Addressing the Alliance

The Parent-Professional Alliance in Home-Based Parenting Support: Importance and Associated Factors

Marieke de Greef

Behavioural Science Institute

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Colofon

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Chapter 1

General Introduction

"As a provider of home-based parenting support I am always excited when I am about to meet parents for the first time. When I stand in front of their front door I wonder whether I will be able to 'get in' and work with this family to help them accomplish their personal goals. I think the ability to develop a strong alliance with parents is one of the core elements of my job and is key to providing effective services."

The assumption that a strong alliance is key to providing effective services, as expressed by a youth care professional providing home-based parenting support, illustrates how the alliance is generally viewed by clients and professionals involved in youth care (e.g., Pijnenburg, 2010; Scholte, 2017). The idea that a strong alliance between clients and professionals is important, even critical, for positive care outcomes is not new. The alliance, defined as a collaborative client-professional relationship that consists of a positive emotional bond and agreement on treatment goals and tasks (Bordin, 1979; Elvins & Green, 2008), has been studied for decades (see Elvins & Green, 2008; Horvath & Luborsky, 1993). Numerous studies in adult (Flückiger, Del Re, Wampold, & Horvath, 2018), youth (McLeod, 2011; Shirk, Karver, & Brown, 2011), and family treatment (Friedlander, Escudero, Heatherington, & Diamond, 2011) indicated that the alliance is a consistent predictor of treatment outcomes.

Surprisingly, the alliance is largely understudied in youth care. Also, most alliance research to date has not involved the client group that is often a main target of youth care services in general, and home-based parenting support in particular: parents. As a consequence, it is yet unclear to what extent the parent-professional alliance predicts outcomes of home-based parenting support, and whether this alliance would thus serve as a relevant focus for quality improvement efforts in this service type. Knowledge about factors contributing to strong parent-professional alliances is also scarce, hindering clear professional guidance on what factors to address when working to develop and maintain a strong parent-professional alliance. The current dissertation aims to address these gaps. Before going into detail on potential effects of, and factors associated with the parent-professional alliance, we will first characterize the youth care service sector and address the reasons why research on the parent-professional alliance may serve the interests of parents and children who rely on home-based parenting support provided by youth care organizations.

Children and Families in Youth Care

Most children and families are functioning well. Nevertheless, annually 5-20% of all children and families in the Netherlands (Statistics Netherlands, 2016), and worldwide (Remschmidt & Belfer, 2005; Stahmer et al., 2009; World Health Organization, 2005), are in need of mental health services because children's psychosocial functioning and

development are at risk. Families faced with severe problems related to parenting and child development typically call upon the youth care service sector for support. Youth care organizations (e.g., child welfare agencies, community-based youth care organizations) provide a range of services, including home-based parenting support, foster care, and residential care (Hilverdink, Daamen, & Vink, 2015). Of all families involved in youth care, the majority (around 80%) receive home-based parenting support (Barth et al., 2005; Child Welfare Information Gateway, 2014; Statistics Netherlands, 2015). Home-based parenting support aims to strengthen parental competencies (Barth et al., 2005; Whittaker & Cowley, 2012), and thereby optimize children's development (Lewis, Feely, Seay, Fedoravicis, & Kohl, 2016), oftentimes with the goal of preserving families (Anglin, 1999; Barth et al., 2005; White, 2007).

Home-based parenting support in youth care is typically provided to a heterogeneous client population in terms of demographic and clinical characteristics (McWey, Holtrop, Stevenson, Wojciak, & Claridge, 2015; Whittaker & Cowley, 2012) as well as motivation to participate in care (McWey et al., 2015; Staudt, 2007). Parental involvement in home-based parenting support can be either voluntary or mandated as result of a court order. Either way, a large group of parents experience problems with engagement in services (McWey et al., 2015; Whittaker & Cowley, 2012). These difficulties may result from the multiple, severe, and interrelated problems of families or care histories that are often fragmented and characterized by unmet needs and disappointments (Bodden & Dekovic, 2016; Ribner & Knei-Paz, 2002; Steens, Hermans, & Van Regenmortel, 2017). The multiple stressors these families encounter hinder parents' engagement in care and serve as risk factors preventing them to benefit from the care provided (McWey et al., 2015).

Working Towards Effective Home-Based Parenting Support

Despite the importance of home-based parenting support and the fact that positive outcomes are by no means self-evident, this service type has undergone relatively little empirical examination (Barth et al., 2005). As a result, knowledge about factors contributing to positive outcomes of home-based parenting support is limited. One important area where knowledge is lacking is whether the alliance between parents and professionals contributes to positive care outcomes. Research addressing the effects of the parent-professional alliance on care outcomes, and factors associated with alliance strength, will serve the interests of families involved in home-based parenting support for two main reasons.

First, as mentioned before, the alliance has been found to be a consistent predictor of outcomes in adult (Flückiger et al., 2018), youth (McLeod, 2011; Shirk et al., 2011), and family treatment (Friedlander et al., 2011). Based on these findings and the widespread

belief of clients, professionals, and researchers (e.g., Hubble, Duncan, Miller, & Wampold, 2010; Norcross, 2010; Pijnenburg, 2010) in the key role of the alliance, a case could be made that a professional's ability to develop and maintain a strong alliance with parents may help to effectively serve the diverse and complex client population involved in home-based parenting support. Empirical evidence regarding the importance of the parent-professional alliance will inform us whether findings from other service sectors translate to home-based parenting support, and aforementioned client and professional assumptions are justified. Moreover, it contributes to a much-needed evidence base that can guide quality improvement efforts in home-based parenting support.

Second, for practice settings serving a complex and heterogeneous client population, and providing services being largely eclectic and grounded in various approaches, research on common factors is considered to be a relevant strategy to optimize care outcomes (Barth et al., 2012). Common factors (e.g., clients' hope and expectations, professional qualities, the alliance) can be defined as factors that are present in, and relate to care processes and outcomes, regardless of the specific treatment model or approach (Barth et al., 2012; Hubble et al., 2010). Of all factors related to care outcomes, the alliance is considered to be one of the largest contributors to outcomes (Duncan et al., 2003; Hubble et al., 2010). Moreover, evidence regarding the parent-professional alliance is relevant for all professionals providing home-based parenting support, regardless of the specific problems of involved families or the specific models and approaches employed in a particular case or organization (e.g., Barth et al., 2012).

The Importance of a Strong Parent-Professional Alliance

As a first step towards a better understanding regarding the importance of the parent-professional alliance, we systematically reviewed studies examining the association between the parent-professional alliance and outcomes of child, parent, and family treatment designed to improve children's psychosocial functioning (Chapter 2). Specifically, we investigated whether the parent-professional alliance was related to clinical outcomes and treatment engagement. We also investigated factors that may influence the alliance-outcome association, distinguishing between theoretical (i.e., related to the context and content of treatment) and methodological factors. Evidence resulting from this systematic review will allow professionals to learn from the aggregated knowledge regarding the importance of the parent-professional alliance. In addition, this study provides insight in issues that need to be addressed in future research investigating the parent-professional alliance.

Next, we examined whether empirical data supported the hypothesized impact of the parent-professional alliance on outcomes of home-based parenting support in youth care

(Chapter 3). Previous alliance research has identified some important methodological requirements for studies examining the alliance-outcome association. These include the use of multi-informant alliance and outcome data as client and professional perspectives on the alliance might differ (Hawley & Garland, 2008), and the strength of the alliance-outcome association might depend on whose perspective on the alliance and outcomes is assessed (Hawley & Garland, 2008; McLeod, 2011; Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014). Moreover, it is important to assess the alliance early and late in care, as the alliance may change over the course of care (Chu, Skriner, & Zandberg, 2014; Kendall et al., 2009), and since both early alliance (McLeod, 2011) and change in alliance (Owen, Miller, Seidel, & Chow, 2016) may serve as predictors of care outcomes. Contrasting a handful of studies investigating the association between the parent-professional alliance and parenting intervention outcomes (e.g., Girvin, DePanfillis, & Daining, 2007; Hukkelberg & Ogden, 2013), the study presented in Chapter 3 follows these recommendations. We investigated the predictive value of early alliance and change in alliance on outcomes, using parent- and professional-reported alliance and outcome data collected early and late in home-based parenting support. This is important, as findings from this study help to build a stronger evidence base regarding the importance of a professional's ability to develop and maintain a strong alliance with parents. If the alliance (early alliance, change in alliance, reported by parents and/or professionals) predicts outcomes of home-based parenting support, it should guide professionals' and youth care organizations' quality improvement efforts.

Factors that Impact the Alliance

Given the expected importance of a professional's ability to develop and maintain a strong alliance with parents for outcomes of home-based parenting support, identification of factors that impact alliance strength is warranted. Moreover, the varying levels of client-professional alliances in clinical practice indicate that strong alliances are by no means self-evident and that certain factors might affect the alliance (e.g., Baldwin, Wampold, & Imel, 2007; Hawley & Garland, 2008). Understanding whether certain factors relate to or predict the alliance may help professionals optimize the parent-professional alliance and thereby outcomes of home-based parenting support. We investigated factors that might impact parent- and professional-reported alliance in two different studies.

First, we examined whether key factors associated with home-based parenting support were related to early alliance, and predicted change in alliance. These factors included: voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems, and parents' and professionals' care expectations. Based on studies on youth-, parent-, and family-treatment (e.g., Haine-Schlagel & Walsh, 2015; Kazdin, Holland, & Crowley, 1997; Sotero, Major, Escudero, &

Relvas, 2016), it is plausible that these factors may influence the parent-professional alliance in home-based parenting support. Findings of this study, presented in Chapter 4, help to guide professionals on what factors to address when working to develop and maintain a strong parent-professional alliance.

Second, a professional's ability to develop and maintain strong parent-professional alliances and to realize positive care outcomes may depend on the strength of the alliance between professionals and their supervisor (hereafter: *supervisory alliance*). A growing number of studies suggest that the organizational context in which professionals provide services to children and families may affect care processes and outcomes (e.g., Bromer & Korfmacher, 2017; Green, Albanese, Cafri, & Aarons, 2014). Indeed, a strong supervisory alliance, viewed as a key element of effective supervision (e.g., Carpenter, Webb, & Bostock 2013; Lewis, Scott, & Hendricks, 2014; Watkins, 2014), has been found to relate to stronger alliances (DePue, Lambie, Liu, & Gonzalez, 2016; Ganske, Gnilka, Ashby, & Rice, 2015; Patton & Kivlighan, 1997) and improved outcomes (Palomo, Beinart, & Cooper, 2010) in adult treatment. While it is plausible that the supervisory alliance may impact early alliance, change in alliance, and (thereby) outcomes of home-based parenting support, empirical tests are lacking (Locke et al., 2018; Watkins, 2014). The study presented in Chapter 5 examined these hypotheses to clarify whether the supervisory alliance would be a relevant focus for quality improvement efforts in home-based parenting support.

To Conclude

Together, the goal of these four studies is to provide insight into the importance of the parent-professional alliance for outcomes of child, parent, and family treatment in general, and home-based parenting support in particular, as well as factors that may impact the alliance and (thereby) outcomes of home-based parenting support. In the General Discussion of this dissertation (Chapter 6), we summarize our main findings and provide suggestions for future research. Finally, we reflect on practical implications for clients, professionals, educators, and policy makers, and indicate why these next steps would serve the interests of parents and children involved in home-based parenting support.

Chapter 2

Parent-professional alliance and outcomes of child, parent, and family treatment: A systematic review

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Abstract

This review systematically explored research examining the relation between parent-professional alliance and outcomes of psychosocial treatments provided to children, and their parents and families. Study findings and methodological characteristics were reviewed to investigate the evidence linking the alliance between parents and professionals to outcomes of child, parent, and family treatment as well as to identify factors that may influence the alliance-outcome association. A systematic review of the literature was conducted that included a search of three electronic databases using specified search terms, followed by a hand search to identify relevant studies. A total of 46 studies (37 published articles and 9 unpublished dissertations) met inclusion criteria. Overall, the findings indicated that higher levels of parent-professional alliance were significantly associated with improved clinical outcomes and stronger treatment engagement. However, some studies found that the parent-professional alliance was not significantly related to clinical outcomes or treatment engagement, and a few studies showed that higher levels of alliance were related to less positive clinical outcomes and lower levels of treatment engagement. Several theoretical (problem type, child age, parent sex) and methodological (source and timing of alliance measurement, alliance-outcome informants, outcome domain, timing of outcome measurement) factors were identified that could influence the alliance-outcome association. Together, our findings emphasize the importance of alliance awareness when working with parents as well as a need for future studies to investigate factors influencing the quality of the parent-professional alliance and alliance-outcome association in child, parent, and family treatment.

Introduction

Most children and families are functioning well. Nevertheless, annually 5-20% of all children and families are in need of mental health services because the functioning or development of children and adolescents (hereafter called *children*) is at risk (Remschmidt & Belfer, 2005; Stahmer et al., 2009; Statistics Netherlands, 2016). A wide range of psychosocial treatments (hereafter referred to as *treatment*) offered by a wide range of mental health professionals (e.g., psychologists, psychiatrists, social workers; hereafter referred to as *professionals*) are available to help improve children's functioning and development (Clark & Samnaliev, 2005; England, Butler, & Gonzalez, 2015).

Given parents' responsibility in shaping children's physical, emotional, and social environment and thus their development (Wittkowski, Dowling, & Smith, 2016), they play an important role in treatments for children (Accurso, Hawley, & Garland, 2013; Chaffin & Bard, 2011; Hawley & Weisz, 2005; Kazdin, Siegel, & Bass, 1990). They can be the main target of treatment (e.g., parenting support) in parent-mediated treatments in which child functioning is targeted via changes in parent behavior (Chaffin & Bard, 2011). Parents can also be involved in child-focused treatments (e.g., child treatment) where they are key partners given their role in seeking treatment, motivating children to become or stay involved in treatment (Hawley & Weisz, 2005; Kazdin et al., 1990), and promoting positive outcomes in everyday life. Finally, in treatments that target the family system (e.g., family preservation programs, multisystemic therapy; McLeod, 2011), parents fulfill both aforementioned roles (Friedlander, Escudero, Heatherington, & Diamond, 2011).

Despite the important role parents play in treatment for children, little empirical evidence exists that can help professionals optimize outcomes of treatment involving parents (Hawley & Weisz, 2005; Myers, 2008). One important area where knowledge is lacking is how the alliance between parents and professionals contributes to outcomes of child-, parent-, and family-focused treatment. Recent meta-analyses have indicated that the alliance, defined as the affective and collaborative aspects of the client-professional relationship (Elvins & Green, 2008; Martin, Garske, & Davis, 2000; Shirk & Saiz, 1992), is a predictor of outcomes of individual treatment for adults (Hubble, Duncan, Miller, & Wampold, 2010; Norcross, 2010), and children (McLeod, 2011; Shirk, Karver, & Brown, 2011). Although it is reasonable to expect that the parent-professional alliance is associated with outcomes of child-, parent-, and family-focused treatment, existing meta-analyses and literature reviews have provided limited information about this relation. Until now, an overview describing available studies on the association between parent-professional alliance and outcomes of child-, parent-, and family-focused treatment, is lacking. As a result, it is not yet possible for professionals working with parents to learn from combined knowledge regarding the importance of the parent-

professional alliance. Furthermore, the absence of an overview limits our ability to identify issues that need to be addressed in future studies to understand how we can optimize outcomes for children of treatments that involve parents.

The concept of the alliance first emerged in the psychodynamic literature (for a detailed description, see Horvath & Luborsky, 1993) and is considered to play an important role in most treatment approaches (Elvins & Green, 2008). Over time, several terms and definitions have been used for the alliance (e.g., therapeutic alliance, working alliance, helping alliance; see Elvins & Green, 2008). Bordin (1979) was the first to develop a definition of the alliance that could be used across treatment approaches. In this definition, alliance is presented as a collaborative relationship, involving three distinct yet related components. The first component, bond, refers to the affective aspects of the client-professional relationship. Goals, the second component, refers to the agreement between client and professional regarding treatment goals. The third component, tasks, refers to the client-professional agreement on tasks to be performed to accomplish treatment goals. In line with Bordin's conceptualization, most current alliance definitions include affective and collaborative aspects of the client-professional relationship (Elvins & Green, 2008; Smith, Msetfi, & Golding, 2010). Of note, some have expanded this classical conceptualization to capture the specific dynamics of family treatment (Friedlander et al., 2011; Pinsof, 1994). This conceptualization differentiates between the alliance of family members with the therapist and the alliance within the family system (for a detailed description, see Friedlander et al., 2011).

A critical component of most alliance definitions is the process between client and professional of forging and maintaining a positive alliance as this is considered a key factor contributing to positive therapeutic change (Bordin, 1979). Hundreds of studies in the adult treatment field indicate that the quality of the client-professional alliance predicts outcomes, regardless of the type of treatment (Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011). In contrast to the adult field, little research has focused on the alliance in child-, parent-, and family-focused treatments (Friedlander et al., 2011; McLeod, 2011; Shirk et al., 2011).

Two recent meta-analyses on the alliance-outcome association in child- and parent-focused treatments, mainly focused on child-focused treatments. The meta-analysis of Shirk et al. (2011) involved 16 studies investigating the child-professional alliance, (n = 10), the child- and parent-professional alliance (n = 4), or the parent-professional alliance (n = 2) in child-focused treatment. Findings indicated that a strong child-professional alliance and a strong parent-professional alliance were related to positive clinical outcomes. However, given the focus on child-focused treatment, it is unknown whether findings regarding the alliance-outcome association also apply to parent- or family-focused treatment. The meta-analysis of McLeod (2011), involving 38

studies, focused on child-, parent-, and family-focused treatment. Again, most studies investigated the child-professional alliance (*n* = 21). Other studies assessed the child-professional and parent-professional (*n* = 15), or parent-professional alliance only (*n* = 2). McLeod (2011) also found that there was no difference between the strength of the alliance-outcome association for the child- and parent-professional alliance. Additionally, McLeod (2011) indicated that the alliance-outcome association was moderated by several theoretical factors (i.e., child age, problem type, referral source, treatment mode) and methodological factors (i.e., source and timing of alliance assessment; domain, technology and source of outcome assessment; single vs. multiple informants). However, because the study did not describe results of moderator analyses for child-professional and parent-professional alliance separately, it remains unclear what specific variables may influence the association between the parent-professional alliance and outcomes.

In their meta-analysis on the alliance-outcome association in family-focused treatments, Friedlander et al. (2011) combined studies on family-focused treatment (*n* = 17) and couple treatment (*n* = 7). Analyses of these studies revealed a significant association between alliance and outcome, including clinical outcomes and treatment retention. Since alliance-outcome analyses were based on aggregated scores of all available family members in each study, it is unclear whether and how the parent-professional alliance was related to outcomes of family-focused treatment. Based on a description of potential moderators of the alliance-outcome association, however, the authors indicated that family role (i.e., parent, spouse, child) may influence the alliance-outcome association. This suggests that the role of parents may be an important aspect to look at when considering factors that may influence the alliance-outcome association.

While these previous studies offered important information regarding the alliance-outcome association in child-, parent-, and family-focused treatment, a number of issues remain. First, available meta-analyses mainly focused on the child-professional or family-professional alliance, rather than on the parent-professional alliance. As a result, there is a lack of information regarding the association between the parent-professional alliance and outcomes (Friedlander et al., 2011) and factors that may influence this relationship (Friedlander et al., 2011; McLeod, 2011; Shirk et al., 2011). Moreover, the specific focus of previous meta-analyses on child- and family-focused treatment precluded the aggregation of knowledge on the association between the parent-professional alliance and outcomes for the broader field of child-, parent-, and family-focused treatment.

Addressing these issues is important, given the role of parents in realizing positive treatment outcomes for children (e.g., Accurso et al., 2013; Chaffin & Bard, 2011). Furthermore, investigating the role the parent-professional alliance plays in promoting

positive outcomes that focus on clinical dimensions (e.g., symptoms, functioning) and treatment engagement (i.e., defined as client participation in treatment activities and regular attendance; McKay & Bannon, 2004) is important. To achieve the goal of effective child-, parent-, and family-focused treatment, treatment engagement is required (Haine-Schlagel & Walsh, 2015; McKay & Bannon, 2004). Retaining clients in treatment, and thereby ensuring that clients receive an adequate treatment dose, is a challenge for professionals (Friedlander et al., 2011; Hawley & Weisz, 2005) given the high number of children and families that terminate treatment prematurely (Hawley & Weisz, 2005; Kazdin, Holland, & Crowley, 1997). Finally, addressing these issues will identify new research directions as well as help professionals who are providing treatment to parents. Considering the absence to date of a relevant literature review on this topic, and in light of the manifold differences between relevant empirical studies, the present study opted for a systematic review to bring together all relevant studies on this topic.

In this study, we focused on the association between the parent-professional alliance and outcomes of child-, parent-, and family-focused treatment. Specifically, we reviewed studies focusing on treatments involving parents designed to improve children's functioning and psychosocial development. We investigated the following research questions: (1) "What is the scientific state of art concerning the association between the parent-professional alliance and outcomes of child-, parent-, and family-focused treatment?" and (2) "Which factors are identified by included studies as factors that may influence this alliance-outcome association?" With respect to the first question, we distinguished outcomes related to clinical outcomes of treatment (i.e., changes in child, parent, or family symptoms and functioning), and outcomes associated with treatment engagement (e.g., attendance, treatment satisfaction). Regarding the second question, we differentiated between theoretical factors – related to the context and content of treatment (e.g., child age, problem type), and methodological factors (e.g., source and timing of alliance assessment). Based on the evidence resulting from this systematic review, we formulated implications for clinical practice and future research.

Method

This systematic review included 46 studies (37 published articles and 9 unpublished dissertations), and is reported in accordance with the PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses (Moher, Liberati, Tetzlaff, & Altman, 2009).

Inclusion Criteria

To ensure that this study was in line with previous studies, we based our inclusion criteria on those used in meta-analyses on alliance (Martin et al., 2000; McLeod, 2011; Shirk et

al., 2011). The first and second criterion partially diverged from previous studies, since this review focused solely on the alliance between parents and professionals, instead of on the alliance between children, parents, and professionals (McLeod, 2011), or adults (not necessarily parents) and professionals (Martin et al., 2000), and since we also included studies that administered outcome during treatment to capture all available knowledge on the alliance-outcome association. Hence, the current review used the following inclusion criteria. First, the study had to include a measure of the alliance between one or two parent(s) and one or more professional(s), assessing the affective (i.e., bond) and/or collaborative (e.g., task and/or goal) components of alliance. Second, the relation between the (parent-professional) alliance and outcome was tested statistically (McLeod, 2011). Alliance measures were not required to be administered prior to outcome measures (McLeod, 2011), and outcome was administered at post-treatment (McLeod, 2011; Shirk et al., 2011) or during treatment. Third, the study examined child-, parent-, and family-focused treatments (McLeod, 2011) directly (child- and family-focused treatment) or indirectly (parent-focused treatment) serving clients aged 18 or younger (McLeod, 2011). Fourth, the study had to include a treatment designed to alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior through counseling, structured or unstructured interaction, a training program, or a predetermined treatment plan. Thus, studies that focused upon participants presenting with a medical problem (physical conditions, such as asthma) were excluded (McLeod, 2011). Fifth, the study had to be clinical rather than analog: it had to involve clients rather than analog cases (Martin et al., 2000; McLeod, 2011; Shirk et al., 2011). Sixth, the study had to include more than ten participants (Shirk et al., 2011). Seventh, the study needed to be presented in English (Martin et al., 2000; McLeod, 2011; Shirk et al., 2011). Eighth and finally, the study had to be published in a peer-reviewed journal or to be available as a full-text dissertation (McLeod, 2011).

