

You will be asked to complete a brief demographics questionnaire. You will then be interviewed for approximately one and a half to two hours. The researcher will ask questions about the role of the therapeutic alliance in therapy with adolescent clients and their parents. The interview will be recorded.

The researcher will send you a summary of the interview approximately one to two months after the interview. The researcher will then contact you approximately two weeks after you received the summary to ask questions about the summary and the initial interview.

### **WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?**

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. You may find some questions we ask you to be upsetting or stressful. There is also a risk that your privacy and confidentiality may be broken.

### **WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?**

You will not get any personal benefit from taking part in this study.

### **DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

### **IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?**

If you do not want to be in the study, there are no other choices except not to take part in the study.

### **WHAT WILL IT COST YOU TO PARTICIPATE?**

There are no costs associated with taking part in the study.

### **WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?**

You will not receive any rewards or payment for taking part in the study.

### **WHO WILL SEE THE INFORMATION THAT YOU GIVE?**



We will make every effort to keep confidential all research records that identify you to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. The recorded interviews will be stored in a locked filing cabinet in a locked room where only the researchers have access. When the interviews are transcribed, you will be assigned an alias to protect your privacy

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Kentucky.

#### **CAN YOUR TAKING PART IN THE STUDY END EARLY?**

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.

The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you.

#### **WHAT ELSE DO YOU NEED TO KNOW?**

There is a possibility that the data collected from you may be shared with other investigators in the future. If that is the case the data will not contain information that can identify you unless you give your consent or the UK Institutional Review Board (IRB) approves the research. The IRB is a committee that reviews ethical issues, according to federal, state and local regulations on research with human subjects, to make sure the study complies with these before approval of a research study is issued.

#### **WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?**

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Jillian Hawks at 859-257-7755 or her advisor, Ronald Werner-Wilson, Ph.D. at 859-257-7750. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428. We will give you a signed copy of this consent form to take with you.

\_\_\_\_\_  
Signature of person agreeing to take part in the study

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person agreeing to take part in the study

\_\_\_\_\_  
Name of (authorized) person obtaining informed consent

\_\_\_\_\_  
Date

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Vita

**Jillian M. Hawks**

**ACADEMIC BACKGROUND**

**2010-2012**                    **M.S., Family Sciences, Focus in Marriage and Family Therapy, University of Kentucky**

**2006-2010**                    **B.S., Human Ecology: Human Development and Family Sciences, The Ohio State University**  
Minors: Women's Studies, Education

**CERTIFICATIONS**

**2012 – Present**                **Marriage and Family Therapy Trainee**  
Pre-Clinical Fellow  
Tennessee Association for Marriage and Family Therapy

**2013 – Present**                **Certified Family Life Educator**  
National Council on Family Relations

**2014**                            **College Teaching and Learning Graduate Certificate**  
University of Kentucky

**PUBLICATIONS**

Hawks, J. M., Parker, T. S., Werner-Wilson, R., Huff, N., Lianekhammy, J. (2015). Adolescents' and Parents' Expression of Empathy: A Social Neuroscience Perspective. *Contemporary Family Therapy*.

Parker, T.S., Blackburn, K.M., Perry, M.S., Puckett, J.M. (2012). Sexting as an intervention: Relationship satisfaction and motivation considerations. *The American Journal of Family Therapy*.

Werner-Wilson, R.J., Lianekhammy, J., Frey, L.M., Parker, T., Wood, N.D., Kimberly, C., Perry, M., Blackburn, K., Smith, L., Terrana, K., Puckett, J., Dalton, M. (2011). Alpha asymmetry in female military spouses following deployment. *Journal of Feminist Family Therapy*. 23(3-4), 202-217. doi: 10.1080/08952833.2011.604534

**TEACHING EXPERIENCES**

**University of Kentucky, FAM 360: Introduction to family intervention: Working with families and individuals**

Primary Instructor, Spring 2014

**University of Kentucky, FAM 352: Issues in Family Sciences**  
Primary Instructor, Spring 2013

**University of Kentucky, FAM 357: Adolescent Development**  
Teaching Assistant, 2010 - 2014

### **PRESENTATIONS**

Hawks, J. M., Nordquist, E., Reed, K., Parker, T., Blackburn, K., Kimberly, C., Werner-Wilson, R., Wood, N. D. (2012, September). Couple's empathy and mirrored physiology: A pilot study. Poster presented at the American Association of Marriage and Family Therapy Conference, Charlotte, NC.

Hawks, J. M., Parker, T. S., Werner-Wilson, R., Wood, N. D. (2013, October). Clients' experiences of spirituality in couple's therapy. Poster presented at the American Association of Marriage and Family Therapy Conference, Portland, OR.

Hawks, J. M., Reed, K., Parker, T. S., Blackburn, K., Sitton, M., Nordquist, E., Werner-Wilson, R., Wood, N. (2013, November). Inside the brain: Couples' affect, empathy, and frontal alpha asymmetry. Poster presented at the National Council on Family Relations Conference, San Antonio, TX.

Parker, T., Blackburn, K., Puckett, J. (2011, September). The elephant in the room: Physiology at work in therapy. Presentation conducted at the American Association of Marriage and Family Therapy Conference, Fort Worth, TX.

Puckett, J., Parker, T., Blackburn, K., Wood, N., Werner-Wilson, R. (2011, September). Seeking help: Effects of perceived demand-withdraw patterns. Poster presented at the American Association of Marriage and Family Therapy Conference, Fort Worth, TX.

Werner-Wilson, R. J., Lianekhammy, J., Frey, L. M., Parker, T., Wood, N. D., Kimberley, C., Perry, M., Blackburn, K., Smith, L., Terrana, K., Puckett, J., & Dalton, M. (2011, November). Alpha asymmetry in female military spouses following deployment. Poster presented at the National Council on Family Relations Annual Conference, Orlando, FL.

Werner-Wilson, R., Lianekhammy, J., Compton, L., Wood, N., Parker, T., Kimberly, C., Perry, M., Blackburn, K., Smith, L., Terrana, K., Dalton, M., Puckett, J. (2011, November). A pilot study comparing influence of deployment on military families. Poster presented at the National Council on Family Relations Annual Conference, Orlando, FL.

### **CLINICAL EXPERIENCE**

**2015 – Present**      **Austin Peay State University, Student Counseling Services**

**2012 - Present**      **Jillian M. Hawks, M.S., Associate Marriage and Family Therapist**

**2014 – 2015**      **Department of Veterans Affairs, Family Therapy Program**  
Marriage and Family Therapy Practicum Student

**2012 – 2013**      **The Ridge Behavioral Health System**  
Intake Counselor

**2010 - 2012**      **University of Kentucky Family Center**  
Marriage and Family Therapy Intern

**PROFESSIONAL AFFILIATIONS**

*American Association of Marriage and Family Therapy*  
Pre-Clinical Fellow, 2010-Present

*National Council on Family Relations*  
Student Member, 2013 - Present

*Tennessee Association for Marriage and Family Therapy*  
Pre-Clinical Fellow, 2015 - Present

*Kentucky Association for Marriage and Family Therapy*  
Pre-Clinical Fellow, 2010-2015