Selection of Studies

To identify relevant studies, the following stepwise procedure was employed. First, databases PsycInfo, ERIC, and MedLine were electronically searched in August 2015, using the search terms “alliance” OR “therapeutic relation*” OR “therapeutic bond” AND “parent*” OR “caregiver*” OR “mother*” OR “father*”. Searches were restricted by year of publication (1990-2015) since previous meta-analyses did not include studies predating 1990 (Friedlander et al., 2011; McLeod, 2011; Shirk et al. 2011). Using these specified terms and restriction, we identified 2627 articles (PsycInfo: 1675, ERIC: 405, MedLine: 547). After removing 368 duplicates, 2259 articles remained.

Second, the first author screened titles and abstracts of these 2259 articles to determine relevance. Application of the inclusion criteria resulted in exclusion of 2197 studies. Main reasons for exclusion: 197 did not include a measure of parent-professional alliance,

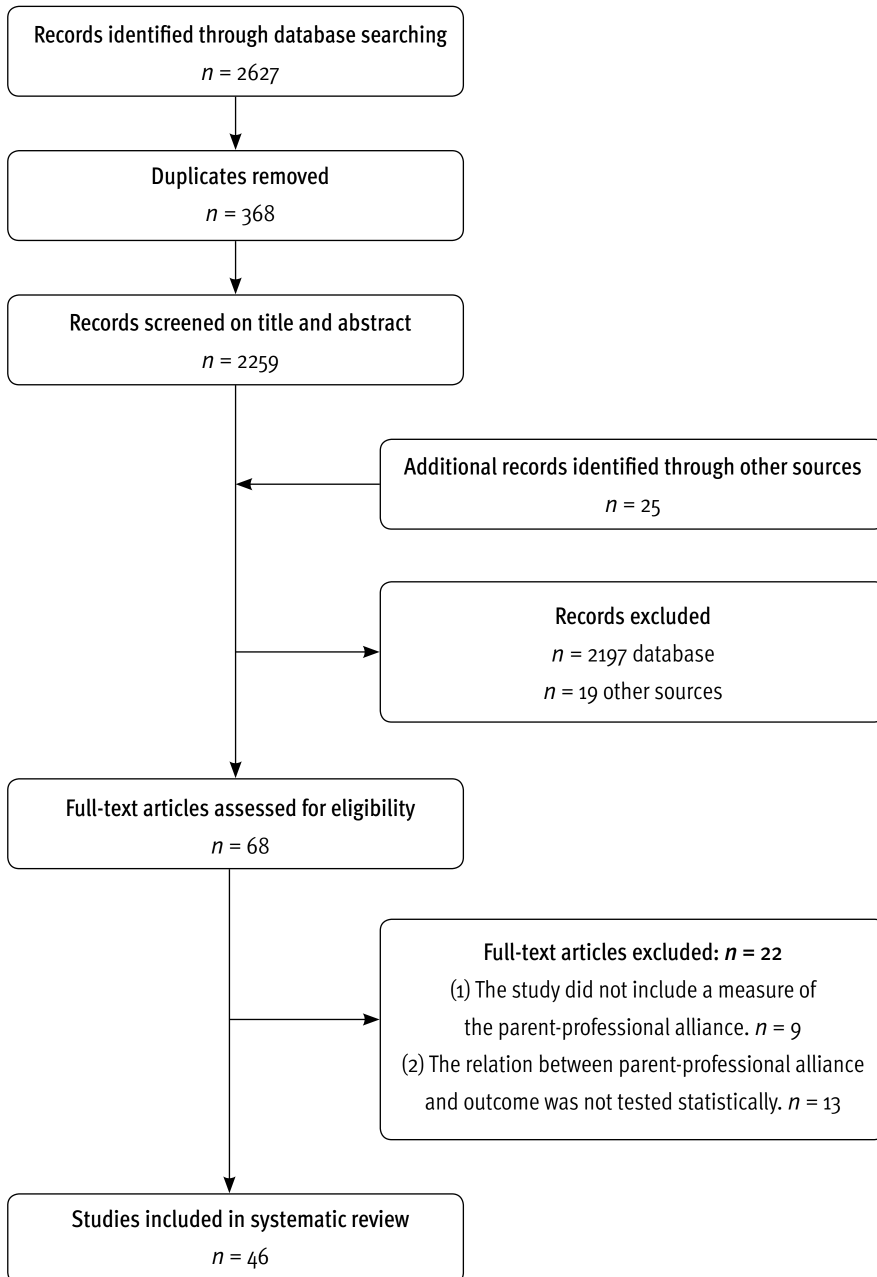

Figure 1 Flow diagram inclusion of studies

379 did not report on alliance, 170 did not include a statistical test of the alliance-outcome association, two were not clinical, 118 had less than ten participants, 167 did not examine child-, parent-, and family-focused treatments delivered for child clients under the age of 18 years, 457 did not include treatments designed to alleviate psychological distress or improving behavior, 693 were not peer reviewed articles (e.g., books, book reviews, conference presentations), seven (dissertations) were not available in full text, three (dissertations) were also published as an article in a peer reviewed journal, and four articles were reviews. Thus, 62 studies remained.

Third, we obtained 25 additional articles by hand-searching the complete reference lists of the 62 remaining studies, relevant reviews and meta-analyses. Screening of titles and abstracts of these articles resulted in exclusion of 19 articles (seven articles did not include a measure of parent-professional alliance, four dissertations were not available in full text, two articles did not report on alliance, and six articles were reviews, systematic reviews or meta-analyses). Thus, six of these 25 additional articles remained.

Fourth, title, abstract and method section of the selected 68 studies were systematically reviewed and assessed for eligibility by four independent reviewers (one postgraduate, three PhD). Each article was considered for inclusion by two reviewers. Inter-rater agreement varied between 87.0% and 91.0% (Cohen's Kappa: .70 - .73). Disagreements between raters were discussed, leading to consensus in all cases. Figure 1 shows the number of rejected articles at each stage, and the reasons for rejection at the final stage. Of these 68 studies, 46 studies met all inclusion criteria and were included in this systematic review.

Results

Study Characteristics

Descriptive Characteristics of Studies

Table 1 provides a summary of the main descriptive characteristics of the 37 studies and nine dissertations that met inclusion criteria. The majority of the included studies were conducted in the United States (n = 34, 73.9%). Studies were completed between 1997 and 2014, most (n = 41, 89.1%) after 2004. A total of 6,280 parents (M = 136.52, SD = 211.17, range 14 - 1,279) were included in the studies. The mean age of parents, as reported by 17 studies, was 36.84 years (SD = 5.55, range 24.38 - 44.76). Studies (n = 30) reporting on parent sex indicated that only a small percentage of the study samples involved fathers as informants (M = 10.5%, SD = 15.15, range 0.0 - 50.0%). Children, as reported by 37 studies, were between 0.0 and 20.0 years old (M = 10.74, SD = 3.98), and

Table 1 Characteristics of Included Studies

	Study	Target problem	Tmnt mode	Tmnt setting	Age child	% male parent	Outc. domain	Alliance measure	Alliance rating	Sample size[a]
1	Accurso et al. (2013)	C: ext	C	Out	9.00	4.0	C, E	Therapeutic Alliance Scale for Caregivers and Parents	Parent	169
2	Anderson et al. (2012)	C: int	C	Onl	12.12		C, E	Working Alliance Inventory-Short Form	Parent	132
3	Becker (2011)[b]	C: mix	P	Onl	6.50	0.0	C, E	Session Rating Scale	Parent	24
4	Bickman et al. (2012)		C	Com	14.80		C	Therapeutic Alliance Quality Scale / Rating	Par, prof	225
5	Canning (1997)[b]	P: oth	P	Mix	2-16	0.0	C	Working Alliance Inventory	Parent	67
6	Chaffin & Bard (2011)	P: oth	P	Com		9.0	C	Working Alliance Inventory-Short Form	Parent	1279
7	Chaffin et al. (2012)	F	P	Com		6.0	C	Working Alliance Inventory	Parent	202
8	Davis (2007)[b]	C: mix	C	Com	2.36	0.0	C	Working Alliance Scale	Parent	151
9	Eder (2003)[b]	C: mix	C	Out	14.64	0.0	C, E	Working Alliance Inventory	Par, prof	40
10	Forsberg et al. (2014)	C: eat	F	Out	14.00	41.0	C	Working Alliance Inventory	Obs	61
11	Friedlander et al. (2012)	F	F	Out	13.21	34.7	C, E	System for Observing Family Therapy Alliances	Parent	36
12	Garland et al. (2012)	C: ext	C	Com	9.00	6.1	E	Therapeutic Alliance Scale for Children	Parent	151
13	Gatta et al. (2012)	C: mix	Co	Out	6-18	50.0	C, E	Working Alliance Inventory-Short Form	Obs	121
14	Girvin et al. (2007)	F	F	Com	8.34	2.2	E	Helping Relationship Inventory	Parent	136
15	Granic et al. (2012)	C: ext	MS	Com	13.70	0.0	C	Working Alliance Inventory-Short Form	Par, prof	89
16	Green et al. (2007)	C: mix	C	In	13.00		C	Family Engagement Questionnaire	Prof	150
17	Green et al. (2001)	C: mix	C	Mix	11.40		C	Family Engagement Questionnaire	Par, prof	55
18	Guzder et al. (2011)	C: mix	F	Day	8.51		C, E	Working Alliance Inventory-Short Form	Parent	44
19	Harvey (2008)	C: mix	C	Out	7.95		C	Therapeutic Alliance	Parent	18
20	Hawley and Garland (2008)		Co	Out	13.50	11.5	C, E	Working Alliance Inventory-Short Form	Parent	78
21	Hawley and Weisz (2005)		C	Out	11.90	10.7	C, E	Therapeutic Alliance Scale for Children	Parent	65
22	Hogue et al. (2006)	C: sub	MS	Out	15.47		C	Vanderbilt Therapeutic Alliance Scale-Revised	Obs	44
23	Hukkelberg and Ogden (2013)	P: par	P	Com	8.70		C	Working Alliance Inventory-Short Form	Parent	331
24	Isserlin and Couturier (2012)	C: eat	F	Out	14.00		C, E	System for Observing Family Therapy Alliances	Obs	14
25	Johnson et al. (2002)	F	F	Com	14.00	27.3	C	Family Therapy Alliance Questionnaire	Parent	55

26	Kazdin et al., (2005)	C: ext	Co	Out	7.20	3.3	C, E	Working Alliance Inventory	Par, prof	185
27	Kazdin et al., (2006)	C: ext	Co	Out	9.60	3.9	C	Working Alliance Inventory	Par, prof	77
28	Kazdin, and Whitley (2006)	C: ext	Co	Out	7.00	3.2	C	Working Alliance Inventory	Par, prof	218
29	Keeley et al. (2011)	C: int	C	Out	13.16		C	Working Alliance Inventory	Par, prof	22
30	Korfmacher et al. (2007)		P	Com	0-1	0.4	E	Helping Relationship Inventory	Parent	728
31	Lerner et al. (2011)	C: mix	P	Out	8.15	11.1	C	Therapy Process Observational Coding System-Alliance Scale	Obs	27
32	McLeod and Weisz (2005)	C: int	F	Out	10.30		C	Therapy Process Observational Coding System-Alliance Scale	Obs	20
33	Myers (2008)[b]	C: mix	P	Com	6.95	9.0	C, E	Working Alliance Inventory	Par, prof	44
34	Pereira et al. (2006)	C: eat	F	Out	15.10	9.8	C, E	Working Alliance Inventory	Obs	41
35	Robbins et al. (2006)	C: sub	MS	Out	14.93	0.0	E	Vanderbilt Therapeutic Alliance Scale-Revised	Obs	30
36	Robbins et al. (2008)	C: sub	F	Out	15.46	50.0	E	Vanderbilt Therapeutic Alliance Scale-Revised	Obs	46
37	Robbins et al. (2003)	C: sub	MS	Out	12-18		E	Vanderbilt Therapeutic Alliance Scale-Revised	Obs	34
38	Santos (2005)[b]	P: oth	P	Com	0.38	2.2	C	Working Alliance Inventory	Par, prof	34
39	Sapyta (2006)[b]	C: mix	C	-	7-10	0.0	C, E	Working Alliance Inventory-Short Form	Parent	229
40	Schmidt et al. (2014)	C: ext	P	Com	7.01	30.1	C	Working Alliance Inventory-Short Form	Par, prof	125
41	Schrag (2005)[b]	C: ext	F	Out	10.09	0.0	E	Parent-Therapist Relationship Measure	Par, prof	123
42	Shelef and Diamond (2008)	C: sub	MS	Out	16.00	20.8	E	Vanderbilt Therapeutic Alliance Scale-Revised	Obs	34
43	Shelef et al. (2005)	C: sub	MS	Out	16.00	16.7	C, E	Vanderbilt Therapeutic Alliance Scale-Revised	Obs	65
44	Smith (2010)[b]	F	F	Mix	0-5	0.0	C, E	Working Alliance Inventory-Short Form	Parent	24
45	The Multisite Violence P. P. (2014)	C: ext	F	Sch	11-12		C, E	Parent Alliance with Provider	Par, prof	334
46	Trute & Hiebert-Murphy (2007)	C: mix	F	Com	4.00	0.0	E	Professional and Parent Alliance Scale	Parent	103

Note. Tmnt = Treatment; Outc. = Outcome; C: ext = Child: externalizing; C: int = Child: internalizing; C: sub = Child: substance abuse; C: eat = Child: eating disorders, C: mix = Child: mixed problems; P: par = Parent: parenting difficulties; P: oth = Parent: other problems; F = Family problems; C = Child-focused treatment, parent involved; P = Parent-focused treatment; F = Family-focused treatment; MS = Multisystem-focused treatment primarily targeting the family system; Co = Combination treatment; In = Inpatient; Out = Outpatient; Sch = School; Com = Community/home; Onl = Online; Day = Day treatment; Mix = Combination; C = Clinical outcomes; E = Treatment engagement; Par = Parent; Prof = Professional.
[a] Sample size reflects the total number of cases involved in alliance-outcome analyses.
[b] Dissertation

61.5% of them were boys (*SD* = 20.31, range 0 - 86.67). Most of the studies reported on the racial/ethnic composition of their sample (*n* = 36, 78.3%), indicating that 55.4% (*SD* = 28.86) of the samples consisted of Caucasian, 17.7% (*SD* = 24.33) of African American, 11.6% (*SD* = 21.24) of Latino American, and 15.3% (*SD* = 18.01) of other racial/ethnic participants. Furthermore, most of the studies (*n* = 36, 78.3%) reported on the number of study participants that dropped out of treatment or that did not provide complete study data. Non-response rates ranged from 3.7% to 81.8% (*M* = 30.60, *SD* = 20.17).

Type of Clients

Most study samples consisted of participants who were referred to treatment (*n* = 22). In other studies, participants were recruited for the purpose of the study (*n* = 1), were required to receive treatment by court order (*n* = 1), or samples were comprised of participants with varying referral sources (e.g., recruited, referred to treatment, and court/judicial system; *n* = 5). A final group of studies did not report on referral source (*n* = 17).

Half of the studies (*n* = 23) involved participants receiving treatment in outpatient settings, and another 28.3% (*n* = 13) focused on home or community based treatment. Treatment settings of other studies included online services (*n* = 2), inpatient treatment (*n* = 1), school-based treatment (*n* = 1), day treatment (*n* = 1), or a combination of settings (*n* = 4). Two studies did not report on treatment setting.

Treatment most often focused on child-related problems: mixed problems (*n* = 12), externalizing problems (*n* = 9), substance abuse (*n* = 6), internalizing problems (*n* = 3), or eating disorders (*n* = 3). Other studies focused on problems related to the parent or parenting (*n* = 4; e.g., parental depression, parent-child interaction), or the family (*n* = 5; e.g., child abuse and neglect). The remaining studies (*n* = 4) did not report a target problem.

Type of Treatment

Most studies (*n* = 19) assessed the parent-professional alliance as part of family-focused treatment or multisystemic treatment primarily targeting the family system. Other studies involved child-focused treatment in which parents were involved (*n* = 12), parent-focused treatment (*n* = 10), or a combination (*n* = 5). Based on studies reporting on treatment dose, treatment consisted on average of 17.61 sessions (*n* = 27, *SD* = 12.96; range 1.00 - 67.80), and spanned 31.92 weeks (*n* = 28; *SD* = 22.97; range 1.00 - 112.67). Finally, the majority of studies (*n* = 40) reported on the level of professional training. Most of the studies involved clinical professionals (*n* = 30), and one study involved graduate students. In nine studies, professionals of different training levels were involved (e.g., professionals and graduate students, professionals and paraprofessionals).

Measurement of Alliance

The included studies used 18 different measures to assess the parent-professional alliance. Almost half of the studies (45.7%) used the Working Alliance Inventory (WAI, *n* = 11; Tracey & Kokotovic, 1989) or the Working Alliance Inventory, Short Form (WAI-S, *n* = 10; Horvath & Greenberg, 1989). Other studies used the Vanderbilt Therapeutic Alliance Scale – Revised (VTAS-R, *n* = 6; Diamond, Liddle, Hogue, & Dakof, 1999), the Therapeutic Alliance Scale for Children (TASC, *n* = 2; Shirk & Saiz, 1992) or the Therapeutic Alliance Scale for Caregivers and Parents (TASC-P, *n* = 1; Accurso et al., 2013), the System for Observing Family Therapy Alliances (SOFTA, *n* = 2; Friedlander et al., 2006), the Helping Relationship Inventory (HRI, *n* = 2; Poulin & Young, 1997), the Family Engagement Questionnaire (FEQ, *n* = 2; Green et al., 2001; Kroll & Green, 1997), and the Therapy Process Observational Coding System for Child Psychotherapy – Alliance Scale (TPOCS-A, *n* = 2; McLeod & Weisz, 2005). Eight alliance measures were used in only one study. In addition to the variety of measures used to assess alliance, instruments and studies differed in their assessment of alliance dimensions, and in the way studies reported on alliance. Most studies (*n* = 30; 65.2%) assessed all three alliance dimensions (i.e., task, goal, bond), 11 studies assessed two dimensions (i.e., bond and task), and five studies assessed one alliance dimension.

Most studies assessed the parent-professional alliance with self-report measures (*n* = 34) or observational measures (*n* = 12). No study combined self-report and observational measures of alliance. With respect to the informant reporting on the parent-professional alliance, most studies (67.4%) relied on a single informant: 18 studies used parent reports, one study used professional reports, and 12 studies used observational reports. Other studies (*n* = 15) used parent and professional reports of alliance. Studies did not use reports of both informants to compute agreement scores on alliance. Regarding the timing of alliance assessment, most studies assessed alliance early in treatment (*n* = 20, 43.5%). Other studies used late (*n* = 1, 2.2%), post-treatment (*n* = 6, 13.0%), or averaged (*n* = 4, 8.7%) assessments.

Measurement of Outcomes

Regarding the measurement of treatment outcomes, studies reported on clinical outcomes (*n* = 20, 43.5%), treatment engagement (*n* = 9, 19.6%), or both (*n* = 17, 37.0%). Most of the studies (*n* = 16, 34.8%) used multiple measures (e.g., pre- and posttest) to assess outcomes. Some used retrospective measures (*n* = 7, 15.2%), treatment data (*n* = 7, 15.2%), or a combination of different kinds of measures.

Study Findings: Alliance-Outcome Association

Most of the studies performed multiple analyses regarding the association between alliance and outcome. We investigated whether studies reported (a) positive significant associations between alliance and outcome (i.e., higher levels of alliance relate to more positive outcomes), (b) non-significant associations (i.e., levels of alliance do not relate to outcome), (c) negative significant associations (i.e., higher levels of alliance relate to less positive outcomes, or lower levels of alliance relate to more positive outcomes), or (d) a combination of these associations. Below (see also Table 2), we describe study findings regarding the association between alliance and clinical outcomes, and the association between alliance and treatment engagement.

Alliance-Outcome Association: Clinical Outcomes

Of all included studies, 80.4% (*n* = 37) reported on the association between the parent-professional alliance and clinical outcomes. The majority of these 37 studies (*n* = 19, 51.4%) reported a combination of positive significant associations, and non-significant associations between alliance and outcome. These findings indicate that, in part of the analyses, higher levels of alliance were associated with more positive clinical outcomes on child, parent, or family level. In other analyses within the same study, alliance was not related to clinical outcomes. Eight studies (21.6%) only found positive significant associations, showing that higher levels of alliance were associated with more positive outcomes. Seven studies (18.9%) reported non-significant associations, indicating that alliance was not related to outcome. The remaining studies (*n* = 3, 8.1%) found a combination of negative significant associations and non-significant associations.

Table 2 Alliance-Outcome Association and Factors Influencing this Association

Study	Alliance rating	Alliance timing	Outcomes		Influencing factors	
			Clinical	Engagement	Methodological	Theoretical
Child-focused treatment (*n* = 12)						
1	PAR	Early	+	+ ns		
2	PAR	Early	+ ns	ns		Age
12	PAR	Early		+		
39	PAR	Early-late-averaged-change	ns	ns		
8	PAR	Mid-late	+ ns			Problem type, Age
19	PAR	Post	+			
21	PAR	Post	ns	+ ns	Domain, Informants A-O	
16	PROF	Early	+			
9	PAR,PROF	Early	ns	ns		
4	PAR,PROF	Early-change	+ ns		Timing A	
17	PAR,PROF	Early	ns -		Informant A	Problem type
29	PAR,PROF	Early-mid-late-change	+ ns		Informant A, Timing A	

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Study	Alliance rating	Alliance timing	Outcomes						Influencing factors	
			Clinical			Engagement			Methodological	Theoretical
Parent-focused treatment (*n* = 10)										
3	PAR	Early	+			+				
23	PAR	Late		ns	-				Informants A-O	
6	PAR	Post	+							
7	PAR	Post	+							
30	PAR	Multiple				+	ns		Timing O	
5	PAR	Unclear	+							
31	OBS	Early-change	+	ns					Timing A	
40	PAR,PROF	Early	+	ns		+	ns			Parent sex
38	PAR,PROF	Early-change	+	ns					Informant A, Timing A	
33	PAR,PROF	Unclear	+	ns		+				
Family-focused treatment (*n* = 19)										
18	PAR	Early		ns		+			Domain	
44	PAR	Early	+	ns		+				
14	PAR	Post				+				
25	PAR	Post	+	ns						Parent sex
46	PAR	Late-post				+				
11	PAR	Early-mid-late		ns		+	ns		Informants A-O, Domain	
10	OBS	Early		ns						
22	OBS	Early	+	ns					Informants A-O, Timing O	Problem type
36	OBS	Early				+				
37	OBS	Early					ns	-		Parent sex
43	OBS	Early		ns		+			Domain	
24	OBS	Early-mid-late	+	ns		+			Timing A	
32	OBS	Early-late-averaged	+	ns						
34	OBS	Early-late	+	ns		+	ns		Timing A	
35	OBS	Change				+				
42	OBS	Multiple					ns			
15	PAR,PROF	Early	+	ns					Informant A, Informants A-O	
41	PAR,PROF	Early				+	ns		Informant A	
45	PAR,PROF	Multiple		ns	-	+	ns			
Other (*n* = 5)										
13	OBS	Early	+	ns		+	ns			Age
20	PAR	Early	+	ns		+	ns		Informants A-O	Problem type
26	PAR,PROF	Averaged	+	ns		+	ns		Informants A-O	
27	PAR,PROF	Averaged	+	ns					Informant A, Informants A-O	
28	PAR,PROF	Averaged	+							

Note. PAR = parent; PROF = professional; OBS = observer; + = positive significant association; ns = non-significant association; - = negative significant association; Age = age child; Domain = outcome domain; A = alliance; O = outcome.

Alliance-Outcome Association: Treatment Engagement

With respect to the association between the parent-professional alliance and outcomes related to treatment engagement, 58.7% (*n* = 27) of the included studies provided data. Eleven of these 27 studies (40.7%) reported positive significant associations indicating that higher levels of alliance were associated with more positive treatment engagement outcomes (e.g., less drop-out). Another 11 studies (40.7%) reported a combination of positive significant associations and non-significant associations between alliance and treatment engagement. These studies showed that for some analyses higher alliance levels were associated with stronger treatment engagement whereas for other analyses in the same study the alliance was not significantly related to treatment engagement. Furthermore, four studies (14.8%) only found non-significant associations, indicating that alliance was not related to outcome. Finally, one study (3.7%) found mixed findings that included negative significant associations (i.e., higher levels of alliance related to poor treatment engagement) as well as non-significant associations between alliance and treatment engagement.

Study Findings: Factors Influencing the Alliance-Outcome Association

Below (see also Table 2), we describe factors that may influence the strength of the association between the parent-professional alliance and outcomes of child-, parent-, and family-focused treatment, as suggested by included studies. Twenty-five of the studies provided information about such variables. We differentiate between theoretical factors (i.e., factors related to the content and context of treatment) and methodological factors (i.e., factors related to the assessment of alliance and outcome) of the alliance-outcome association.

Factors Influencing the Alliance-Outcome Association: Theoretical Factors

Nine of the 25 studies provided information about theoretical factors influencing the alliance-outcome association. Studies identified three theoretical factors. First, four of these nine studies indicated that the alliance-outcome association differed depending on the nature of children's problems. Three of these studies (Green et al., 2001; Hawley & Garland, 2008; Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006) distinguished between outcomes related to internalizing and externalizing problem behavior. While problem type seemed to influence the alliance-outcome association, studies presented mixed findings on the nature of this effect. Two studies (Hawley & Garland, 2008; Hogue et al., 2006) described a positive significant association such that higher levels of alliance were linked to lower levels of child externalizing behavior, and a non-significant association between alliance and child internalizing behavior. In contrast, a third study (Green et al., 2001) reported opposite effects: a negative significant association for

internalizing such that a higher alliance was linked to lower levels of child functioning (i.e., more internalizing problems), and a non-significant association between alliance and other child functioning measures. A fourth study (Davis, 2007) showed a significant positive association linking a strong alliance to better maternal functioning for mothers with children diagnosed with pervasive development disorder not otherwise specified, but not for mothers with children diagnosed with autism.

Second, three studies indicated that children's age influenced the alliance-outcome association. Here again, available studies presented mixed results. Two studies (Anderson et al., 2012; Gatta et al., 2012) found a positive significant association such that a strong parent-professional alliance was related to improved adolescent, but not child, clinical improvement. One of these studies (Gatta et al., 2012), however, reported a positive significant association between alliance and compliance for children, but not for adolescents. A third study (Davis, 2007) reported a positive significant association between alliance and maternal functioning for mothers with younger children (< 36 months), but not for mothers with older children (> 36 months).

Third, three of the nine studies reporting on theoretical factors indicated that parent sex was associated with the strength of the alliance-outcome association. Two of these studies (Robbins, Turner, Alexander, & Perez, 2003; Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014) showed that the strength of the alliance-outcome association depended on which parent reported on alliance. One study (Schmidt et al., 2014) described a positive significant alliance-outcome association for mother-, but not father-reported alliance. The other study (Robbins et al., 2003) found a negative significant association for composite scores (i.e., combined father and mother reports of alliance with professional), and non-significant alliance-outcome associations for individual parent-professional alliances. A third study (Johnson, Wright, & Ketring, 2002) reported that significant alliance-outcome associations were found for different alliance subscales for mothers and fathers: for mothers, a significant alliance-outcome association was explained by the task subscale, not by goal or bond subscales; for fathers, a significant alliance-outcome effect was explained by the goal subscale, not the task or bond subscales.

Factors Influencing the Alliance-Outcome Association: Methodological Factors

The majority of the 25 studies that provided information about factors that influenced the alliance-outcome association, reported on methodological factors (*n* = 19), five factors in total. First, eight of these 19 studies indicated that the alliance-outcome association was stronger when both alliance and outcome were reported by the same informant, compared to different informants (Friedlander, Kivlighan, & Shaffer, 2012; Granic et al., 2012; Hawley & Garland, 2008; Hawley & Weisz, 2005; Hogue et al., 2006; Hukkelberg & Ogden, 2013; Kazdin, Marciano, & Whitley, 2005; Kazdin, Whitley, & Marciano, 2006).

Second, six of the 19 studies showed that source of alliance measurement affected the alliance-outcome association, albeit these findings were mixed. With respect to the predictive value of parent versus professional-reported alliance, two studies (Granic et al., 2012; Green et al., 2001) indicated that the alliance-outcome association was stronger for professional-reported alliance, while two other studies (Kazdin et al., 2006, Schrag, 2005) found that the alliance outcome association was stronger for parent-reported alliance. A final two studies (Keeley, Geffken, Ricketts, McNamara, & Storch, 2011; Santos, 2005) presented mixed findings.

Third, six of the 19 studies also presented mixed findings for the alliance-outcome association depending on the timing of alliance measurement. Two studies (Isserlin & Couturier, 2012; Keeley et al., 2011) reported mixed alliance-outcome effects for differently timed alliance assessments, while four studies indicated that the alliance-outcome association was stronger when alliance was assessed later in treatment (Pereira, Lock, & Oggins, 2006), or when change in alliance was used as predictor variable (Bickman et al., 2012; Lerner, Mikami, & McLeod, 2011; Santos, 2005), compared to alliance assessed early in treatment.

Fourth, four of the 19 studies suggested that outcome domain (i.e., clinical outcomes or treatment engagement) influenced the alliance-outcome association. These studies (Friedlander et al., 2012; Guzder, Bond, Rabiau, Zelkowitz, & Rohar, 2011; Hawley & Weisz, 2005; Shelef, Diamond, Diamond, & Liddle, 2005) assessed the association between alliance and clinical outcomes, and the association between alliance and treatment engagement. All studies found a positive significant association between alliance and treatment engagement, and non-significant associations for clinical outcomes.

Fifth, two of the 19 studies reported mixed results regarding the effect of the timing of outcome assessment on the alliance-outcome association. One of these studies (Hogue et al., 2006) showed that the association between alliance and adolescent clinical outcomes was stronger for earlier assessed outcomes (i.e., post-treatment) compared to outcomes assessed later (i.e., 6-month follow-up). The other study (Korfmacher, Green, Spellman, & Thornburg, 2007) presented mixed results regarding the role of outcome assessment timing in affecting the alliance-outcome association.

Discussion

This systematic review focused on the association between the parent-professional alliance and outcomes of child, parent and family treatment, and factors influencing this association. With respect to outcomes, we distinguished between outcomes related to clinical outcomes and treatment engagement. Regarding factors potentially

influencing the alliance-outcome association, we differentiated between theoretical and methodological factors. Most studies found that higher levels of parent-professional alliance were associated with improved clinical outcomes for involved children, parents and families. Furthermore, most studies found that higher levels of alliance were associated with stronger treatment engagement, such as lower levels of drop-out. However, a number of studies found that the parent-professional alliance was not significantly related to outcomes, and a few studies showed that higher levels of alliance were related to less positive outcomes. Overall, our review shows that a stronger parent-professional alliance was generally linked with positive outcomes, but that this did vary across samples.

Regarding factors that may influence the strength of the alliance-outcome association, a little more than half of the studies provided information about such variables. Together, these studies identified three theoretical factors (problem type, child age, and parent sex) and five methodological factors (alliance and outcome reported by the same informant, source of alliance measurement, timing of alliance measurement, outcome domain, and timing of outcome assessment) that may influence the alliance-outcome association. Findings indicated that the alliance-outcome association was stronger when the alliance was assessed later in treatment or based on change scores (as opposed to alliance assessed early in treatment), and when studies assessed treatment engagement instead of clinical outcomes. Furthermore, the alliance-outcome association was more likely to be significant when the alliance and outcome were reported by the same informant as compared to different informants, due to shared method variance (McLeod, 2011). Finally, regarding the role of the nature of children's problems, children's age, parent sex, source of alliance measurement, and timing of outcome measurement, studies presented mixed results. As a result, it was not possible to draw clear-cut conclusions on how these factors may influence the association between the parent-professional alliance and outcome.

Overall, the present findings regarding the alliance-outcome association are largely consistent with previous meta-analyses, indicating that a positive alliance is associated with more positive outcomes in adult (Hubble et al., 2010; Norcross, 2010), child (McLeod, 2011) and family (Friedlander et al., 2011) treatment. However, consistent with meta-analyses that focused on child, parent, and family treatment (Friedlander et al., 2011; McLeod, 2011), the current study also indicated that a number of studies did not find significant alliance-outcome associations, which raises questions about the overall strength of the alliance-outcome association in this literature. In addition to previous meta-analyses, this review also found that findings regarding the nature and strength of the alliance-outcome associations not only differed between studies, but also differed within studies. These findings highlight the need for future studies to identify specific circumstances in which the parent-professional alliance is more or less important in predicting clinical outcomes and treatment engagement.

In line with previous studies (e.g., Friedlander et al., 2011), this review indicated that for the parent-professional alliance, a limited number of studies provided direct tests of factors influencing the association between the parent-professional alliance and outcomes. Still, our review suggests that some of the factors that have been found to influence the alliance-outcome association in previous meta-analyses (McLeod, 2011) may have a similar influence in this study set: outcome domain, timing of alliance assessment, and the use of a single informant for alliance and outcome. In addition to previous meta-analyses, studies included in the current review also indicated that parent sex may influence the alliance-outcome association. Although studies mainly focused on the mother-professional alliance, and findings did not permit definitive conclusions, studies do highlight the need to investigate the role of parent sex in the alliance-outcome association. Parent sex may influence the alliance-outcome association, given the possibly different dynamics in mother-professional and father-professional alliances, mother-father differences in parenting styles (Russell et al., 1998) and relationships with children in the family (Minuchin, 1985).

However, regarding the effects of several other factors influencing the alliance-outcome association, current findings showed discrepancies with findings of previous studies. Although this review indicated that child age, problem type, and source of alliance assessment influenced the alliance-outcome association, available knowledge was too limited and mixed to provide clear conclusions. One explanation for this discrepancy is that we compared findings within studies, while previous studies compared findings across studies using meta-analytic techniques. Another explanation is that the dynamics in the parent-professional alliance and its association with outcome, may differ from the child-professional alliance (Hawley & Weisz, 2005). Thus, additional studies investigating factors influencing the alliance-outcome association, both original as well as meta-analytic studies, are needed to test this assumption.

Finally, in contrast to the meta-analysis of McLeod (2011), a review of the studies did not reveal any trends related to referral source potentially impacting the alliance-outcome association. Most studies did not suggest an influence of treatment mode (i.e., child-focused, parent-focused, family-focused), although a relatively large percentage of studies on parent-focused treatment did report positive significant alliance-outcome associations. This finding suggests that professionals should be aware of the important, yet possibly treatment-mode specific role of the parent-professional alliance in promoting positive outcomes. For future studies, it is necessary to further investigate the role of treatment mode and referral source in the context of the alliance-outcome association using meta-analytic techniques that are well-suited for testing the potential moderating role of these two factors. Furthermore, future studies need to be sensitive to the specific dynamics of different treatment modes when investigating the role of the parent-professional alliance in predicting outcomes of child, parent, and family treatment.

Major strengths of this systematic review were the specific focus on the parent-professional alliance, and the focus on child-, parent-, and family-focused treatments designed to improve the situation of children by involving parents. As a result, this study offered an overview of all available knowledge on the importance of the parent-professional alliance for outcomes of child-, parent-, and family-focused treatment. Furthermore, in contrast to previous studies, this review provided information on the association between the parent-professional alliance and outcomes related to clinical outcomes and treatment engagement. Finally, this study was the first to synthesize available knowledge on factors influencing the association between the parent-professional alliance and treatment outcomes.

Several limitations need to be kept in mind when interpreting these findings. First, we did not systematically assess the quality of the included studies, since the aim of our review was to provide an overview of the available knowledge on the association between the parent-professional alliance and outcomes of child, parent, and family treatment, independently of study characteristics. Still, since we only included studies fitting our inclusion criteria, the quality of selected studies benefited from the exclusion of studies with small sample sizes, descriptive or qualitative studies, and studies not being dissertations or not having been published in peer reviewed journals.

Second, the possibility of publication or reporting bias needs to be considered, since studies with non-significant findings are less likely to be published and published studies may have omitted non-significant findings (McLeod & Weisz, 2004). Although we included unpublished dissertations in this review to restrict effects of publication bias, it is unclear whether studies have been conducted but never reported (Rosenthal, 1979), and whether studies were biased in reporting mainly significant findings.

Notwithstanding these caveats, this review showed that it is necessary to further and more in depth investigate the role of the parent-professional alliance, given its importance in promoting positive outcomes in the field of child-, parent-, and family-focused treatment. The alliance in parent-focused treatment warrants special attention, given the paucity of studies and the key role of the parent-professional alliance in this type of treatment.

We suggest that future studies investigate the strength of the association between the parent-professional alliance and treatment outcomes, combined with the identification of factors and patterns influencing alliance formation or the strength of the alliance-outcome association. These studies are crucial. They provide professionals, educators and policy makers with more knowledge on how important the parent-professional alliance may be for outcomes, and they also provide suggestions on how best to optimize and monitor the quality and development of alliance. More specifically, it is

useful when studies investigate how the interplay between parent, professional and case characteristics (e.g., sex, target problem, referral source, treatment mode) relates to alliance quality and alliance-outcome associations. Furthermore, it is relevant to know which measure of alliance (e.g., reported by parent, professional, observer, combined parent and professional scores; task, goal or bond alliance; early, late, change scores, developmental trajectories of alliance) is most useful in predicting clinical outcomes and treatment engagement. Finally, to understand more fully the development of alliances and the association of alliance and outcome in different treatment modes, it is useful to apply validated and clinically relevant alliance instruments that match the specific dynamics of these treatment modes. We may also consider complementing research designs and statistics based on traditional linear models of causality, with methods derived from dynamic systems research (Lewis, 2000). This more developmental approach (Granic & Hollenstein, 2003) looks at clinical collaboration as a process of continuous and nonlinear interplay between client, professional, process and context variables, which is in line with the complex nature of everyday practice (Hubble et al., 2010).

Together, the findings in this review emphasize the importance of alliance awareness when working with parents, as well as a need for future studies to investigate factors influencing the quality of alliance and alliance-outcome association. This will serve (future) professionals in working effectively with parents. More importantly, it will serve the interests of children and parents who rely on treatments in the field of child, parent and family treatment.

Chapter 3

Predictive value of parent-professional alliance for outcomes of home-based parenting support

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Abstract

Home-based parenting support within youth care services is one of the key interventions provided to families encountering difficulties with child rearing and child development. However, knowledge on factors contributing to positive outcomes of home-based parenting support is limited. The current study investigated the predictive value of (1) early parent-professional alliance and (2) change in alliance during care for outcomes of home-based parenting support. Multi-informant self-report alliance and outcome data from 146 parents (*M* age = 40.00, *SD* = 7.10; range 19-57 years) and their professionals collected early and late in care were analyzed using latent growth curve modeling. Findings demonstrated that higher levels of early parent-reported alliance predicted higher levels of parent-reported satisfaction with care, and improved parent functioning. Higher levels of early professional-reported alliance predicted higher levels of parent- and professional-reported of satisfaction, and improved parent functioning. Increases in professional-reported alliance during care predicted higher levels of professional-reported satisfaction and parent functioning but were not related to parent-reported outcomes. Change in parent-reported alliance was not related to outcomes. Together, our findings suggest that a strong parent-professional alliance represents a key process factor in realizing positive outcomes of home-based parenting support. Consequently, efforts in research and practice are needed to investigate precursors of strong alliances and to optimize professionals' ability to develop and maintain strong parent-professional alliances.

Introduction

Youth care systems provide services to families that need assistance as a result of difficulties related to parenting or child development. Within the youth care service sector (hereafter referred to as *youth care*) home-based parenting support is a key service provided to families. Of all the families involved in youth care services, ranging from home-based services to residential treatment, the majority (around 80%) receive home-based parenting support (Barth et al., 2005; Child Welfare Information Gateway, 2014; Statistics Netherlands, 2015). Providers of home-based parenting-support services (e.g., child welfare agencies, community-based youth care organizations) aim to promote parental competencies (Barth et al., 2005; Whittaker & Cowley, 2012) and thereby optimize children's development (Lewis, Feely, Seay, Fedoravicis, & Kohl, 2016), oftentimes with the goal of trying to preserve families. Although these services are important, they have undergone relatively little empirical examination (Barth et al., 2005). As a result, knowledge about factors contributing to positive outcomes of home-based parenting support is scarce.

One factor that may play an important role in facilitating positive outcomes in parent-focused services is the parent-professional alliance. The alliance can be defined as a collaborative client-professional relationship involving a positive and supportive bond, agreement on treatment goals, and agreement on tasks to be performed to accomplish these goals (Elvins & Green, 2008; Smith, Msetfi, & Golding, 2010). Numerous studies conclude that a strong alliance predicts positive outcomes of individual adult treatment (Horvath, Del Re, Flückiger, & Symonds, 2011; Hubble, Duncan, Miller, & Wampold, 2010; Martin, Garske, & Davis, 2000; Norcross, 2010) and family treatment (Friedlander, Escudero, Heatherington, & Diamond, 2011) across a variety of theoretical orientations and diagnoses. Although less studied, previous meta-analyses also indicate that a strong parent-professional alliance predicts positive outcomes of youth treatment (McLeod, 2011; Shirk, Karver, & Brown, 2011).

Based on these findings, it is reasonable to expect that a strong parent-professional alliance may contribute to positive outcomes of home-based parenting support. Parents are the main target of service and improvements in children's functioning mainly depend on the parents' ability to improve their parenting skills. Moreover, parents likely present to these services with varying levels of motivation, especially for court-mandated cases (Faver, Crawford, & Combs-Orme, 1999; McWey, Holtrop, Stevenson Wojciak, & Claridge, 2015; Staudt, 2007). For these reasons, a professional's ability to develop and maintain a positive alliance with parents may be important to engage parents in services and thereby realize positive outcomes. Surprisingly though, the parent-professional alliance, especially in parent-focused care, is largely understudied (De Greef, Pijnenburg, Van Hattum, McLeod, & Scholte, 2017). Consequently, it remains

unknown how important the parent-professional alliance is for home-based parenting support outcomes.

To our knowledge, only two studies have examined the association between the parent-professional alliance and outcomes of parenting support in youth care samples. First, Hukkelberg and Ogden (2013) examined the relation between alliance and children's externalizing problem behaviors in a sample of 331 parents involved in Parent Management Training-Oregon model following recruitment from youth care organizations. Higher levels of late parent-reported alliance predicted less change in parent-reported child problem behavior from start to post-treatment and were not related to change in teacher-reported problem behavior. Second, Schmidt, Chomcycz, Houlding, Kruse, and Franks (2014) studied the alliance-outcome association in a sample of 117 families involved in a group Triple P intervention. A little more than half of the parents had past involvement or were currently involved in youth care services. Higher levels of early parent-reported alliance predicted greater improvement in parenting skills, parental sense of competence, and child conduct problems. Therapist-reported alliance only predicted therapist-reported evaluation of parent progress and improvement.

Two additional studies have investigated the association between the parent-professional alliance and outcomes of home-based services for families. First, Girvin, DePanfillis, and Daining (2007) examined the association between alliance and program completion in a sample of 136 families enrolled in Family Connections, a home-based child neglect preventive intervention. Parents who completed services reported higher levels of parent-reported alliance at post-treatment compared to noncompleters. Second, Korfmacher, Green, Spellmann, and Thornburg (2007) studied the association between the alliance and program participation in a sample of 728 families involved in voluntary and preventive early childhood home visiting services. Parent-reported alliance was associated with higher concurrent levels of parent-reported program satisfaction and higher levels of professional-reported family-involvement. Parent-reported alliance did not predict subsequent levels of program satisfaction or drop-out.

The findings from these four studies suggest that a strong alliance might be related to positive outcomes of home-based parenting support provided to youth care samples. However, the direction and strength of these effects differed within and between studies. Moreover, since these studies focused on evidence-based (group) interventions (Hukkelberg & Ogden, 2013; Schmidt et al., 2014) or preventive interventions (Girvin et al., 2007; Korfmacher et al., 2007) it is questionable whether the findings generalize to usual care. Parenting support is usually provided in-home to individual families (Barth et al., 2005) and evidence-based interventions are underused in youth care (Barth et al., 2005; Horwitz, Chamberlain, Landsverk, & Mullican, 2010; Veerman & De Meyer, 2015).

Indeed, home-based parenting support services in youth care are typically eclectic, non-protocolized, and grounded in various approaches (e.g., Intensive Family Treatment; Veerman & De Meyer, 2015). Moreover, parenting support in youth care is typically provided to families with already developed and often severe psychosocial problems related to parenting, child functioning and parent-child interaction. To help establish if findings from previous studies will generalize it is important to evaluate the alliance-outcome association in typical care.

In this paper, we investigated the alliance-outcome association in home-based parenting support and we employed several methodological features to strengthen the interpretability of our findings. First, we assessed the alliance and outcomes from the perspective of parents and professionals, as previous studies indicated that client- and professional-reports of alliance might differ (Hawley & Garland, 2008). Client- and professional-reports might also be differentially related to outcomes, with stronger associations for client-reported alliance (Hawley & Garland, 2008; Schmidt et al., 2014). Moreover, studies showed that the alliance-outcome association is stronger when the same informants report on both alliance and outcome (De Greef et al., 2017; McLeod, 2011). The use of multiple-informant data enables us to investigate the association between parent- and professional perceptions of the alliance and whether these perspectives are differentially related to outcomes. Second, we assessed alliance early in care (i.e., first half) to avoid potential confounding with improved client functioning (Kazdin, 2007; McLeod, 2011). Third, we assessed the alliance multiple times to investigate if the alliance changed over the course of care (Chu, Skriner, & Zandberg, 2013; Kendall et al., 2009). Also, investigating the predictive value of early alliance and change in alliance informs professionals about the potential importance of establishing and maintaining positive alliances for positive outcomes of home-based parenting support. Fourth, alternative third-variable explanations that may account for the alliance-outcome association were evaluated. Finally, we used the Working Alliance Inventory, Short Form to assess the alliance, which has strong score reliability and validity.

To expand on previous studies, we examined the predictive value of the parent-professional alliance for outcomes of home-based parenting support in youth care settings, using two-wave data from a sample of 146 parent-professional dyads. We investigated whether early alliance and change in alliance predicted satisfaction with the process and outcomes of care, and changes in parent functioning. We hypothesized early alliance and increases in alliance to be positively related to outcomes. Further, we expected that the alliance-outcome association would be stronger for parent-reported alliance compared to professional-reported alliance. Finally, we expected the alliance-outcome association to be stronger when the same informant reported on alliance and outcome as opposed to different informants.

Method

Participants

Participants were 146 parents (*M* age = 40.00 years, *SD* = 7.10; range 19-57 years) drawn from nine Dutch youth care organizations providing home-based parenting support to target severe psychosocial problems related to parenting, child behavior, and parent-child interaction. As these often multiple and interacting problems put the development of children in these families at risk, home-based parenting support also aims at preventing out-of-home care. On average, parents (89.0% female) received support for 6.64 months (*SD* = 2.31; range 2.60-20.01) for 1.80 hours (*SD* = 0.98; range 0.50-5.00) a week. Some parents (12.5%) were required to receive services by court order. The majority of parents were born in the Netherlands (90.4%), others were born in another Western (2.7%) or Non-Western (6.9%) country. Children were mostly boys (60.4%) and were between 1 and 19 years old (*M* = 10.74 years, *SD* = 4.37). Services were part of routine practices in participating youth care organizations, meaning that services were eclectic, non-protocolized, and grounded in various approaches (e.g., Intensive Family Treatment; Veerman & De Meyer, 2015). Ninety-one professionals (*M* age = 43.89 years, *SD* = 10.49; range 23-62 years) provided services to one to five families (*M* = 1.60, *SD* = 0.89). The majority of professionals were female (92.3%), born in the Netherlands (97.8%), and held a professional bachelor degree (88.4%). Their average level of experience as a provider of home-based services was 8.40 years (*SD* = 6.17, range = 4 months-36 years).

Procedure

Professionals providing home-based parenting-support asked parents to participate in this study when they were admitted to or just started care. Parents were excluded from study participation if children (age 0-21) were not living at the parents' home (e.g., residential facility or foster family) or if the start of parent-professional collaboration was the result of assigning a new professional to the case. Parents were given written information about the study and were informed that refusal to participate in the study did not exclude them from access to services. A total number of 241 parents met inclusion criteria, agreed to participate, and completed permission forms. Subsequently, parents and professionals completed T_1 questionnaires. To be included in the analyses, parents and professionals needed to meet our criteria for T_1 measurement by completing T_1 questionnaires in early phases (i.e., first half) of care; 146 cases met this requirement. Of these 146 parent-professional dyads, 107 parents and 143 professionals completed T_2 questionnaires at the end of services or at the end of the study period. Since professionals were instructed to select cases for study participation where the expected

end of care did not exceed the study period, we consider the timing of T_2 assessments to be late in care. Parents and professionals had no access to each other's answers. All procedures were institutional review board approved.

Measures

Alliance

At T_1 and T_2, the alliance between parents and professionals was assessed with the Working Alliance Inventory, Short Form (WAI-S; Tracey & Kokotovic, 1989). The WAI-S consists of 12 items. Four items assess task-related elements of the alliance (e.g., "My professional and I agree about things I will need to do in care to help improve my situation"), four items assess goal-related elements (e.g., "My professional and I are working towards mutually agreed upon goals"), and four items assess bond-related elements of the alliance (e.g., "I believe my professional likes me"). Answers are given on a 5-point scale ranging from 1 (never) to 5 (always). WAI-S scores have shown strong internal consistency in parent samples (Granic, Otten, Blokland, Solomon, Engels, & Ferguson, 2012; Hukkelberg & Ogden, 2016), and predictive validity for care outcomes (Keeley, Geffken, Ricketts, McNamara, & Storch, 2011). Total scales showed strong internal consistency in the current sample (parent version: α T_1 = .94, α T_2 = .93; professional version: α T_1 = .92, α T_2 = .96). Parents and professionals completed separate but identical versions of the WAI-S.

Satisfaction with care

At T_2, we used the EXIT questionnaire (Jurrius, Havinga, & Stams, 2008) to derive information on parents' and professionals' satisfaction with the care received or offered. The EXIT questionnaire, a standard instrument in the Dutch youth care system, consists of 11 items and two subscales. Four items assess satisfaction with the care process (e.g., "The care offered by this professional went well"), six items assess satisfaction with care results (e.g., "As a result of the provided care I have more confidence in the future"). Answers are given on a four-point scale, ranging from 1 (totally disagree) to 4 (totally agree). A final item of this questionnaire asks for a grade (1-10) to assess general satisfaction with the provided care. To ensure that all outcome measures could be reported by parents and professionals, we developed a professional version of the EXIT questionnaire for the purpose of this study. The parent version of this scale has demonstrated strong internal consistency in previous studies (Stichting Alexander, 2008) and the current sample (α care process = .89, α care results = .84). Analyses in the current sample indicated that the psychometric qualities of the professional version (α care process = .77, α care results = .84) are also adequate.

Global change in parent functioning

At T_2, we used the global measure of change (Alexander & Luborsky, 1986; Stinckens, Ulburghs, & Claes, 2009) to assess global change in parent functioning during care trajectories. Both parents and professionals evaluated the extent to which they perceived the situation of parents to be changed as a result of provided care (i.e., “Since I started to collaborate with this professional, my situation got…”). Answers are given on a 9-point Likert-scale, ranging from -4 (very much worse) to 4 (very much better). Previous studies investigating the association between alliance and treatment outcome used this instrument to assess treatment outcome (e.g., Stinckens et al., 2009). Moreover, previous studies indicated that both the client and the therapist version of this single question demonstrated high correlations with more extensive measures to assess clients’ development during care (Hatcher & Gillaspy, 2006), and produced similar patterns of correlations with alliance as more extensive change measures did (Hatcher, 1999).

Statistical Analyses

The effects of early alliance and alliance change on outcomes were investigated by means of latent growth curve models (LGM) within a structural equation modeling (SEM) framework (Bollen & Curran, 2006) in Mplus 7.3 (Muthén & Muthén, 1998-2012). Note that a typical LGM with equally spaced assessments is not identified with only two waves of data. However, when times of assessment are varying across individuals, as was the case in our study, it becomes possible to estimate all standard LGM parameters. By applying the TSCORES option in Mplus, the program accommodates individual slope loadings via the implementation of definition variables. This involves creating a set of slope factor loadings unique to each individual, in our case based on the time intervals (in months) between the start of care and the alliance assessments.

Analyzing (correlates of) change by means of LGM in Mplus has several advantages. First, change in alliance is modeled as a latent factor. As pointed out by Raykov (1999), modeling change on a latent dimension is often a better approach than modeling observed change scores (see also Voelkle, 2007). Whereas observed change scores contain measurement error, the latent slope within an LGM represents the true difference score. Second, by using LGM with individually varying times of observation we were able to account for the individual differences in timing of the T_1 and T_2 assessments. Thus, the intercept and slope become clearly interpretable as the level of alliance at the start of care and the monthly increase in alliance during care, respectively. Third, we were able to make use of all available data and provide better estimations of standard errors when normality assumptions are violated by applying a full-information maximum likelihood (FIML) estimator with robust standard errors, implemented as MLR in Mplus. Finally,

non-independence of observations due to the fact that clients were nested within professionals could be accounted for by means of the sandwich variance estimator (Type=COMPLEX) as implemented in Mplus. The sandwich estimator produces corrected standard errors for non-independent data.

In our models the outcome variables were regressed on the intercept and slope factors to investigate the effects of early alliance and alliance change on outcomes, respectively. Separate models were specified for parent and professional reported alliance. Moreover, we examined whether the associations between alliance and outcome held when controlling for a series of background variables (i.e., client characteristics: child age and sex, parent age, sex and ethnicity; case characteristics: court ordered care; professional characteristics: age, sex, ethnicity, work experience). We collectively added these background variables to our models, and specified paths from these variables to the intercept and slope factors and outcome variables.

Results

Preliminary Analyses

On average, the first time point for selected cases (n = 146) fell a little over two months after admission (*M* parents: 2.33, *SD* = 1.21; range 1 week-6.3 months, *M* professionals: 2.34, *SD* = 1.12; range 2 weeks-6.8 months). Parents (*n* = 107) and professionals (n = 143) completed T_2 questionnaires (parents: M months after T_1 = 3.71, *SD* = 1.72; range 1.38-13.80, professionals: *M* months after T_1 = 3.93, *SD* = 1.40; range 1.68-8.77) at the end of services or at the end of the study period. The selected sample did not differ from the total sample (*n* = 241) on demographic variables (age, sex, ethnicity) or parent's voluntary or mandated involvement in services. Data were missing completely at random (Little's missing completely-at-random test χ = 52.42, *df* = 40, *p* = .09) and missingness was not related to parent- or professional-reported alliance at T_1. We thus used a full-information maximum likelihood (FIML) estimator with robust standard errors, implemented as MLR in Mplus to address the missing data. As a result, we could make use of all available data (*n* = 146).

Means and standard deviations of alliance and outcome variables are presented in Table 1. Both parents and professionals reported high levels of early and late alliance, with parents reporting significantly higher levels of alliance (early: $t(145) = 9.11$, $p < .001$; late: $t(103) = 7.34$, $p < .001$), satisfaction with care (process: $t(89) = 6.06$, $p < .001$; results: $t(89) = 3.72$, $p < .001$; grade: $t(102) = 8.00$, $p < .001$), and change in parent functioning ($t(103) = 2.75$, $p < .01$).

Table 1 Means and Standard Deviations for Alliance and Outcome Variables

	Parent-report		Professional-report		
	M	*SD*	*M*	*SD*	*p* <
Early alliance	4.36	0.57	3.89	0.51	.001
Late alliance	4.46	0.46	3.90	0.62	.001
Satisfaction: Process	3.67	0.42	3.31	0.38	.001
Satisfaction: Results	3.25	0.49	3.00	0.46	.001
Satisfaction: Grade	8.20	0.98	7.11	0.93	.001
Change in parent functioning	2.32	1.21	1.84	1.15	.01

Means and variances for intercepts and slopes of alliance variables are presented in Table 2. Intercept means showed parents' and professionals' high mean levels of early alliance; their significance indicates that scores significantly differed from zero (which is trivial for ratings on a 1-5 scale). Intercept variances indicated that there are substantial individual differences in early parent- (σ^2 = .14, p < .001) and professional-reported (σ^2 = .25, *p* < .001) alliance. However, slope means and variances revealed no significant change in alliance over time, and no significant variation in alliance change across cases (parent-reported alliance: *M* = .01, *p* = .32; σ^2 = .001, *p* = .56; professional-reported alliance: *M* = -.01, *p* = .68; σ^2 = .005, *p* = .10). Correlational analyses showed strong correlations between early and late alliance ratings from parents (*r* = .52, *p* < .001) and professionals (*r* = .56, *p* < .001). Correlations between parent- and professional-reported alliance indicated a moderate relation between both reports early in care (*r* = .33, *p* < .001), and a small and non-significant relation in late phases (*r* = .16, *p* = .12).

Table 2 Means and Variances for Intercepts and Slopes of Alliance Variables

	Intercept		Slope	
	M	σ^2	*M*	σ^2
Parent-reported alliance	4.36***	.14***	.01	.001
Professional-reported alliance	3.91***	.25***	-.01	.005

Note. *** *p* < .001.

Early Alliance Predicting Outcome

We examined whether parent- and professional-reported alliance predicted parent- and professional-reported satisfaction with care and change in parent functioning, using a

series of regression analyses. Table 3 shows the unstandardized regression coefficients for the effects of early alliance and alliance change on outcome variables. With respect to the predictive value of early alliance, we found a positive significant relation between parent-reported alliance and parent-reported satisfaction with care (process: B = .87, $p < .001$; results: B = .72, $p < .001$; grade: B = 1.99, $p < .001$), and change in parent functioning (B = .95, $p < .001$). Also, early parent-reported alliance significantly predicted higher levels of professional-reported satisfaction with the care process (B = .28, $p < .001$) and results (B = .22, $p < .001$), but did not evidence a significant relation with professional-reported general satisfaction with care (grade: B = .15, $p = .07$) and change in parent functioning (B = .07, $p = .33$). Thus, a strong parent-reported alliance early in care predicted higher parent- and professional-reported levels of satisfaction with care, and parent-reported improvement in parent functioning as assessed late in care trajectories.

Second, regarding the predictive value of early professional-reported alliance we found that alliance significantly predicted higher levels of satisfaction as reported by parents (process: B = .25, $p < .001$; results: B = .34, $p < .001$; grade: B = .91, $p < .001$) and professionals (process: B = .54, $p < .001$; results: B = .63, $p < .001$; grade: B = 1.16, $p < .001$). Moreover, alliance was also found to be a significant predictor of parent- and professional-reported change in parent functioning (parent: B = .87, $p < .001$; professional: B = .83, $p < .001$). Thus, a strong professional-reported alliance early in care predicted higher parent- and professional-reported levels of satisfaction with care and improvement in parent functioning as assessed late in care trajectories.

Change in Alliance Predicting Outcome

We examined whether changes in parent- and professional-reported alliance during care predicted parent- and professional-reported satisfaction with care and change in parent functioning (see Table 3). We found that changes in parent-reported alliance were not significantly related to parent- or professional reported outcomes. However, we found a positive significant relation between increases in professional-reported alliance and professional-reported satisfaction with care (process: B = 3.93, $p = .01$; results: B = 5.67, $p < .01$; grade: B = 13.69, $p < .01$), and change in parent functioning (B = 10.32, $p = .01$). Changes in professional-reported alliance were not significantly related to parent-reported outcome variables. Thus, improved professional-reported alliances over the course of care predicted higher levels of professional-reported satisfaction with care and improvement in parent functioning as assessed late in care.

Table 3 Unstandardized Regression Coefficients for the Effects of Early Alliance and Change in Alliance on Outcomes

	Parent-reported outcomes				Professional-reported outcomes			
	Satisfaction: Process	Satisfaction: Results	Satisfaction: Grade	Change in functioning	Satisfaction: Process	Satisfaction: Results	Satisfaction: Grade	Change in functioning
	B	B	B	B	B	B	B	B
Alliance: Parent-report								
Intercept	.87***	.72***	1.99***	.95***	.28***	.22***	.15	.07
Slope	7.66	4.89	9.00	8.27	4.37	7.44	13.10	9.06
Alliance: Professional-report								
Intercept	.25***	.34***	.91***	.87***	.54***	.63***	1.16***	.83***
Slope	.76	2.28	2.97	4.73	3.93**	5.67**	13.69**	10.32**

Note. * $p \leq .05$, ** $p \leq .01$, *** $p \leq .001$.

Competing Constructs that Might Explain the Alliance-Outcome Association

To rule out potential alternative explanations of the significant alliance-outcome associations (Feeley, DeRubeis, & Gelfand, 1999), we examined whether a series of client (child: age, sex; parent: age, sex, ethnicity), case (court ordered care yes/no), and professional (age, sex, ethnicity, work experience) characteristics acted as third variables. When we reexamined significant alliance-outcome associations with these client, case, and professional characteristics entered as covariates, previous findings largely held. However, early parent-reported alliance was no longer a significant predictor of professional-reported satisfaction with the care process (B = .09, $p = .40$) and results (B = -.01, $p = .93$). All other alliance-outcome associations remained significant, indicating that these findings were not likely to be explained by confounding factors.

Discussion

The current study investigated the predictive value of the parent-professional alliance for outcomes of home-based parenting support in youth care. We examined the role of early alliance and change in alliance in predicting satisfaction with care and change in parent functioning, as assessed late in care. The findings showed that strong early alliance predicted higher levels of satisfaction with care and improved parent functioning. Parent-reported early alliance predicted parent-reported outcomes, whereas professional-reported early alliance predicted parent- and professional-reported outcomes. Furthermore, increases in professional-reported alliance over time predicted higher levels of professional- but not parent-reported outcomes. Changes in parent-reported alliance were not predictive of outcomes. These findings indicate that a stronger parent-professional alliance was generally linked with positive outcomes, although findings did vary across informants and alliance assessments.

Overall, these findings are consistent with and support previous studies that found a strong parent-professional alliance is associated with improved outcomes of parenting interventions (Schmidt et al., 2014), and youth treatment (De Greef et al., 2017; McLeod, 2011; Shirk et al., 2011). Furthermore, in line with our expectations, findings indicated that several factors might impact the strength of the alliance-outcome association. First, the alliance-outcome association differed across alliance assessments. As expected, both early alliance and change in alliance predicted outcomes. However, only change in professional-reported alliance was significantly related to outcomes, with increasing alliances predicting improved outcomes. Moreover, increasing professional-reported alliances only predicted improved professional-reported outcomes, with smaller effects compared to early professional-reported alliance. It is possible parent-reported alliance did not predict outcomes due to ceiling effects (i.e., scores were high and stable over

time; Hukkelberg & Ogden, 2013; McLeod et al., 2016). High early parent-reported alliance scores leave little room for improvement (Owen, Miller, Seidel, & Chow, 2016). Furthermore, parent- and professional-reported alliances seem to be relatively unaffected by what happens between early and late phases of care – although alliance assessments throughout services could have provided more detailed and different information on the alliance trajectories (e.g., McLeod et al., 2016). Moreover, absence of substantial variance in alliance change might explain limited findings regarding the predictive value of change in alliance. Still, even small increases in professional-reported alliance seem to be clinically relevant given their predictive value for outcomes. Also, previous studies indicate that alliance growth in initial (i.e., first seven) sessions predicts outcomes of youth treatment (Owen et al., 2016). The present study did not capture alliance growth in initial sessions, and the alliance as reported by parents and professionals might already have been stabilized at the time of our early alliance assessment.

Second, in line with expectations and previous studies (De Greef et al., 2017; McLeod, 2011), our findings indicate that the alliance-outcome association was stronger when the same informant reported on alliance and outcome. However, significant alliance-outcome associations were not restricted to one informant and were not solely accounted for by common rater variance. Contrasting our hypothesis, the professional-reported alliance turned out to be a more consistent predictor of outcomes compared to parent-reported alliance. This difference in findings might be explained by the very high alliance levels as reported by parents, resulting in little variability among parent-reported alliance (Green, Albanese, Cafri, & Aarons, 2014; Shirk & Karver, 2003). Another possible explanation is that this may be due to the fact that previous studies did not (Hukkelberg & Ogden, 2013) or only partly (Schmidt et al., 2014) include professional-reported outcome measures. As a result, the stronger alliance-outcome association for parent-reported alliance might have been inflated by common rater variance. Notwithstanding these contrasting findings, both parent and professional alliance reports are valuable sources of information since both predict outcomes, and given the discrepancies (i.e., low correlations) between alliance reports of both informants (Kazdin & Whitley, 2006). A challenge for future studies is to further investigate alliance agreement and its role in predicting outcome (e.g., see Fjermestad et al., 2016; Goolsby et al., 2018).

In several ways the current study extends prior research. First and foremost, we investigated the association between alliance and outcomes of parenting support in typical care: home-based services provided to individual families without the opportunity to rely on evidence-based intervention programs. As a result, our findings can be generalized with some confidence to everyday clinical practice in youth care settings. Second, in contrast to previous studies, alliance was assessed at multiple time points, enabling us to provide information on the predictive value of early alliance and alliance change for parenting support outcomes. Finally, this study was the first in home-based

care to rely on multiple informants for all alliance and outcome measures. Consequently, it offers insight in parent and professional thoughts on alliance and outcomes and we were able to address the issue of shared-method variance when investigating the alliance-outcome association.

Notwithstanding these strengths, a few limitations of the study warrant attention. First, although the current sample likely reflects the diversity of clients, service content and duration of typical home-based parenting support, we were only partly able to assess and control for these aspects. As a result, we were not able to fully characterize the sample and provided care; it remains unclear whether any factors not captured in this study (e.g., problem level, intervention characteristics) might have affected the alliance-outcome association. Second, our study design does not allow definite conclusions regarding the temporal sequence and mutual influence of alliance and outcome variables. Although we assessed alliance prior to outcome and thereby indicated that alliance was predictive of later care outcomes, this does not rule out the possibility that early levels of satisfaction and change in functioning impacted early alliance and alliance change (McLeod & Weisz, 2005). Also, the retrospective assessments of satisfaction with care and experienced change in parent functioning might have been confounded by alliance. Third, while we used psychometrically sound outcome measures that are being used in clinical practice, the retrospective and global assessment of change in parent functioning does not fully capture the change in this complex and multifaceted dimension. Finally, although the primary caregiver participated in this study, this focus does not provide insight in the specific dynamics (i.e., involving multiple client-professional and within family alliances) of working with families (Friedlander & Escudero, 2017; Friedlander et al., 2011).

Implications for future research and clinical practice are indicated by both the findings and limitations of this study. Since this is, to our knowledge, the first study that investigated the alliance-outcome association in home-based parenting support in youth care settings, replication of these findings is important. Future studies should also capture developmental trajectories of alliance and its interplay with client, professional, interactional, contextual, and intervention factors over the course of provided services. For these studies it is important to assess the alliance at least three times, to employ systemic models and measures to capture alliance dimensions specific to working with families (e.g., see Friedlander & Escudero, 2017), and to use more specific and extensive measures to assess parent functioning that have demonstrated score reliability for the current sample. Furthermore, given the strong predictive value of early parent-professional alliance and the finding that alliance was relatively stable over time, it is crucial to identify factors that influence the strength of early alliances (e.g., mandated versus voluntary service involvement). Proposed research directions will serve efforts of professionals, educators and policy makers to strengthen the alliance. In anticipation

of new findings, current findings indicating that a strong parent-professional alliance represents a key process ingredient predicting outcomes, need to guide professional behavior and education of current and future professionals. It may be helpful for professionals to be aware of the role that the alliance may play in promoting positive outcomes when working with parents. This includes helping professionals realize that a common understanding between professionals and parents of goals, tasks, and the emotional bond is not self-evident. It thus may be useful to monitor the alliance, ask for alliance feedback, and address cases with low or decreasing levels of parent- or professional-reported alliance in everyday clinical practice. Finally, future studies and clinical practice may benefit from incorporating observational measures, such as the Therapy Process Observational Coding System for Child Psychotherapy – Alliance Scale (TPOCS-A; McLeod & Weisz, 2005) or the System for Observing Family Therapy Alliances (SOFTA; Friedlander, Escudero, Horvath, Heatherington, Cabero, & Martens, 2006). Observations do not only add a more objective perspective to clients' and professionals' own, often hardly related alliance reports, it also provides professionals with the opportunity to reflect on alliance strength and identify potential improvements of alliance and alliance skills.

To conclude, the present study highlights the need for developing and maintaining strong parent-professional alliances in home-based parenting support. Furthermore, it emphasizes the importance of future studies to investigate precursors of strong alliances and optimizing professionals' alliance building strategies. Together, these studies and improvement efforts have the potential to improve outcomes for parents and children involved in youth care.

Chapter 4

Predictors of parent-professional alliance in home-based parenting support

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Abstract

A strong parent-professional alliance that increases over the course of care predicts positive outcomes of home-based parenting support. However, little is known about factors that influence the development or maintenance of the alliance in home-based parenting support, limiting professionals' ability to optimize the parent-professional alliance and thereby the quality of care. Therefore, the present study examined whether voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems, and care expectations were associated with early parent-professional alliance and predicted change in alliance during home-based parenting support services. Questionnaire data from 60 parents (*M* age = 40.65 years, *SD* = 6.81, range 23-55 years) and their professionals collected early and late in care were analyzed using structural equation modeling. Results indicated that previous involvement in similar services was related to lower levels of early parent-reported alliance, whereas positive care expectations were related to stronger early parent- and professional-reported alliances. Moreover, care expectations predicted change in professional-reported alliance during care, with positive parent expectations predicting a decrease and positive professional expectations predicting an increase in alliance. Voluntary versus mandated service involvement, parenting stress and child psychosocial problems were not found to influence the alliance. These findings emphasize the need for professionals to discuss previous service involvement and care expectations as well as a need for future studies to identify other factors that influence alliance and alliance-building skills.

Introduction

A professional's ability to develop and maintain a positive alliance with their clients is an indicator of the quality of care provided by mental health organizations (Green, Albanese, Cafri, & Aarons, 2014; McLeod, Southam-Gerow, Tully, Rodriguez, & Smith, 2013). A variety of terms (e.g., therapeutic alliance, working alliance, helping alliance) and measures have been used to define and assess the alliance (see Elvins & Green, 2008; McLeod, 2011). Herein we use the term alliance to refer to a collaborative client-professional relationship that consists of a positive emotional bond and agreement on treatment goals and tasks (Bordin, 1979; Elvins & Green, 2008). Studies in the adult (Horvath, Del Re, Flückiger, & Symonds, 2011) and youth (McLeod, 2011; Shirk, Karver, & Brown, 2011) treatment fields indicate that the alliance is a consistent predictor of treatment outcomes and is considered an important element of evidence-based treatment (Norcross, 2010). Despite the importance of the alliance in treatment, the varying quality of client-professional alliances in clinical practice indicates that positive alliances are by no means self-evident and that certain factors might affect the alliance (e.g., Baldwin, Wampold, & Imel, 2007; Hawley & Garland, 2008).

Understanding whether certain factors influence the alliance may help professionals optimize the client-professional alliance. This might be particularly important in youth care, a sector of the youth mental health system that provides a range of services (e.g., home-based parenting support, foster care, residential treatment) intended to optimize child development (Anglin, 1999; White, 2007). Home-based parenting support, the most common type of service provided in youth care, aims to help parents overcome parenting or child developmental problems (Barth et al., 2005; Lewis, Feely, Seay, Fedoravicis, & Kohl, 2016; Whittaker & Cowley, 2012). Youth care professionals providing home-based parenting support typically encounter a heterogeneous group of parents in terms of clinical characteristics and levels of motivation for treatment (Faver, Crawford, & Combs-Orme, 1999; McWey, Holtrop, Wojciak, & Claridge, 2015; Staudt, 2007) who may experience problems with involvement in services (Whittaker & Cowley, 2012). For these reasons, the ability to form a strong parent-professional alliance may be particularly important in home-based parenting support.

Parents are the client in home-based parenting support, and the parent-professional alliance may play a facilitative role by helping to enhance parent satisfaction and involvement in care. Meta-analyses on youth treatment (i.e., McLeod, 2011; Shirk et al., 2011) along with studies examining parenting support services in youth care samples have found that the parent-professional alliance, assessed prior to outcomes, is related to improved treatment attendance (Kazdin & Whitley, 2006), satisfaction with service (McLeod, 2011), and positive outcomes (e.g., improved parenting practices and child symptoms; Kazdin & Whitley, 2006; McLeod, 2011; Schmidt, Chomcycz, Houlding,

Kruse, & Franks, 2014). These findings indicate that the ability to form a strong alliance with parents in home-based parenting support may help professionals improve parent engagement (i.e., client participation in treatment activities and regular attendance; McKay & Bannon, 2004) and outcomes. Thus, it is important to identify factors that may affect the strength of the parent-professional alliance in home-based parenting support (De Greef, Pijnenburg, Van Hattum, McLeod, & Scholte, 2017).

Although it is plausible that a number of factors in home-based parenting support might influence the quality of the parent-professional alliance, empirical studies testing these associations are limited. Consequently, there is no clear guidance on what factors to address when working to develop and maintain a strong parent-professional alliance. Thus, the goal of the current study was to investigate whether key factors associated with home-based parenting support were related to the parent-professional alliance.

Previous studies on parent- and family-focused treatment have argued that voluntary versus mandated service involvement might influence the parent-professional alliance (Staudt, 2007). Parental involvement in home-based parenting support can be either voluntary or mandated as result of a court order. Mandated parents may have lower levels of motivation and perceived need for parenting support (Faver et al., 1999; McWey et al., 2015) and might not, at least initially, feel the need to engage in services (McWey et al., 2015; Staudt, 2007). Thus, it could be more challenging for professionals to develop and maintain a positive alliance with mandated parents (Staudt, 2007). This hypothesis is supported by an empirical study on family therapy in which mandated families were found to have weaker observed alliances in the first treatment session compared to families with voluntary treatment involvement (Sotero, Major, Escudero, & Relvas, 2016). Although the alliance for mandated families improved by session four, the observed alliance continued to be lower than for voluntary families. These findings suggest that voluntary versus mandated service involvement might be associated with the quality of the parent-professional alliance.

Another factor that might influence the parent-professional alliance is parents' previous involvement in similar services (Platt, 2012). Parents in home-based parenting support oftentimes have been involved in previous youth care services (Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016). To our knowledge, previous studies have not examined the relation between previous involvement in similar services and the alliance. However, a recent review focused on parent engagement in child and family treatment (Haine-Schlagel & Walsh, 2015) and concluded that previous service use for similar problems relates to lower levels of parental engagement in parent training programs (Dumas & Albin, 1986; Haine-Schlagel & Walsh, 2015). It is plausible that previous service use may influence parent engagement via the alliance (McLeod et al.,

2014). Thus, previous involvement in similar services might be negatively related to the parent-professional alliance in home-based parenting support.

Level of parenting stress may also be related to the quality of the parent-professional alliance. To our knowledge, no studies have directly investigated this link. However, research does indicate that level of parenting stress does relate to treatment engagement. Barriers to treatment studies investigate difficulties of participating in treatment, including problems with the client-professional alliance, practical obstacles, and perceptions that treatment is not relevant (Kazdin, Holland, & Crowley, 1997). These studies found that higher levels of parenting stress predicted more parent- and professional-reported barriers to treatment (including weaker parent-professional alliances; Kazdin et al., 1997), and higher drop-out rates from families involved in youth treatment and parenting support (Kazdin et al., 1997; Kazdin & Mazurick, 1994; McWey et al., 2015). The association between parenting stress and several care process outcomes seen in this prior work suggests that higher levels of parenting stress might hinder parents and professionals to realize a strong alliance.

Severity of child psychosocial problems may also influence the parent-professional alliance. To our knowledge, only one study has investigated the association between child symptoms and parent- and professional-reported process outcomes. A study on youth treatment (Kazdin et al., 1997) showed that more severe child psychosocial problems at intake (i.e., conduct disorder symptoms, history of antisocial behavior) predicted more parent- and professional-reported barriers to treatment at the end of treatment (including weaker parent-professional alliances). This finding suggests that, as with parent functioning, more severe child psychosocial problems might negatively impact the strength of the parent-professional alliance.

Other factors that might influence the alliance are clients' and professionals' care expectations: beliefs clients and professionals have, related to the process and outcomes of care (Nock & Kazdin, 2001). In adult treatment, studies show that positive client and professional expectations regarding the usefulness of care relate to a stronger client-professional alliance (Ackerman & Hilsenroth, 2003; Joyce & Piper, 1998). Parents' positive expectations regarding their involvement in, and the effects of individual youth treatment are associated with fewer perceived barriers to treatment (including stronger parent-professional alliances; Nock & Kazdin, 2001). Together, these findings suggest that positive parent and professional expectations regarding the process and outcome of home-based parenting support may positively impact the quality of parent-professional alliances.

Based on findings from previous studies on youth-, parent-, and family-treatment, it is plausible that voluntary versus mandated service involvement, previous involvement in

similar services, parenting stress, child psychosocial problems and care expectations may influence the parent-professional alliance in home-based parenting support. Given the lack of empirical studies (De Greef et al., 2017), understanding how these factors relate to alliance is an important research objective.

To investigate the relation between these factors and the alliance, we employed four methodological features intended to strengthen the interpretability of our findings. First, we assessed the alliance during the first ("early" alliance) and second ("late" alliance) half of home-based parenting support services. This allowed us to evaluate whether the factors influenced the alliance in the first half of care as well as over the course of care. Second, we assessed the alliance from the perspective of parents and professionals, as it is possible that these informants may differ from one another (Hawley & Garland, 2008). Third, we used the Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989) to assess the alliance, which is a widely used instrument with strong score reliability and validity (De Greef et al., 2017; Hukkelberg & Ogden, 2016; McLeod, 2011). Finally, the current study focuses on the most common service provided to families involved in youth care: home-based parenting support (Barth et al., 2005; Child Welfare Information Gateway, 2014; Statistics Netherlands, 2015), which has been found to impact youth outcomes (e.g., Veerman & De Meyer, 2015).

The present study examined whether a series of factors were related to the quality of parent- and professional-reported early alliance or predicted change in alliance over the course of home-based parenting support services delivered in community settings using data from a sample of 60 parent-professional dyads. We hypothesized that mandated service involvement, previous involvement in similar services, and higher levels of parenting stress and child psychosocial problems would predict lower levels of early parent-professional alliance and less change in alliance over time. Moreover, we hypothesized that positive care expectations would predict stronger early alliances and steeper increases in alliance over time.

Method

Participants

The study sample consisted of 60 parents (91.7% mothers; *M* age = 40.65 years, *SD* = 6.81; range 23-55 years) receiving home-based parenting support (*M* duration in months = 6.87, *SD* = 2.20; range 2.60-12.78) to target parenting or child developmental problems. Some parents received these services by court order (16.7%). Most parents previously received child- or parent-focused care (75.0%). The majority of parents were born in the Netherlands (86.7%); the remaining parents were born in another Western (3.3%) or

Non-Western (10.0%) country. Involved children (70.7% male) were between 3 and 17 years old (*M* = 11.35 years, *SD* = 3.98). Home-based parenting support services were part of routine practices of nine Dutch youth care organizations, meaning that services were eclectic, non-protocolized, and grounded in various approaches (e.g., Intensive Family Treatment; Veerman & De Meyer, 2015). Services were provided by 42 professionals (90.5% female; *M* age = 45.82 years, *SD* = 9.74; range 29-60 years), serving one to four families each (*M* = 1.43, *SD* = 0.70). Most professionals were born in the Netherlands (95.2%) and held a professional bachelor degree (88.1%). On average, professionals had 8.55 years (*SD* = 7.31, range 4 months-36 years) of experience providing home-based parenting support.

Procedure

Recruitment started in January 2015 and ended in January 2016. When parents were admitted to, or recently started home-based parenting support, their professional asked them to participate in the study. Parents received written information about the study including a statement that refusal to participate would not exclude them from access to services. Parents were excluded from study participation if children were not living at the parents' home (e.g., residential facility or foster family), when children's age fell more than one year outside of the Strengths and Difficulties Questionnaire age-range (i.e., < 3 or > 17), or when the start of the parent-professional collaboration was the result of assigning a new professional to the case. Eighty-nine parents met inclusion criteria, agreed to participate, and completed permission forms. Next, parents and professionals completed T_1 questionnaires without access to each other's answers. For 60 cases, T_1 questionnaires were completed early (i.e., first half) in care and were included in the current study. Independent samples T-tests showed that the selected sample (*n* = 60) did not differ from the total sample (*n* = 89) in terms of demographic variables (age, sex, ethnicity, or voluntary or mandated involvement in home-based parenting support).

For selected cases, T_1 questionnaires were completed just over two months after admission (*M* months for parents = 2.36, *SD* = 1.35, range 1 week-5.49 months; *M* months for professionals = 2.31, *SD* = 1.18, range 2 weeks-5.32 months). Of these 60 parent-professional dyads, 46 parents and 58 professionals completed T_2 questionnaires (parents: *M* months after T_1 = 4.22, *SD* = 1.64, range 1.64-10.58; professionals: *M* months after T_1 = 4.21, *SD* = 1.45, range 1.89-8.77) at the end of services or at the end of the study period. Since professionals were instructed to select cases for study participation where the expected end of care did not exceed the study period, we consider the timing of T_2 assessments to be late in care. Study procedures were reviewed and approved by the Ethics Committee of the Faculty of Social Sciences of the Radboud University.

Measures

Voluntary versus mandated service involvement

Professionals indicated whether parents received home-based parenting support by court order (no or yes).

Previous involvement in services

Parents were asked whether they had received care to target child-, parent-, or family-functioning (no or yes) prior to their current involvement in home-based parenting support.

Parenting stress

The short version of the Parenting Stress Questionnaire (PSQ-S; Vermulst, Kroes, De Meyer, Nguyen, & Veerman, 2015) was used to assess the parent's level of parenting stress. The PSQ-S consists of 10 items, assessing problems in the parent-child relationship (e.g., “I feel happy when I am with my child”), parenting problems (e.g., “My child listens to me”), and parental depressive moods (e.g., “I often feel good”). Answers were given on a 4-point scale ranging from 1 (not applicable) to 4 (fully applicable). A total PSQ-S score (range 10-40) is based on the sum of all recoded items. Higher scores indicated higher levels of parenting stress, with scores higher than 20 reflecting clinical range problems. Cronbach's alpha for the PSQ-S in the current sample (α = .91) was consistent with previous studies involving clinical (Vermulst et al., 2015) and nonclinical (Damen, Veerman, Vermulst, Nieuwhoff, De Meyer, & Scholte, 2017) samples.

Child psychosocial problems

The Dutch parent version of the Strengths and Difficulties Questionnaire (SDQ; Van Widenfelt, Goedhart, Treffers, & Goodman, 2003) was used to assess psychosocial problems of children and adolescents. The SDQ includes five subscales (i.e., emotional symptoms, conduct problems, hyperactivity-inattention, peer problems, prosocial behavior) consisting of five items each. Parents rated their child's behavior on a three-point scale, ranging from 0 (not true) to 2 (certainly true). In the current study, we used the total difficulty score (range 0-40), based on the sum of the emotional symptoms, conduct problems, hyperactivity-inattention, and peer problem subscales. Higher scores indicate more difficulties (0-13: normal psychosocial functioning; 14-16: raised levels of psychosocial problems; 17-40: high levels of psychosocial problems). The parent version of the SDQ showed acceptable levels of reliability to assess child and adolescent (age

4-16) psychosocial problems (Van Widenfelt et al., 2003). Cronbach's alpha for the SDQ in the current sample (α = .83) was consistent with previous studies involving Dutch samples (Van Widenfelt et al., 2003).

Care expectations

For the purpose of this study, two questions were formulated to assess parents' and professionals' expectations regarding the process of care (i.e., "I believe that the process of this care trajectory will be positive") and outcomes of care (i.e., "I believe this care trajectory will help to improve my/this parents' situation"). Questions were answered on a 4-point scale ranging from 1 (not applicable) to 4 (fully applicable). Given the strong associations between both questions (r parent-report = .86, $p < .001$; r professional-report = .92, $p < .001$), mean scores were used in subsequent analyses. In the current sample, Cronbach's alpha's for the parent-report was .93, and was .96 for professional-report.

Alliance

We used the Working Alliance Inventory, Short Form (WAI-S; Tracey & Kokotovic, 1989) to assess the alliance between parents and professionals. The WAI-S consists of 12 items, and assesses task-, goal-, and bond-related elements of the alliance (e.g., "My professional and I are working towards mutually agreed upon goals"). Items are scored on a 5-point scale ranging from 1 (never) to 5 (always). Cronbach's alpha for the WAI-S in the current sample (α parent version = .96, α professional version = .91) was consistent with previous studies involving parent samples (Granic, Otten, Blokland, Solomon, Engels, & Ferguson, 2012; Hukkelberg & Ogden, 2016).

Data Analytic Plan

Structural equation modeling in Mplus 7.3 (Muthén & Muthén, 1998-2012) was used to investigate whether voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems and care expectations were related to early alliance and change in alliance. Four separate models were specified to assess the association with (1) parent-reported early alliance, (2) professional-reported early alliance, (3) change in parent-reported alliance (i.e., late alliance controlling for early alliance scores), and (4) change in professional-reported alliance. Non-independence of observations (i.e., parents were nested within professionals) was accounted for by means of the sandwich variance estimator (Type=COMPLEX) as implemented in Mplus. The sandwich estimator produces corrected standard errors for non-independent data and thus produces more accurate estimates.

Prior to analyses, we examined missing data patterns. Rates of missing data at T_1 were 3.3% for SDQ and PSQ-S data, and there were no missing data across other variables. At T_2, rates of missing alliance data were 23.3% for parent-reported alliance, and 3.3% for professional-reported alliance. With respect to observed variables, data were missing completely at random (Little's missing-completely-at-random test $\chi^2 = 42.33$, $df = 39$, $p = .33$) and were not related to early alliance scores. In structural equation models, missing variables were taken into account using a full-information maximum likelihood (FIML) estimator with robust standard errors, implemented as MLR in Mplus. Finally, using regression analyses, we investigated whether parent, child, and professional background characteristics were related to alliance and needed to be included as control variables in post hoc structural equation models.

Results

Preliminary Analyses

Table 1 presents means and standard deviations of all study variables and Table 2 shows correlations between study variables. Parents and professionals each reported high and stable levels of alliance. Correlational analyses indicated strong associations between early and late parent-reported alliance ($r = .56$, $p < .001$), and early and late professional-reported alliance ($r = .65$, $p < .001$). Paired-samples t-tests showed that parent- and professional-reported alliance did not significantly change from early to late in care (parent-reported alliance: $t(45) = -1.32$, $p = .19$; professional-reported alliance: $t(57) = -1.68$, $p = .10$). Compared to one another parents reported significantly higher levels of alliance compared to professionals (early alliance: $t(59) = 5.66$, $p < .001$; late alliance: $t(44) = 4.26$, $p < .001$). Parent- and professional-reports of alliance showed significant correlations early in care ($r = .26$, $p < .05$), and non-significant correlations late in care ($r = .09$, $p = .58$). Finally, parent reports of expectations were significantly higher than professional reports, $t(59) = 5.09$, $p < .001$.

Factors Related to Early Alliance

Table 3 displays the standardized regression coefficients of voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems, and care expectations in relation to early alliance. For early parent-reported alliance, we found a significant association between previous service involvement and lower levels of alliance ($\beta = -.11$, $p < .01$). Furthermore, more positive parental care expectations were significantly related to higher levels of parent-reported alliance ($\beta = .68$, $p < .001$). In contrast, voluntary versus mandated service involvement, parenting stress, child psychosocial problems, and professional expectations were not significantly related to early parent-reported alliance.

With respect to early professional-reported alliance, higher levels of parent (β = .27, $p < .05$) and professional ($\beta = .47$, $p < .001$) care expectations were significantly associated with higher levels of alliance. None of the other variables were significantly related to early professional-reported alliance.

Table 1 Descriptive Statistics for Study Variables

	N	Mean	SD	Min	Max
Early alliance: parent	60	4.41	0.58	2.67	5.00
Early alliance: professional	60	3.93	0.48	2.92	5.00
Late alliance: parent	46	4.49	0.42	3.17	5.00
Late alliance: professional	58	4.02	0.59	2.25	5.00
Mandated care: no/yes	60	0.17	0.38	0.00	1.00
Previous services: no/yes	60	0.75	0.44	0.00	1.00
Parenting stress	58	22.30	6.18	11.00	38.00
Child psychosocial problems	58	15.60	6.53	2.00	32.00
Care expectations: parent	60	3.43	0.62	2.00	4.00
Care expectations: professional	60	2.94	0.55	2.00	4.00

Table 2 Correlations Between Study Variables

	1	2	3	4	5	6	7	8	9
1 Early alliance: parent									
2 Early alliance: professional	.26*								
3 Late alliance: parent	.56***	.21							
4 Late alliance: professional	.03	.65***	.09						
5 Mandated care: no/yes	-.10	-.14	.05	-.09					
6 Previous services: no/yes	-.23†	.07	.00	.16	.16				
7 Parenting stress	-.23†	.07	-.16	.04	-.27*	.03			
8 Child psychosocial problems	.09	.04	.09	-.04	-.13	.03	.38**		
9 Care expectations: parent	.73***	.32*	.57***	.05	-.02	.02	-.27*	.05	
10 Care expectations: professional	.26*	.44***	.16	.52***	.09	-.13	-.21	-.22†	.21

Note: † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 3 Regression Results of Factors Related to Early Alliance

	Early alliance: Parent-report			Early alliance: Professional-report		
	β	S.E.	R^2	β	S.E.	R^2
Mandated care: no/yes	-.05	.09		-.15	.14	
Previous services: no/yes	-.22**	.08		.16	.09	
Parenting stress	-.09	.12		.18	.12	
Child psychosocial problems	.11	.07		.04	.10	
Care expectations: parent	.68***	.08		.27*	.11	
Care expectations: professional	.11	.07		.47***	.13	
			.61***			.33**

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

Factors Predicting Change in Alliance

Table 4 shows the standardized regression coefficients for voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems, and care expectations predicting change in alliance (i.e., late alliance controlling for early alliance scores). Regarding parent-reported alliance, voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems, and care expectations were not found to significantly predict change in parent-reported alliance over the course of care.

With respect to change in professional-reported alliance, we found that positive care expectations from parents significantly predicted a decrease in professional-reported alliance (β = -.18, $p < .05$). In contrast, positive professional care expectations predicted an increase in professional-reported alliance between early and late phases of care (β = .37, $p < .01$). Voluntary versus mandated service involvement, previous involvement in similar services, parenting stress and child psychosocial problems were not found to predict change in professional-reported alliance.

Exploring Alternative Explanations

To rule out alternative explanations of the significant associations (Feeley, DeRubeis, & Gelfand, 1999) we examined whether other factors may have served as third variables. We first investigated whether a series of client (child: age, sex; parent: age, sex, ethnicity) and professional characteristics (age, sex, ethnicity, work experience, education level) were significantly related to parent- or professional-reported early

Table 4 Regression Results of Factors Predicting Change in Alliance

	Late alliance: Parent-report			Late alliance: Professional-report		
	β	S.E.	R^2	β	S.E.	R^2
Early alliance: parent	.37*	.17		-	-	
Early alliance: professional	-	-		.54***	.11	
Mandated care: no/yes	.09	.08		-.11	.08	
Previous services: no/yes	.02	.14		.17	.09	
Parenting stress	.05	.15		.03	.10	
Child psychosocial problems	.06	.11		-.01	.09	
Care expectations: parent	.30	.21		-.18*	.09	
Care expectations: professional	-.02	.15		.37**	.11	
			.37*			.59***

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

alliance or change in alliance. Regression analyses indicated that child age was significantly related to early parent-reported alliance ($\beta = .45$, $p < .05$), suggesting that parents with older children reported stronger early parent-professional alliances compared to parents of younger children. Parent sex was significantly related to professional-reported alliance ($\beta = .28$, $p < .05$), indicating that professionals reported stronger early parent-professional alliances when working with mothers. Of note, this finding has to be interpreted with caution as the sample includes only five fathers. No other variables were significantly related to early alliance, and we found no significant predictors of change in parent- or professional-reported alliance. Next, we entered child age as covariate in the model testing factors' relation with early parent-reported alliance, and we entered parent sex as covariate in the model testing factors' relation with early professional-reported alliance. All previous findings held, indicating that these factors are not likely to explain previously noted associations with alliance and change in alliance.

Discussion

The goal of this study was to examine whether a series of factors were related to parent- and professional-reported early alliance and predicted change in alliance between early and late phases of home-based parenting support. We found stronger early parent-reported alliances for parents with no previous involvement in similar services and

positive care expectations. Positive parent and professional care expectations were associated with stronger early professional-reported alliances. None of the factors predicted change in parent-reported alliance. However, care expectations did predict change in professional-reported alliance: parents' positive expectations predicted a decrease; professionals' positive expectations predicted an increase in professional-reported alliance. Voluntary versus mandated service involvement, parenting stress and child psychosocial problems were not found to impact early alliance or change in alliance. Together, these findings suggest that previous care experiences and care expectations may be particularly important for alliance development, whereas care expectations may also play a role in maintaining strong alliances during care.

Our finding that parents' previous involvement in similar services was associated with lower levels of parent-reported alliance early in care is consistent with conceptual (Platt, 2012) and review studies (Haine-Schlagel & Walsh, 2015) that concluded previous experiences with services influence subsequent parental engagement in services. This is an important finding as a large group of families present to youth care with long, fragmented care histories (Ribner & Knei-Paz, 2002; Steens, Hermans, & Van Regenmortel, 2017), often characterized by unmet needs and disappointments (Bodden & Dekovic, 2016; Ribner & Knei-Paz, 2002; Steens et al., 2017). Although the current study does not provide insight in the tone of previous care experiences, our findings raise the possibility that these experiences may exert a detrimental effect on alliance development in subsequent services, suggesting that professionals may want to investigate ways to actively discuss parents' care history to ascertain how it may influence alliance formation.

As hypothesized, we found that positive care expectations were related to early alliance and predicted change in the alliance during care. These findings are consistent with previous studies on adult (e.g., Arnkoff, Glass, & Shapiro, 2002) and youth treatment (e.g., Nock & Kazdin, 2001) and suggest that positive care expectations may play a role in developing and maintaining a strong parent-professional alliance in home-based parenting support. Contrary to our hypothesis, positive parental care expectations predicted a decrease in professional-reported alliances. This finding may be the result of high and potentially unrealistic levels of parental care expectations, leading to decreasing alliance levels when expectations are not met. Qualitative studies may help to provide insight into how care expectations relate to the alliance over the course of care. Our findings do, however, suggest that care expectations of parents may play a role in alliance formation and change in the alliance and professionals may thus want to discuss care expectations with parents early in care.

In contrast to previous research (e.g., Sotero et al., 2016; Kazdin et al., 1997), voluntary versus mandated service involvement and client functioning were not related to the

alliance or change in alliance. A few factors might explain these null findings. First, the small number of mandated cases may have undermined our ability to detect a relation. Second, mandated parents may believe that they must cooperate in services to prevent poor outcomes (e.g., out-of-home-placement of children; Steens et al., 2017) which may lead parents and professionals to report a strong alliance. Third, we used court-ordered status as a proxy for being mandated to receive care, but it may not capture all circumstances in which parents are mandated to receive care (Sotero et al., 2016; Steens et al., 2017). For example, other sources (e.g., mental health professional) may mandate parents to participate in home-based parenting support. Asking parents their reasons for service involvement may be more precise and thus represents a more accurate way to evaluate whether voluntary versus mandated service involvement impacts alliance development and maintenance.

In contrast to previous research (e.g., Kazdin et al., 1997; McWey et al., 2015), our findings suggest that parenting stress and child psychosocial problems may not impact the parent-professional alliance. It is possible that other domains of functioning such as social competencies might be more important for alliance development (Kazdin & Durbin, 2012). Moreover, relations between client functioning and alliance might depend on other client factors such as motivation, or professionals' ability to compensate for challenges related to client functioning with increased alliance building strategies (Chu, Skriner, & Zandberg, 2014; Fjermestad et al., 2017). Future research is needed to replicate current findings and to determine whether and how (other domains of) client functioning relate to the alliance.

Our study has several strengths. To our knowledge, this was the first study to identify factors that relate to the development and predict the maintenance of parent-professional alliances in home-based parenting support. Our focus on usual clinical care in a widely used service provided to families enhances relevance and generalizability of current findings. Second, we assessed alliance at multiple time points from multiple perspectives, allowing us to identify whether factors play different roles in forming and maintaining parent- or professional reported alliances. Finally, we investigated potential alliance predictors that are usually known or present at the start of home-based parenting support. As a result, professionals can apply current findings to optimize parent-professional alliances in their everyday practice.

Implications for future research are also indicated by some limitations of the current study. First, the use of two data points does not provide insight in the temporal sequence and mutual influence of the factors and alliance over care. Future studies assessing alliance, parenting stress, child psychosocial problems, and care expectations multiple times over care could provide insight into the trajectory of the alliance and its interplay with other factors. For these studies it is important to assess early alliance in the first

three sessions to increase comparability with previous alliance studies (e.g., Fjermestad et al., 2017). Second, the small sample size highlights the need for larger studies to replicate and extend current findings. For example, our small sample did not allow for an investigation of differences between subgroups (e.g., with respect to child age or parent sex), which may help to identify other predictors of alliance formation and development. Third, though it is important to establish a relation between fixed factors (e.g., voluntary versus mandated service involvement) and the alliance, future studies should investigate mutable factors that professionals can address with clients. Fourth, this study only investigated a small number of factors. For future studies it is important to investigate whether and how other factors such as family characteristics (e.g., socioeconomic situation, family stress) and dynamics (Friedlander, Escudero, Heatherington, & Diamond, 2011; Saïas et al., 2016), professional characteristics and competencies (Baldwin et al., 2007; McLeod et al., 2016), or intervention characteristics of home-based parenting support (e.g., content, intensity, effectiveness) affect the alliance. Finally, parents and professionals reported high and stable levels of alliance. This ceiling effect is often seen with self-report alliance instruments (e.g., Hukkelberg & Ogden, 2013) and may have undermined our ability to find predictors of alliance change (Hukkelberg & Ogden, 2013; McLeod et al., 2016; Owen, Miller, Seidel, & Chow, 2016). Future studies incorporating observational and self-report instruments sensitive to change may provide advantages for both research and clinical practice.

Notwithstanding these limitations, findings of this study have clinical implications. As indicated, it is important for professionals to be aware of the potential impact of previous care experiences and care expectations on alliance. To increase the likelihood of a strong alliance, it seems helpful to discuss experiences and expectations with parents early in care (Ingoldsby, 2010). This allows parents to express their thoughts regarding care and enables professionals to actively deal with negative and build on positive experiences and expectations. Moreover, given the impact of care expectations on change in alliance, monitoring of how parent and professional care expectations evolve over time is useful. Finally, when working to develop and maintain strong alliances it might help professionals to realize that their view of the alliance may well be not in line with how parents judge the alliance. To realize agreement on goals, tasks and the emotional bond, and to increase awareness of factors that might impact the alliance, it is useful to monitor the alliance and ask for alliance feedback.

Together, our findings emphasize the need for professionals to be aware of and attend to previous care experiences and care expectations in home-based parenting support. This strategy, combined with future research identifying other parent, professional or interactional factors that impact alliance and alliance-building skills, might lead to strengthened parent-professional alliances and ultimately to improved outcomes of home-based parenting support.

Supervisory alliance: Key to positive alliances and outcomes in home-based parenting support?

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Abstract

The current study investigated whether the strength of the supervisory alliance between professionals and their supervisor contributes to strong client-professional alliances and positive client outcomes. We examined these questions in the context of home-based parenting support provided by Dutch youth care organizations. Multi-informant self-report supervisory alliance, alliance, and outcome data from 124 parents (*M* age = 39.83 years, *SD* = 6.98; range 19-57 years), their professionals (*n* = 84, *M* age = 43.66 years, *SD* = 10.46; range 23-62 years), and supervisors (*n* = 26, *M* age = 47.18 years, *SD* = 8.28; range 35-61 years) collected early and late in care were analyzed using structural equation modeling. Results demonstrated that a stronger supervisory alliance was related to a stronger alliance early in care when both were professional-reported. A stronger supervisory alliance reported by professionals predicted higher levels of parent- and professional-reported satisfaction with care. A stronger supervisory alliance reported by supervisors predicted parent-reported improvement in parent functioning, and higher levels of professional-reported satisfaction with care. Finally, effects of professional-reported supervisory alliance on professional-reported satisfaction with care were mediated through higher levels of professional-reported alliance. Together, our findings suggest that a strong supervisory alliance may relate to strong alliances and contribute to positive outcomes of home-based parenting support. Future research is needed to help identify factors that contribute to strong supervisory alliances and explain linkages between the supervisory alliance, the alliance, and outcomes.

Introduction

In mental health care, the alliance between professionals and their supervisor (hereafter: *supervisory alliance*) is viewed as a key element of supervision that helps to optimize the client-professional alliance (hereafter: *alliance*) and client outcomes (e.g., Lewis, Scott, & Hendricks, 2014; Watkins, 2014). Defined as a collaborative relationship involving a positive emotional bond and agreement on supervision goals and tasks (Bordin, 1983; Pearce, Beinart, Clohessy, & Cooper, 2013; Watkins, 2014), a small number of theoretical (Watkins, 2014) and empirical (DePue, Lambie, Liu, & Gonzalez, 2016; Palomo, Beinart, & Cooper, 2010) studies suggest that the supervisory alliance may impact the alliance and outcomes in adult treatment. While it is possible that the supervisory alliance may play an important role in other service sectors, empirical studies have not yet investigated these hypotheses.

The supervisory alliance may play an important role in youth care. Youth care organizations provide care to families (e.g., parenting support, foster care, residential treatment) for problems related to parenting and child psychosocial development. A common goal of youth care services is family preservation or reunification (Anglin, 1999; Barth et al., 2005; White, 2007). Supervisors in youth care play an important role in supporting professionals' ability to deliver effective care to children and families (e.g., Mor Barak, Travis, Pyun, & Xie, 2009; Wilkins, Lynch, & Antonopoulou, 2018). Supervision serves a wide range of functions, including professional education and development, provision of personal and clinical support, performance evaluation, administrative and managerial responsibilities, and mediation between professionals and the organization (Carpenter, Webb, & Bostock, 2013; Mor Barak et al., 2009). In youth care, supervision is typically provided by the professional's manager in one-to-one or group meetings and includes several activities (e.g., advice, instruction, modeling, coaching and training; Carpenter et al., 2013; Mor Barak et al., 2009). The ultimate goal of supervision is to optimize care processes and outcomes for clients, and a strong supervisory alliance is argued to be essential for supervision to be effective (Carpenter et al., 2013; Kadushin & Harkness, 2002).

Youth care professionals may benefit from supervision given their demanding day-to-day work (Mor Barak et al., 2009). Professionals typically encounter a heterogeneous client population in terms of motivation to participate in services (McWey, Holtrop, Stevenson Wojciak, & Claridge, 2015; Staudt, 2007) and clinical characteristics (McWey et al., 2015; Whittaker & Cowley, 2012). Often, the families treated by the professionals face multiple, complex, and interrelated problems (Bodden & Dekovic, 2016). Additionally, youth care professionals encounter productivity and paperwork demands (Horwath, 2016; Mor Barak et al., 2009). A strong supervisory alliance may thus be crucial for professionals to deal with these challenges and to realize strong alliances and positive care outcomes

(Mor Barak et al., 2009; Williams & Glisson, 2014). Surprisingly though, impact of the supervisory alliance on care processes and outcomes has not been studied in youth care (Carpenter et al., 2013).

A few studies from other fields suggest that the supervisory alliance may impact professionals' ability to develop and maintain strong alliances. Existing studies, all focusing on clinical supervision of counseling trainees, indicated that a stronger professional-reported supervisory alliance was related to stronger professional-reported alliances (DePue et al., 2016; Ganske, Gnilka, Ashby, & Rice, 2015). Findings regarding the association between professional-reported supervisory alliances and client-reported alliances were mixed: one study indicated that stronger supervisory alliances were related to stronger alliances (Patton & Kivlighan, 1997), whereas another study did not find significant associations (DePue et al., 2016).

While these findings suggest that the supervisory alliance may impact the alliance, current evidence is only of limited relevance to professionals and supervisors in youth care. First, supervision of professionals in community settings likely differs from supervision of trainees in university counseling settings, given the high caseloads, comorbidity in the client population, and a large percentage of clients being referred or mandated to receive services in community settings (Patton & Kivlighan, 1997; Southam-Gerow & Kendall, 2016). Second, cited studies exclusively focused on clinical supervision, whereas supervision in community settings such as youth care serves a variety of other functions in addition to a focus on clinical work (Carpenter et al., 2013; Mor Barak et al., 2009). Moreover, studies have mainly relied on single informants to assess the supervisory alliance (DePue et al., 2016; Patton & Kivlighan, 1997) and the alliance (Ganske et al., 2015; Patton & Kivlighan, 1997), which may provide limited insight into associations between the supervisory alliance and the alliance. Finally, most studies assessed the alliance only once (DePue et al., 2016; Ganske et al., 2015). Studies thus did not provide insight in how the supervisory alliance relates to a professional's ability to develop and maintain a strong alliance, while both have been found to predict youth care outcomes (De Greef et al., 2018).

The quality of the supervisory alliance may also impact care outcomes (e.g., Lewis et al., 2014; Watkins, 2014). To our knowledge, only two studies have evaluated this relation. A study on supervision of clinical psychology trainees showed that a stronger trainee-reported supervisory relationship correlated with more trainee-reported client progress (Palomo et al., 2010). Moreover, a study on adult treatment for depression indicated that supervision with a focus on the alliance positively influenced client-reported outcomes (i.e., depression symptoms, client satisfaction; Bambling, King, Raue, Schweitzer, & Lambert, 2006). Although the underlying mechanism connecting the supervisory alliance with care outcomes is unclear (Carpenter et al., 2013; Watkins,

2014), theoretical models of supervision suggest that the alliance may play a role in connecting both factors (Lewis et al., 2014). It is plausible that the alliance is a mediator, as previous studies suggest that the supervisory alliance relates to the alliance (DePue et al., 2016; Patton & Kivlighan, 1997), which in turn influences care outcomes. The quality of the alliance is a consistent predictor of care outcomes in adult treatment (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011; Norcross, 2010), youth treatment (McLeod, 2011), and home-based parenting support (De Greef et al., 2018).

Existing studies provide initial support for the hypothesis that the supervisory alliance may be related to care outcomes. However, studies have not tested whether the supervisory alliance predicts care outcomes controlling for the alliance, or if the alliance accounts for the relation between the supervisory alliance and outcomes. Investigating these questions is important as it provides empirical evidence to a small and mostly theoretical body of knowledge on whether and how the supervisory alliance may support care outcomes (e.g., Carpenter et al., 2013; Lewis et al., 2014; Palomo et al., 2010). Moreover, knowing whether a strong supervisory alliance supports a professional's ability to develop and maintain strong alliances, and (thereby) provide effective care to families involved in youth care, may help identify factors that need to be addressed in clinical practice to optimize supervision and care outcomes (Wilkins, Forrester, & Grant, 2017). Given the lack of empirical studies it is yet unclear whether the supervisory alliance would be a relevant focus for quality improvement efforts in youth care (e.g., Accurso, Taylor, & Garland, 2011).

The goal of the present study was to investigate the relation between the supervisory alliance, the alliance, and outcomes in youth care. To strengthen the interpretability of our findings we employed five methodological features. First, data regarding the supervisory alliance, alliance, and outcomes were collected from multiple informants as associations between the supervisory alliance, the alliance, and outcomes may differ across informants (e.g., DePue et al., 2016; De Greef, Pijnenburg, Van Hattum, McLeod, & Scholte, 2017; Hawley & Garland, 2008; McLeod, 2011; Schmidt, Chomycz, Houlding, Kruse, & Franks, 2014). Second, we used a longitudinal design to evaluate the predictive value of the supervisory alliance for care outcomes (DePue et al., 2016; Pearce et al., 2013; Watkins, 2014). Third, we assessed the supervisory alliance and the alliance early in care to limit potential confounding with client outcomes (Kazdin, 2007; McLeod, 2011). Fourth, we assessed the alliance early and late in care to investigate if the alliance changed over the course of care (Chu, Skriner, & Zandberg, 2013; Kendall et al., 2009). Finally, we evaluated the role of the supervisory alliance in community settings (Pearce et al., 2013). We focused on the most common service provided to families involved in youth care: home-based parenting support (Barth et al., 2005; Child Welfare Information Gateway, 2014; Statistics Netherlands, 2015).

In the current study, we examined the relation between the supervisory alliance, parent-professional alliances, and outcomes of home-based parenting support, using two-wave multi-informant questionnaire data from a sample of 124 parent-professional-supervisor triads. Specifically, we investigated whether (a) the supervisory alliance related to the strength of the alliance early in care and predicted change in the alliance over the course of care, (b) the supervisory alliance predicted outcomes of home-based parenting support above and beyond the predictive value of the alliance, and (c) the alliance mediated the association between the supervisory alliance and outcomes of home-based parenting support. We hypothesized that a stronger supervisory alliance would relate to stronger and increasing alliances. Moreover, we expected that a stronger supervisory alliance would positively impact care outcomes, in addition to effects of the alliance on outcomes. Finally, we hypothesized that the relation between the supervisory alliance and care outcomes would be mediated by the alliance.

Method

Participants

Participants were 124 parents (*M* age = 39.83 years, *SD* = 6.98; range 19-57 years) drawn from nine Dutch youth care organizations providing home-based parenting support. On average, parents (87.1% female) received support for 6.67 months (*SD* = 2.39; range 2.60-20.01 months) to target problems related to parenting or child psychosocial functioning and development. Some parents (13.1%) were mandated to receive services by court order. The majority of parents were born in the Netherlands (90.3%), other parents were born in other Western (2.4%) or Non-Western (7.3%) countries. Children were mostly boys (61.0% male) and were between 1 and 19 years old (*M* = 10.55 years, *SD* = 4.36). Services were part of routine care provided in participating youth care organizations, meaning that services were likely eclectic, non-protocolized, and grounded in various approaches (e.g., Intensive Family Treatment; Veerman & De Meyer, 2015). Eighty-four professionals (91.7% female, *M* age = 43.66 years, *SD* = 10.46; range 23-62 years) provided services to families included in this study (*M* = 1.48 families per professional, *SD* = 0.74). The majority of professionals were born in the Netherlands (98.8%) and held a professional bachelor degree (87.1%). Their average number of years as a provider of home-based services was 8.62 years (*SD* = 6.14, range = 4 months-36 years).

Twenty-six supervisors (80.8% female, *M* age = 47.18 years, *SD* = 8.28; range 35-61 years) provided supervision. Supervision was provided in one-to-one and group meetings and included professional education and development, provision of personal and clinical support, performance evaluation, administrative and managerial responsibilities, and

mediation between professionals and the organization. The majority of supervisors were born in the Netherlands (91.7%), and held a professional bachelor (71.4%) or master degree (28.6%). Supervisors worked with 1 to 15 professionals included in this study (*M* = 4.77, *SD* = 4.07). On average, supervisors had 8.30 years (*SD* = 5.38; range 3 months-20 years) of experience in supervising youth care professionals.

Procedure

Recruitment started January 2013 and ended January 2016. Professionals providing home-based parenting support asked parents to participate in the study when parents were admitted to or had recently started care. Parents received a written information sheet about the study including a statement that refusal to participate in the study would not exclude them from access to services. Parents were excluded from study participation if children (age 0-21) were not living at the parents' home (e.g., residential facility or foster family) or when the current parent-professional collaboration was the result of assigning a new professional to the case. A number of 241 parents who met inclusion criteria, agreed to participate and completed permission forms. Next, parents, professionals, and supervisors completed T_1 questionnaires without having access to each other's answers. Cases were excluded from analyses if T_1 questionnaires were not completed in early phases of care (i.e., first half; *n* = 95), when professionals switched supervisors during the study period (*n* = 4), or when professionals and supervisors completed questionnaires more than 1.5 month apart (i.e., > 1 *SD*; *n* = 18). Thus, a total number of 124 cases were included in subsequent analyses. Independent samples t-tests showed that the selected sample (*n* = 124) did not differ from the total sample (*n* = 241) in terms of demographic variables (age, sex, ethnicity), parents' voluntary or mandated involvement in home-based parenting support, or levels of early alliance and supervisory alliance.

For selected cases, T_1 questionnaires were completed between two and three months after admission (*M* parents: 2.35, *SD* = 1.19; range 0.23-6.31 months, *M* professionals: 2.36, *SD* = 1.14; range 0.26-6.77 months, *M* supervisors: 2.79, *SD* = 1.42; range 0.00-7.52 months). Of these 124 parent-professional-supervisor triads, 89 parents and 122 professionals completed T_2 questionnaires (parents: *M* months after T_1 = 3.68, *SD* = 1.83; range 1.38-13.70, professionals: *M* months after T_1 = 3.96, *SD* = 1.41; range 1.68-8.77) at the end of services or at the end of the study period. Since professionals were instructed to select cases for study participation for whom the expected end of care did not exceed the study period, we consider the timing of T_2 assessments to be late in care. All study procedures were reviewed and approved by the Ethics Committee of the local university.

Measures

Supervisory alliance

At T_1, the supervisory alliance between professionals and supervisors was assessed with the Supervisory Working Alliance Inventory, Short Form (SWAI-S). We based the SWAI-S on the Working Alliance Inventory, Short Form (WAI-S; Tracey & Kokotovic, 1989) to ensure that the alliance and supervisory alliance instruments were in line. WAI-S wording was adjusted to reflect the focus of supervision in community-based youth care services. The SWAI-S consists of 12 items. Four items assess task-related elements of the supervisory alliance (e.g., “My supervisor and I agree about things I need to do to become a better professional”), four items assess goal-related elements (e.g., ‘My supervisor supports me to work towards mutually agreed upon goals’), and four items assess bond-related elements of the supervisory alliance (e.g., “I believe my supervisor likes me”). Answers are given on a 5-point scale ranging from 1 (never) to 5 (always). Total scales showed strong internal consistency in the current sample (professional version: α T_1 = .95; supervisor version: α T_1 = .93). Professionals and supervisors completed separate, parallel versions of the SWAI-S.

Alliance

At T_1 and T_2, the alliance between parents and professionals was assessed with the WAI-S (Tracey & Kokotovic, 1989). The WAI-S consists of 12 items. Four items assess task-related elements of the alliance (e.g., “My professional and I agree about things I will need to do in care to help improve my situation”), four items assess goal-related elements (e.g., “My professional and I are working towards mutually agreed upon goals”), and four items assess bond-related elements of the alliance (e.g., “I believe my professional likes me”). Answers are given on a 5-point scale ranging from 1 (never) to 5 (always). WAI-S scores have shown strong internal consistency in parent samples (Granic et al., 2012; Hukkelberg & Ogden, 2016), and predictive validity for care outcomes (Keeley, Geffken, Ricketts, McNamara, & Storch, 2011). Total scales showed strong internal consistency in the current sample (parent version: α T_1 = .94, α T_2 = .94; professional version: α T_1 = .92, α T_2 = .96). Parents and professionals completed separate but parallel versions of the WAI-S.

Satisfaction with care

At T_2, we used the EXIT questionnaire (Jurrius, Havinga, & Stams, 2008) to derive information on parents’ and professionals’ satisfaction with the care received or offered. The EXIT questionnaire is a standard instrument in the Dutch youth care system and consists of 10 items and two subscales. Four items assess satisfaction with the care

process (e.g., “The care offered by this professional went well”), six items assess satisfaction with care results (e.g., “As a result of the provided care I have more confidence in the future”). Answers are given on a four-point scale, ranging from 1 (totally disagree) to 4 (totally agree). To ensure that all outcome measures could be reported by parents and professionals, we developed a professional version of the EXIT questionnaire for the purpose of this study. The parent version of this scale has demonstrated strong internal consistency in previous studies (Stichting Alexander, 2008) and the current sample (α care process = .89, α care results = .86). Analyses in the current sample indicated that the psychometric qualities of the professional version (α care process = .78, α care results = .84) are also adequate.

Global change in parent functioning

At T_2, we used the global measure of change (Alexander & Luborsky, 1986; Stinckens, Ulburghs, & Claes, 2009) to assess global change in parent functioning during care trajectories. Both parents and professionals evaluated the extent to which they perceived parents’ situation to be changed as a result of provided care (i.e., “Since I started to collaborate with this professional, my situation got…”). Answers are given on a 9-point Likert-scale, ranging from -4 (very much worse) to 4 (very much better). Previous studies investigating the association between alliance and treatment outcome used this item to assess treatment outcome (e.g., Stinckens et al., 2009). Moreover, previous studies indicated that both the client and the therapist version of this single question demonstrated high correlations with more extensive measures to assess clients’ development during care (Hatcher & Gillaspy, 2006), and produced similar patterns of correlations with alliance as more extensive change measures did (Hatcher, 1999).

Statistical Analyses

We used structural equation modeling in Mplus 7.3 (Muthén & Muthén, 1998-2012) to investigate whether supervisory alliance was related to early alliance, predicted change in alliance, and predicted outcomes of home-based parenting support. As missing data were missing completely at random (Little’s missing-completely-at-random test χ^2 = 77.95, df = 70, p = .24), these were taken into account using a full-information maximum likelihood (FIML) estimator with robust standard errors, implemented as MLR in Mplus. As a result, we could make use of all available data and addressed any deviates from normality.

Prior to data analyses, we investigated whether Multilevel Modeling was needed to account for non-independence of observations due to the fact that clients were nested within professionals, and professionals were nested within supervisors. We therefore

computed design effects, serving as indicators of how much standard errors are underestimated in a complex sample compared to a simple random sample (Maas & Hox, 2005). Design effects for the nesting of clients within professionals ($\mathit{Deff} < 1.25$) and the nesting of professionals within supervisors ($\mathit{Deff} < 1.83$) were all small (i.e., not exceeding 2.0; Maas & Hox, 2005; Muthén & Satorra, 1995). Thus, there was no need to analyze the data in a multilevel framework (Bonnet, Goossens, & Schuengel, 2011; Maas & Hox, 2005).

We subsequently specified eight separate mediation models to test for direct effects of the supervisory alliance on the alliance and outcomes, and for indirect effects of the supervisory alliance on outcomes via the alliance. Four models included early alliance measures, four models included measures of change in alliance. All change scores were in the form of residualized change scores to control for individual differences in initial ratings (Fjermestad et al., 2016; Keeley et al., 2011). To identify indirect effects, we used the joint significance test (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002). This test evaluates whether the combination of the supervisory alliance-to-alliance and alliance-to-outcome paths is significant and thus indicates a mediation effect.

Results

Preliminary Analyses

Table 1 presents means and standard deviations of study variables, and Table 2 lists correlations between study variables. Both professionals and supervisors reported moderate to high levels of supervisory alliance, with supervisors reporting significantly higher levels of supervisory alliance, $t(77) = -3.51$, $p < .01$. Parents and professionals reported high levels of alliance and outcomes, with parents reporting significantly higher levels of early alliance, $t(123) = 8.70$, $p < .001$, satisfaction with care (process: $t[73] = 6.75$, $p < .001$; results: $t[73] = 4.36$, $p < .001$), and change in parent functioning, $t(86) = 3.38$, $p < .01$. Paired-samples *t*-tests showed that parent- and professional-reported alliance did not significantly change from early to late in care (parent-reported alliance: $t[88] = -1.73$, $p = .09$; professional-reported alliance: $t[121] = -.25$, $p = .80$). Correlational analyses showed moderate correlations between professional- and supervisor-reported supervisory alliance ($r = .42$, $p < .001$). Correlations between parent- and professional-reported alliance and outcomes indicated a moderate relation for early alliance ($r = .33$, $p < .001$), a small and non-significant relation for change in alliance ($r = .16$, $p = .17$), and moderate relations for outcome variables (satisfaction with care process: $r = .35$, $p < .001$; satisfaction with care results: $r = .49$, $p < .001$; change in parent functioning: $r = .36$, $p < .01$).

Table 1 Descriptive Statistics for Supervisory Alliance, Alliance, and Outcome Variables

	M	*SD*	Range
Supervisory alliance: Professional	3.46	.76	1.42 – 5.00
Supervisory alliance: Supervisor	3.77	.58	2.42 – 4.92
Early alliance: Parent	4.35	.58	2.67 – 5.00
Early alliance: Professional	3.87	.52	2.67 – 5.00
Change in alliance: Parent	0.00	.39	-1.18 – 0.71
Change in alliance: Professional	0.00	.55	-1.98 – 1.09
Satisfaction process: Parent	3.69	.42	2.50 – 4.00
Satisfaction process: Professional	3.29	.40	2.25 – 4.00
Satisfaction results: Parent	3.27	.50	2.17 – 4.00
Satisfaction results: Professional	2.99	.46	1.83 – 4.00
Change in functioning: Parent	2.43	1.07	-1.00 – 4.00
Change in functioning: Professional	1.85	1.18	-3.00 – 4.00

Associations Between Supervisory Alliance and (Change in) Alliance

We examined associations between professional- and supervisor-reported supervisory alliance and (change in) parent- and professional-reported alliance, using a series of regression analyses. With respect to the effects of supervisory alliance on early alliance, results indicated a significant positive relation between professional-reported supervisory alliance and professional-reported early alliance (β = .27, p < .01). Professional-reported supervisory alliance did not evidence a significant relation with parent-reported early alliance (β = .12, p = .17). Moreover, supervisor-reported supervisory alliance was not found to be associated with parent-reported early alliance (β = .06, p = .52) or professional-reported early alliance (β = -.03, p = .70). Thus, a strong supervisory alliance was related to stronger alliances early in care, only when both were professional-reported.

Regarding the effects of supervisory alliance on change in alliance, results indicated no significant effects. Professional- and supervisor-reported supervisory alliance were not found to predict change in parent-reported alliance (professional-reported supervisory alliance: β = .08, p = .49; supervisor-reported supervisory alliance: β = .03, p = .75) or change in professional-reported alliance (professional-reported supervisory alliance: β = -.04, p = .74; supervisor-reported supervisory alliance: β = .07, p = .46).

Table 2 Correlations Between Study Variables

	1	2	3	4	5	6	7	8	9	10	11
1 Supervisory alliance: Professional											
2 Supervisory alliance: Supervisor	.42***										
3 Early alliance: Parent	.12	.08									
4 Early alliance: Professional	.27**	-.01	.38***								
5 Change in alliance: Parent	.08	.03	.00	.12							
6 Change in alliance: Professional	-.04	.04	-.12	.00	.16						
7 Satisfaction process: Parent	.24**	.03	.45***	.29*	.54***	.15					
8 Satisfaction process: Professional	.13	.04	.20*	.38***	.22†	.52***	.35**				
9 Satisfaction results: Parent	.13	.11	.25**	.26**	.44***	.23†	.58***	.36**			
10 Satisfaction results: Professional	.21*	.17*	.04	.40***	.25*	.54***	.34**	.79***	.49***		
11 Change in functioning: Parent	.21†	.23*	.23*	.34**	.29**	.24	.44***	.25†	.60***	.43***	
12 Change in functioning: Professional	.05	.03	-.04	.18*	.11	.40***	.07	.53***	.28**	.59***	.36**

Note: † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Supervisory Alliance Predicting Outcome

We examined whether professional- and supervisor-reported supervisory alliance predicted parent- and professional-reported outcomes of care in addition to the predictive value of the alliance. For models including early alliance (see Table 3), we found that parent- and professional-reported alliance predicted parent- and professional-reported outcomes. Regarding the effects of the supervisory alliance, we found that professional-reported supervisory alliance did not significantly predict parent- or professional-reported outcomes above and beyond the effects of parent- and professional-reported alliance on outcomes. However, we found a significant positive association between supervisor-reported supervisory alliance and parent-reported change in parent functioning (models 3 and 7: $\beta = .26$, $p < .05$), and professional-reported satisfaction with care results (model 8: $\beta = .19$, $p < .05$). No other significant associations were found between the supervisory alliance and outcomes. Thus, stronger supervisor-reported supervisory alliance predicted more parent-reported improvement and higher levels of professional-reported satisfaction with care results, above and beyond the predictive value of early parent- and professional-reported alliance.

For models including change in alliance (see Table 4), we found that change in parent- and professional-reported alliance predicted parent- and professional-reported outcomes. In addition to the effects of change in alliance, we found significant positive associations between professional-reported supervisory alliance and parent-reported satisfaction with care process (model 1: $\beta = .19$, $p < .05$; model 5: $\beta = .25$, $p < .01$), and professional-reported satisfaction with care results (model 6: $\beta = .21$, $p < .01$). Moreover, we found significant positive associations between supervisor-reported supervisory alliance and parent-reported change in parent functioning (model 3: $\beta = .26$, $p < .05$), and professional-reported satisfaction with care results (model 8: $\beta = .14$, $p < .05$). No other significant associations were found between the supervisory alliance and outcomes. Thus, above and beyond effects of change in alliance on outcomes, stronger professional-reported supervisory alliance predicted higher levels of parent-reported satisfaction with care process, and higher levels of professional-reported satisfaction with care results. Stronger supervisor-reported supervisory alliance predicted more parent-reported improvement and higher levels of professional-reported satisfaction with care results.

Mediation Analyses

Since only the association between professional-reported supervisory alliance and professional-reported early alliance was significant, we examined indirect effects of professional-reported supervisory alliance on parent- and professional-reported outcomes. Indirect effects of professional-reported supervisory alliance were significant

Table 3 Standardized Regression Coefficients for the Effects of Early Alliance and Supervisory Alliance on Outcomes

	Parent-reported outcomes			Professional-reported outcomes		
	Satisfaction: Process	Satisfaction: Results	Change in functioning	Satisfaction: Process	Satisfaction: Results	Change in functioning
	β	β	β	β	β	β
Models 1 & 2						
Early alliance: Parent	.45***	.26**	.22*	.24**	.06	-.05
Supervisory alliance: Professional	.18†	.08	.18	-.01	.10	.06
Models 3 & 4						
Early alliance: Parent	.44***	.20*	.13	.24**	.02	-.06
Supervisory alliance: Supervisor	-.02	.12	.26*	.03	.18†	.05
Models 5 & 6						
Early alliance: Professional	.25*	.27**	.34**	.40***	.40***	.19†
Supervisory alliance: Professional	.16	.03	.10	-.05	.02	.00
Models 7 & 8						
Early alliance: Professional	.25†	.25*	.29*	.37***	.41***	.20*
Supervisory alliance: Supervisor	.03	.13	.26*	.06	.19*	.05

Note: † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Table 4 Standardized Regression Coefficients for the Effects of Change in Alliance and Supervisory Alliance on Outcomes

	Parent-reported outcomes			Professional-reported outcomes		
	Satisfaction: Process	Satisfaction: Results	Change in functioning	Satisfaction: Process	Satisfaction: Results	Change in functioning
	β	β	β	β	β	β
Models 1 & 2						
Change in alliance: Parent	.51***	.42***	.27*	.24*	.23*	.10
Supervisory alliance: Professional	.19*	.08	.18	.02	.09	.04
Models 3 & 4						
Change in alliance: Parent	.49***	.41***	.31**	.21†	.22*	.07
Supervisory alliance: Supervisor	.03	.13	.26*	.03	.17†	.04
Models 5 & 6						
Change in alliance: Professional	.16	.25*	.27†	.54***	.56***	.40***
Supervisory alliance: Professional	.25**	.13	.23†	.14†	.21**	.07
Models 7 & 8						
Change in alliance: Professional	.15	.22	.28†	.53***	.52***	.39***
Supervisory alliance: Supervisor	.04	.14	.26†	.01	.14*	.02

Note: † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

for professional-reported satisfaction with care (process: $\beta = .06$, $p < .05$; outcomes: $\beta = .07$, $p < .05$) but not for professional-reported change in parent-functioning ($\beta = .08$, $p = .11$). Thus, higher levels of professional-reported supervisory alliance predicted higher levels of professional-reported satisfaction with care through higher levels of professional-reported early alliance. No significant indirect effects were found for professional-reported supervisory alliance on parent-reported outcomes.

Discussion

This study examined the relation between the supervisory alliance, the alliance, and care outcomes in home-based parenting support. Results showed that a stronger professional-reported supervisory alliance was related to a stronger professional-reported alliance early in care. The supervisory alliance did not predict change in alliance. In addition to the predictive value of early alliance and change in alliance, a stronger supervisory alliance reported by professionals predicted higher levels of parent- and professional-reported satisfaction with care. A stronger supervisory alliance reported by supervisors predicted parent-reported improvement in parent functioning, and higher levels of professional-reported satisfaction with care. We found that a stronger professional-reported supervisory alliance predicted higher levels of professional-reported satisfaction with care through higher levels of professional-reported alliance. Together, these findings suggest that the supervisory alliance may relate to strong alliances and contribute to positive outcomes of home-based parenting support above and beyond the predictive value of the alliance, although findings varied across informants and alliance assessments.

Our findings are consistent with a small number of theoretical (e.g., Lewis et al., 2014) and empirical studies (DePue et al., 2016; Ganske et al., 2015; Patton & Kivlighan, 1997) in adult treatment indicating that the supervisory alliance relates to the alliance. In line with research involving counseling trainees (DePue et al., 2016; Ganske et al., 2015), we found significant relations between the supervisory alliance and the alliance when the professional is the reporter. Current findings suggest that for youth care professionals a strong supervisory alliance may help them develop a strong alliance with parents. Moreover, it provides support to previous research suggesting that a strong supervisory alliance represents an important ingredient of effective supervision in youth care (e.g., Carpenter et al., 2013).

A few findings ran contrary to previous studies relating to the association between the supervisory alliance and the alliance. First, while Patton and Kivlighan (1997) found significant relations between professional-reported supervisory alliances and client-reported alliances, our results only showed significant associations between the supervisory alliance and the alliance early in care when professionals reported on both.

These contrasting findings potentially result from differences in study designs. We did not assess the supervisory alliance and alliance at the exact same session like Patton and Kivlighan (1997). Moreover, our study focused on supervision serving a wide range of functions, whereas Patton and Kivlighan (1997) looked at clinical supervision with a focus on client-professional interactions (i.e., real-time observations of treatment sessions, direct and in-session feedback and modeling).

Second, we did not find that the supervisory alliance predicted change in alliance. Although this might indicate that the supervisory alliance is not important for how alliance changes over care, it is possible that assessing the supervisory alliance at a single time point might not reflect the complex dynamics and mutual interactions between the supervisory alliance and the alliance. As suggested by previous studies, changes in the supervisory alliance throughout care (Patton & Kivlighan, 1997) or interactions between professionals and supervisors in times of alliance ruptures (Friedlander, 2015) may be particularly important for how the alliance evolves during care.

Our finding that a strong supervisory alliance is related to positive care outcomes is consistent with research in other service settings (e.g., adult treatment; Bambling et al., 2006; Palomo et al., 2010). Professional- and supervisor-reported supervisory alliances predicted parent- and professional-reported outcomes of home-based parenting support, above and beyond the predictive value of early alliance and change in alliance. This suggests that a strong supervisory alliance may help professionals realize positive care outcomes. It also indicates that professional and supervisor perspectives on the supervisory alliance are both relevant sources of information when investigating the supervisory alliance and its role in predicting outcomes (e.g., Locke et al., 2018; Watkins, 2014). Our finding regarding the mediating role of alliance supports the idea that, for youth care professionals, the supervisory alliance may impact care outcomes through stronger alliances. This finding is consistent with theoretical studies (Lewis et al., 2014) suggesting that the alliance plays a role in connecting the supervisory alliance with care outcomes. It also provides support to research in adult treatment (e.g., Bambling et al., 2006; Bambling & King, 2014; DePue et al., 2016; Friedlander, 2015), highlighting the need for supervision that includes a focus on the supervisory alliance and its relation with the alliance, when aiming to improve care outcomes.

However, associations between the supervisory alliance and outcomes were not significant for all supervisory alliance and outcome assessments across models including early alliance and alliance change. Moreover, apart from the professional-reported alliance linking professional-reported supervisory alliances and outcomes, the alliance was not found to play a role in connecting all other supervisory alliance and outcome variables. These inconsistent findings may result from the large number of interacting factors involved in determining care outcomes (e.g., Lewis et al., 2014;

Palomo et al., 2010; Pijnenburg, 2010), with many of these factors not captured in this study. For example, the impact of the supervisory alliance on outcomes may depend on professional or client characteristics (Lewis et al., 2014), or might be explained by other factors than the alliance (e.g., professional outcomes such as job satisfaction work-related stress; Carpenter et al., 2013; Locke et al., 2018). Moreover, our finding that the supervisor-reported supervisory alliance predicts client improvement and not satisfaction with care processes, might indicate that the supervisor-reported supervisory alliance is particularly important for client outcomes. However, as suggested by theoretical studies (Lewis et al., 2014) strong supervisory alliances may also result from a professional's ability to realize positive care outcomes in other cases. For future work it is thus important to identify circumstances and mechanisms that explain when, why, and how the supervisory alliance predicts care outcomes.

Our study was the first to evaluate the relation between the supervisory alliance, the alliance, and outcomes in home-based parenting support. The use of multiple informants for key constructs and a longitudinal design represent strengths of our study that allowed us to investigate how relations among these variables played out over care, and to address the issue of shared-method variance when investigating associations between the supervisory alliance, the alliance, and outcomes. Finally, the focus on usual clinical care in a widely used service enhances relevance and generalizability of our findings.

Several limitations of this study must be noted as well. First, although the current sample likely reflects the population and content of supervision and parenting support as typically provided in Dutch youth care organizations, we were not able to fully characterize the sample nor the supervision and care provided. It thus remains unclear whether factors not included in this study (e.g., supervision, intervention, professional or client characteristics) might affect or help explain the associations between the supervisory alliance, the alliance, and outcomes. Second, our study design does not provide insight in the temporal sequence and mutual influence of supervisory alliance, alliance, and outcome variables. Although we assessed the supervisory alliance prior to outcome and thereby found evidence for the supervisory alliance predicting care outcomes, we assessed the supervisory alliance only once and concurrently with early alliance and used retrospective measures to assess care outcomes. It thus remains unclear whether the supervisory alliance predicts early alliance or vice versa, and whether developmental trajectories of both variables influence each other over time (e.g., see Patton & Kivlighan, 1997). Also, it is not clear whether early experiences of satisfaction and client functioning impacted alliance or alliance change (McLeod & Weisz, 2005), or whether our retrospective outcome measures might have been confounded by alliance.

Implications for future research are indicated by the findings and limitations of this study. It is of primary importance to replicate our findings and to build a stronger evidence base regarding the association of the supervisory alliance with care processes and outcomes in youth care. Future studies should capture developmental trajectories and interplay of the supervisory alliance, the alliance and client functioning over the course of provided care (e.g., see Lange et al., 2017; Patton & Kivlighan, 1997). Ideally, these studies also investigate whether professional- or supervisor-level factors (e.g., competencies, job satisfaction; Carpenter et al., 2013; Ganske et al., 2015; Watkins, 2014), and organizational factors (e.g., organizational culture and climate; availability of support for supervisors; Glisson & Green, 2011; Wilkins et al., 2017; Williams & Glisson, 2014) influence the supervisory alliance or explain its association with alliance and care outcomes. Finally, supervisory alliance research would benefit from the development of validated, clinically relevant, and practically feasible questionnaires (Schweitzer & Witham, 2017) and observational measures (Watkins, 2014) that match the specific dynamics of supervision in youth care. To date, knowledge regarding the supervisory alliance is mainly based on self-report data (Watkins, 2014). Observations will add another perspective to professionals' and supervisors' reports on the supervisory alliance. Observations also enable reflection on the strength of the supervisory alliance, and help to identify actual behaviors and interactions that constitute a strong supervisory alliance.

Although our knowledge regarding the supervisory alliance is still in its formative stage, the current findings have clinical implications. For professionals, supervisors, and youth care organizations it is important to be aware of the role that the supervisory alliance may play in promoting positive alliances and outcomes for parents involved in home-based parenting support. As a common understanding between professionals and supervisors of the strength of the supervisory alliance is not self-evident (e.g., Palomo et al., 2010), it is useful to monitor the supervisory alliance and regularly ask for feedback. Discussing and learning from supervisory alliance feedback also allows to signal and repair low or decreasing levels of the supervisory alliance (Falender & Shafranske, 2014; Watkins, 2014), and serves as an example for professionals on how to use alliance feedback with clients (Patton & Kivlighan, 1997).

To conclude, our findings highlight the importance of a strong supervisory alliance in home-based parenting support. Future research is needed to identify factors that contribute to strong supervisory alliances and explain linkages between the supervisory alliance, the alliance, and outcomes. This represents an important area for future research and quality improvement, as efforts to strengthen the supervisory alliance may likely improve the parent-professional alliance and outcomes for parents and children in home-based parenting support.

Chapter 6

General Discussion

The current dissertation aimed to advance knowledge regarding the importance of the alliance between parents and professionals for outcomes of child, parent, and family treatment in general, and home-based parenting support in particular. Moreover, we examined whether key factors in home-based parenting support and the supervisory alliance may impact the parent-professional alliance, and (thereby) outcomes of home-based parenting support. In this concluding chapter, we summarize and reflect on main findings of the four studies included in this dissertation. Subsequently, we provide suggestions for future research, indicated by the findings as well as strengths and limitations of this dissertation. We conclude with implications for professionals, educators, and policy makers, and indicate why these proposed quality improvement efforts would serve the interests of parents and children involved in home-based parenting support.

Summary of Main Findings

As a first step towards a better understanding regarding the importance of the parent-professional alliance, we started this dissertation with a systematic review on the association between the parent-professional alliance and outcomes of child, parent, and family treatment (Chapter 2). We found that a stronger parent-professional alliance was generally linked with improved clinical outcomes and stronger treatment engagement, although findings did vary across samples. Several methodological factors were found to influence the alliance-outcome association. The association was stronger for alliance assessed later in treatment or based on change scores (as opposed to alliance assessed early in treatment), for treatment engagement instead of clinical outcomes, and when the same informant reported on alliance and outcome. As studies presented mixed results regarding the role of other methodological factors (alliance source, timing of outcome measurement), and theoretical factors (problem type, child age, parent sex), no clear-cut conclusions could be drawn on how these factors may influence the alliance-outcome association.

Next, we examined whether empirical data supported the hypothesized importance of the parent-professional alliance for outcomes of home-based parenting support in youth care (Chapter 3). Specifically, we investigated the predictive value of early alliance and change in alliance during care on outcomes (i.e., satisfaction with care, change in parent functioning). Regarding the predictive value of early alliance, we found a stronger parent-reported alliance to predict more positive parent-reported outcomes, and a stronger professional-reported alliance to predict more positive parent- and professional-reported outcomes. Increases in professional-reported alliance during care predicted higher levels of professional-reported satisfaction and parent functioning but were not related to parent-reported outcomes. Change in parent-reported alliance was not related to outcomes.

Given the importance of a professional's ability to develop and maintain a strong alliance with parents for outcomes of home-based parenting support, we investigated factors that might impact the parent-professional alliance in two different studies. First, we examined whether factors key to home-based parenting support were related to early parent-professional alliances and predicted change in alliance during care (Chapter 4). This study showed that parents' previous involvement in similar services was related to lower levels of early parent-reported alliance, whereas positive care expectations were related to stronger early parent- and professional-reported alliances. Moreover, care expectations predicted change in professional-reported alliance during care; positive parent expectations predicted a decrease in alliance whereas positive professional expectations predicted an increase in professional-reported alliance. Voluntary versus mandated service involvement, parenting stress and child psychosocial problems were not found to influence the alliance.

In Chapter 5, we examined whether the strength of the supervisory alliance contributes to strong alliances and (thereby to) positive outcomes of home-based parenting support. Results demonstrated that a stronger supervisory alliance was related to a stronger alliance early in care when both were professional-reported. A stronger supervisory alliance reported by professionals predicted higher levels of parent- and professional-reported satisfaction with care. A stronger supervisory alliance reported by supervisors predicted parent-reported improvement in parent functioning, and higher levels of professional-reported satisfaction with care. Finally, effects of professional-reported supervisory alliance on professional-reported satisfaction with care were mediated through higher levels of professional-reported alliance.

Reflection on Main Findings

The Importance of a Strong Parent-Professional Alliance

The findings reported in this dissertation indicate that the alliance between parents and professionals represents a key process factor in realizing positive outcomes of treatments involving parents that are designed to help improve children's development in general (Chapter 2), and home-based parenting support in particular (Chapter 3). These findings are consistent with the alliance literature which shows that a strong client-professional alliance predicts positive outcomes of adult (Flückiger, Del Re, Wampold, & Horvath, 2018), youth (McLeod, 2011; Shirk, Karver, & Brown, 2011), and family treatment (Friedlander, Escudero, Heatherington, & Diamond, 2011). Moreover, findings are in line with a relatively small evidence base regarding the importance of a strong parent-professional alliance for positive outcomes of youth treatment (McLeod, 2011) and parenting interventions (e.g., Schmidt, Chomycz, Houlding, Kruse, & Franks,

2014). These results underscore the importance of a professional's ability to realize strong alliances with parents, in order to effectively serve families.

In addition to our overall conclusion that a strong parent-professional alliance plays a key role in promoting positive care outcomes, findings reported in this dissertation also show that several factors may impact the strength of the alliance-outcome association (Chapters 2 and 3). Consistent with previous research (e.g., McLeod, 2011), associations were generally stronger when the same informant reported on alliance and outcome, alliance was assessed later in care or based on change scores, and outcome measures were related to care processes instead of clinical outcomes. Our empirical study (Chapter 3) provided additional insights in whom and when to question when assessing the parent-professional alliance. In terms of timing of alliance assessments, this study underscores the importance of early alliance assessments in addition to assessing change in alliance during care, given their predictive value for outcomes of home-based parenting support. Regarding the alliance informant, the clients' view on the alliance is generally considered to be the best predictor for outcomes (Norcross, 2010). However, we found the professionals' view on the alliance to be an even more consistent predictor for outcomes of home-based parenting support, with its effects not being restricted to professional-reported outcomes. Although replication of current findings is important, this study showed that both early alliance and alliance change, as well as parents' and professionals' view on the alliance provide relevant information when aiming to predict outcomes of home-based parenting support.

A perfect alliance?

In addition to findings regarding the alliance-outcome association, two other observations (Chapters 3, 4, 5) deserve further discussion. First, parent- and professional-reported alliance scores were very high and stable over time. Although these high alliance levels may give rise to the idea that professionals do an excellent job in developing and maintaining strong alliances with parents, these scores may also reflect something else than perfect alliances. As high levels of client-professional alliances are often seen throughout the alliance literature (e.g., Miller, Duncan, Sorrell, & Brown, 2005), several scholars have sought to interpret and explain this phenomenon. It has been suggested that parents present themselves and how they feel about the provided care and their alliance with professionals different from how they actually feel (DePue, Lambie, Liu, & Gonzalez, 2016; Korfmacher, Green, Spellmann, & Thornburg, 2007; Steens, Hermans, & Van Regenmortel, 2017). High levels of parent-reported alliance may be due to social desirability (DePue et al., 2016; Hatcher & Gillaspy, 2006; Korfmacher et al., 2007) given the often dependent position of parents in youth care and far-reaching consequences (e.g., child placement and permanency decisions) of how parents collaborate during care (McWey, Holtrop, Stevenson Wojciak, & Claridge, 2015; Steens et al., 2017). High

and stable alliance scores may also result from problems with alliance measures. It might be hard to discriminate between lower-end scores of scales (DePue et al., 2016; Hatcher & Gillaspy, 2006), or measures may not be sensitive to changes in alliance strength. Finding ways to accurately capture how parents and professionals view their alliance would thus be useful (Korfmacher et al., 2007). Still, in line with previous research (Duncan et al., 2003), small differences between alliance scores and small changes in alliance over time do predict outcomes of home-based parenting support (Chapter 3). As such, this knowledge should guide interpretation of alliance scores in clinical practice.

Second, although parents and professionals both reported positive alliances, low correlations between parents' and professionals' view on the alliance (Chapters 3, 4, 5) indicate discrepancies in how both partners experience the strength of their alliance (Fjermestad et al., 2016; Kazdin & Whitley, 2006). This finding is in line with alliance research in youth treatment, also indicating generally low cross-informant agreement on the alliance (e.g., Fjermestad et al., 2012; Kendall et al., 2009; McLeod & Weisz, 2005). It underscores that parents' alliance evaluation is not necessarily in line with how professionals experience the alliance (e.g., Duncan et al., 2003). Moreover, one can question whether individuals' view on the alliance (i.e., parent beliefs about the professional and vice versa) truly captures the alliance, defined as a collaborative relationship including a positive emotional bond, and client-professional agreement on treatment goals and tasks (Bordin, 1979; Elvins & Green, 2008; Fjermestad et al., 2016). Guided by a handful of studies in youth treatment (e.g., Altena et al., 2017; Fjermestad et al., 2016), and models to conceptualize and analyze dyadic processes (Back & Kenny, 2010), our understanding of the role of the alliance in predicting outcomes of home-based parenting support may benefit from approaches treating the alliance as an interpersonal construct. For example, one can examine whether the degree of parent-professional alliance agreement predicts outcomes (e.g., Fjermestad et al., 2016; Goolsby et al., 2018), or decompose alliance scores into parent, professional, and relationship components and see how these components relate to care outcomes (e.g., Altena et al., 2017; Back & Kenny, 2010). Together, these studies can help answer the question whether the degree of interpersonal agreement on alliance strength may serve as an indicator of how perfect the parent-professional alliance actually is, and how well alliance agreement serves as a predictor of care outcomes.

Factors that Impact the Alliance

This dissertation indicated that several factors key to home-based parenting support (Chapter 4) and factors in the organizational context in which youth care professionals provide their services (Chapter 5), relate to a professional's ability to develop a strong alliance with parents. Consistent with conceptual studies in youth care (Platt, 2012) and empirical studies in adult (e.g., Arnkoff, Glass, & Shapiro, 2002) and youth treatment

(e.g., Haine-Schlagel & Walsh, 2015; Nock & Kazdin, 2001), we found stronger parent-professional alliances early in care if parents had no previous involvement in similar services, and when parents and professionals held more positive care expectations. These results emphasize the need for professionals to discuss parents' previous care experiences and care expectations when working to develop strong parent-professional alliances.

With respect to factors in the organizational context that might impact the alliance, this dissertation indicated that a strong supervisory alliance may help professionals to develop a strong alliance with parents. Moreover, both professionals' and supervisors' view on their supervisory alliance were found to predict outcomes of home-based parenting support. These findings are in line with a small number of studies on adult treatment, suggesting that a strong supervisory alliance relates to the alliance (DePue et al., 2016; Ganske, Gnilka, Ashby, & Rice, 2015; Patton & Kivlighan, 1997), and care outcomes (e.g., Palomo, Beinart, & Cooper, 2010). Interestingly, the predictive value of the supervisory alliance for outcomes was only partly explained by improved alliances, and the supervisory alliance was found to contribute to outcomes of home-based parenting support, above and beyond the predictive value of the alliance on outcomes. Together, these results underscore that supervision in youth care can help professionals to optimize care processes and outcomes (e.g., Carpenter, Webb, & Bostock, 2013), with the supervisory serving as a leverage point for bolstering parent-professional alliances, and (thereby) outcomes of home-based parenting support.

Is it really that simple?

Although we identified some factors as being important for alliance development, this dissertation also showed that we cannot simply predict the likelihood of developing and particularly maintaining strong alliances on the basis of a few separate factors, at least not those examined in this dissertation. Several factors key to home-based parenting support were not related to alliance strength early in care (i.e., voluntary versus mandated service involvement, level of parenting stress and child psychosocial problems; Chapter 4), and none of the factors investigated in this dissertation (i.e., key factors in home-based parenting support, supervisory alliance) served as a clear predictor for change in alliance over the course of home-based parenting support (Chapters 4 and 5). Current findings paralleled limited and inconsistent results from studies searching for alliance predictors (e.g., type and severity of client problems, client and professional background characteristics) in adult (e.g., Horvath & Bedi, 2002) and youth treatment (e.g., Ayotte, Lanctôt, & Tourigny, 2015; Chu, Skriner, & Zandberg, 2014; Jensen-Doss & Weisz, 2006). Together, previous research and current findings give rise to the idea that alliance strength is determined by multiple and constantly interacting factors that are at play in home-based parenting support. For example, the impact of client functioning

on the alliance may depend on other client factors such as motivation, or professionals' ability to compensate for challenges related to client functioning with increased alliance building skills (Chu et al., 2014; Fjermestad et al., 2018). Awareness regarding the potential impact of care expectations, care experiences, and the supervisory alliance may thus help professionals to address challenges in alliance development. However, developing and maintaining a strong alliance likely asks for more complex professional skills as well, including ongoing adjustment of professional behaviors and strategies to match the unique needs of parents involved in that particular case.

Directions for Future Research

How to Explain Associations?

This dissertation contributed to a small and rather dispersed body of knowledge regarding the parent-professional alliance in the context of services that aim to promote child psychosocial functioning and development. Our systematic review (Chapter 2) synthesized all available studies investigating the association between the parent-professional alliance and outcomes of child, parent, and family treatment. Together, our empirical studies (Chapters 3, 4, 5) were the first to show that early alliance and change in alliance predicted outcomes of home-based parenting support, and that several key factors in home-based parenting support as well as the supervisory alliance related to alliance strength. However, these studies cannot explain why the parent-professional alliance relates to outcomes, and can only partly explain differences in alliance strength. Moreover, although we employed several methodological features that strengthened the interpretability of our findings (e.g., multiple time points, multiple informants for key constructs), our study design did not enable us to provide insight in the temporal sequence and mutual influence of studied variables. To guide quality improvement efforts in youth care, future research needs to identify circumstances and mechanisms that explain when, why, and how the alliance predicts outcomes, and to provide insight in what professionals can do to develop and maintain strong parent-professional alliances.

For these future studies, it is important to capture developmental trajectories of alliance, client (e.g., functioning, motivation), professional (e.g., competencies), and contextual (e.g., supervisory alliance) factors throughout care. Changes in the parent-professional alliance and other variables (e.g., supervisory alliance) may occur quickly, resulting from, or causing changes in other factors and processes in care (e.g., Friedlander, 2015; Patton & Kivlighan, 1997). Fine-grained research designs that correspond to the natural rate of change of the alliance and other variables are needed (Van Geert & Lichtwarck-Aschoff, 2005) to capture change, and to provide insight in how interactions

between alliance and other variables play out over care (e.g., Lange et al., 2017; Patton & Kivlighan, 1997).

To gain insight into what professionals can do to develop and maintain strong parent-professional alliances, the field may benefit from observational studies that focus on parents' and professionals' actual behavior and parent-professional interactions, and see how these relate to alliance strength. There might be much to gain from studying differences between professionals in terms of their behavior in interaction with parents, as professionals differ in their ability to realize strong alliances and (thereby) positive care outcomes (Baldwin, Wampold, & Imel, 2007; Miller et al., 2005; Miller, Hubble, & Chow, 2018). Some highly competent professionals may be able to develop strong alliances with most parents, irrespective of parents' clinical and background characteristics. In contrast, other professionals may only succeed in building strong alliances with parents who are able to and motivated to form an alliance and engage in care. If we are able to identify and visualize professional behaviors and parent-professional interaction patterns that help or hinder professionals to build strong alliances with parents in general, or with parents with specific clinical or background characteristics, this could improve professional training and supervision.

Content and Outcomes of Home-Based Parenting Support

An important strength of the current dissertation (Chapters 3, 4, 5) was the focus on the parent-professional alliance in the context of usual clinical care in a key service provided by youth care organizations: home-based parenting support. This enhanced the relevance and generalizability of our findings. Although study samples likely reflect the population involved in home-based parenting support, and the content and duration of home-based parenting support and supervision as typically provided in Dutch youth care organizations, we were not able to fully characterize the sample nor the care or supervision provided. It thus remains unclear whether factors not included in studies (e.g., client, professional, intervention or supervision characteristics) might affect or help explain associations between the alliance, outcomes, factors in home-based parenting support, and the supervisory alliance. Future research should characterize the population and provided services to better understand how these factors influence the alliance and its association with care outcomes.

As mentioned in our general introduction, the goal of home-based parenting support is to optimize parental competencies (Barth et al., 2005) and thereby positively change child development (Lewis, Feeley, Seay, Fedoravicis, & Kohl, 2016). In this dissertation (Chapters 3 and 5) we relied on outcome measures assessing satisfaction with care and experienced change in parent functioning. We chose to focus on satisfaction as this was the sole outcome measure that was consistently used across all participating youth care

organizations. We focused on change in parent functioning as this is directly targeted in home-based parenting support, and given the short and reliable measure that was compatible with already high workloads of professionals. However, these retrospective and global outcome measures do not fully capture effects of home-based parenting support. Parenting is a complex and multifaceted construct, and a study design including multiple (e.g., pre- and post-treatment) direct (e.g., observations) and indirect (e.g., questionnaires) measures of parent functioning (e.g., parent-child interaction, parenting stress) would have provided a more complete picture of changes in parent functioning (e.g., Dishion et al., 2017; Schmidt et al., 2014; Vlahovicova, Melendez-Torres, Leijten, Knerr, & Gardner, 2017). For future studies, it is important to investigate to what extent effects of the parent-professional alliance generalize to more specific outcome measures capturing parent functioning and other outcome domains including child psychosocial functioning and development.

Multiple Alliances at Work

This dissertation (Chapters 3, 4, 5) focused on the alliance between professionals and primary caregivers, mostly mothers. Although this focus on one parent is consistent with daily practice and parallels most of the studies included in our systematic review (Chapter 2), it does not fully reflect the complexity and dynamics of working with families. Oftentimes, other family members (e.g., fathers, children), members of families' social networks, and other professionals are at least partly or indirectly involved in home-based parenting support (e.g., Bartelink & Verheijden, 2015; Bolt, 2017; Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016; Van der Steege, 2015). Moreover, with respect to the supervisory alliance, the current dissertation focused on professionals' supervisory alliance with their line manager (Chapter 5) while youth care professionals often work with a clinical supervisor as well (Carpenter et al., 2013). Professionals are thus presented with the challenging task to simultaneously develop and maintain strong alliances with multiple people involved in a particular case (Pijnenburg, 2010; Welmers-van de Poll et al., 2017). For future studies it is important to capture these alliance dynamics of working with client systems, and all professionals and supervisors involved. Also, future studies involving a larger percentage of fathers are needed. Current knowledge about the parent professional alliance is largely based on the mother-professional alliance, while mothers and fathers may place different degrees of emphasis on each of the alliance components (i.e., task, goal, bond), and the alliance-outcome association may be different for both parents (e.g., Johnson, Wright, & Ketring, 2002).

Conceptual and empirical studies on family treatment (e.g., Pinsof, 1994; Friedlander et al., 2011) provided a framework and instrument (i.e., System for Observing Family

Therapy Alliances; SOFTA; Friedlander et al., 2006) that guides alliance assessments in the context of working with families. These studies suggest that it is warranted to assess the client-professional alliance for all people involved in a case, since the strength of each alliance may differ, and unbalanced or split alliances in client systems have been found to negatively impact care outcomes (Flicker, Turner, Waldron, Brody, & Ozechowski, 2008; Robbins, Turner, Alexander, & Perez, 2003; Welmers-van de Poll et al., 2017). Moreover, it is relevant to investigate the within family alliance, or the extent to which the client system experiences an emotional bond, and is willing to collaborate in care (also called: shared sense of purpose; Friedlander et al., 2011; Pinsof, 1994). Finally, it is important to assess the level of safety within the therapeutic system, since what is said in sessions with a professional can have repercussions outside these sessions, and feelings of unsafety can impact individual's willingness to open up in care (Friedlander et al., 2011; Welmers-van de Poll et al., 2017).

Like it is challenging for professionals to develop and maintain strong alliances with multiple clients, professionals, and supervisors, so is to study this complex network of interacting alliances. Still, family treatment studies indicated that this challenging type of research can be done (e.g., Escudero, Friedlander, Varela, & Abascal, 2008; Friedlander, Kivlighan, & Shaffer, 2012; Sheehan & Friedlander, 2015). Smaller-scale studies (e.g., case studies) using a mixed-methods design (e.g., observations, questionnaires, interviews; see Escudero et al., 2008; Friedlander et al., 2012; Sheehan & Friedlander, 2015) may help to shed light on what works in developing and maintaining multiple alliances, and to investigate how these alliances relate to outcomes of home-based parenting support.

It Is Not Just the Alliance

This dissertation focused on the parent-professional alliance, to clarify whether research findings from other service sectors regarding the importance of a strong alliance for care outcomes translates to home-based parenting support, and whether and how the alliance between parents and professionals could thus serve as a focus of quality improvement efforts in this service type. Although research on common factors such as the alliance is considered to be a relevant strategy to optimize outcomes in practice settings such as youth care (Barth et al., 2012), there are of course multiple other factors that also determine care outcomes. To help youth care professionals to work effectively with the complex and heterogeneous client population in home-based parenting support, more research is needed on other common factors (e.g., clients' hope and expectations, professional qualities) in interaction with the alliance, and the extent to which knowledge on these factors enables us to actually improve the effectiveness of home-based parenting support.

In addition to studying common factors, the youth care service sector may benefit from common elements research (Barth et al., 2012). Common elements refer to discrete treatment practices such as psychoeducation, rewards, and time-out that comprise an intervention (Chorpita, Becker, & Daleiden, 2007; Chorpita, Daleiden, & Weisz, 2005). Evidence on the effectiveness of specific techniques in home-based parenting support for particular clients is important, as it guides professional decision making in terms of what techniques to use in a specific case. Moreover, a modular approach to care based on common elements research offers the well-needed flexibility to match the needs and dynamics of the complex and heterogeneous client population involved in services such as home-based parenting support (Barth et al., 2012). Ideally, future research combines studying common elements and common factors, as this may increase insight into the relative importance of these factors for outcomes of parenting support. Resulting evidence can guide future research as well as quality improvement efforts in clinical practice, by suggesting which elements or factors are most promising to address to optimize outcomes of home-based parenting support.

Practical Implications

This dissertation indicated that a strong parent-professional alliance contributes to positive outcomes of child, parent, and family treatment in general, and home-based parenting support in particular. This finding, combined with gained knowledge on what factors to address when working to realize strong alliances, and ultimately, positive outcomes, has important implications for (future) professionals, supervisors, youth care organizations, educators and policy makers directly or indirectly involved in home-based parenting support.

First, for professionals it is important to be aware of the importance of the alliance in promoting positive outcomes when working with parents. This includes helping professionals realize that their view on the alliance may well not be in line with how parents judge the alliance, that strong alliances are not self-evident, and that there is no such thing as a ‘one size fits all recipe’ for strong alliances given the uniqueness of every clients’ situation and client-professional interaction in a specific case. It thus may be useful to monitor how parents and professionals view the alliance early in care, and whether the alliance changes over the course of care. To assess the parent-professional alliance, professionals can use the Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989), which has been used in this dissertation. However, it is also possible to build on knowledge and tools (e.g., Session Rating Scale; Duncan et al., 2003; Janse, Boezen-Hilberdink, Van Dijk, Verbraak, & Hutschemaekers, 2014) to monitor and discuss the alliance, as developed for adult and youth treatment settings. Alliance monitoring and feedback has been found to be helpful for professionals to signal weak alliances or

alliance ruptures during care (Duncan, Miller, & Sparks, 2004), thereby decreasing the risk of clients dropping out, and increasing chances for clients to benefit from provided care (Miller et al., 2005). Discussing the alliance also empowers parents, as it allows them to actively guide their own care trajectory, and make sure that it matches their personal goals and preferences in terms of how care is provided (e.g., Duncan et al., 2003).

Second, to increase the likelihood of a strong alliance, the current dissertation indicated that it appears helpful for professionals to discuss parents' previous care experiences and parents' and professionals' care expectations. This allows parents to express their thoughts regarding care and enables professionals to actively deal with negative, and build on positive experiences and expectations. Another promising avenue towards stronger alliances and positive outcomes of home-based parenting support, is the supervisory alliance. As with the alliance, a strong supervisory alliance cannot be assumed (e.g., Palomo et al., 2010), and thus asks for monitoring and feedback. This not only allows professionals and supervisors to signal and repair alliance ruptures (Falender & Shafranske, 2014; Watkins, 2014), it also serves as an example for professionals on how to use alliance feedback with clients (Patton & Kivlighan, 1997).

Addressing the alliance and factors associated with alliance strength is not only important for professionals and supervisors currently involved in providing home-based parenting support. Efforts from youth care organizations, educators of (future) professionals, and policy makers are needed to increase the likelihood that knowledge regarding the parent-professional alliance is actually used in clinical practice. For example, an organizational context in which the alliance is highly valued, where monitoring and learning from alliance feedback are part of daily routines, and feedback systems fit the realities of practice settings, likely supports professionals to address the alliance with parents (e.g., Duncan et al., 2003; Jensen-Doss et al., 2018; Miller et al., 2005; Miller et al., 2018). Moreover, it is important to explicitly educate (future) professionals about the importance of a strong parent-professional alliance, and to train their skills to manage the alliance. Finally, policy makers, having a strong and growing interest in home-based parenting support as the preferred service type for families with parenting and child developmental problems (Barth et al., 2005; Child Welfare Information Gateway, 2014; Hilverdink, Daamen, & Vink, 2015), can guide professionals' and organizational behavior as well. Knowing that the parent-professional alliance relates to care outcomes, a case could be made that the parent-professional alliance may serve as a quality indicator of home-based parenting support provided by youth care organizations (e.g., see also Green, Albanese, Cafri, & Aarons, 2014; McLeod, Southam-Gerow, Tully, Rodrigues, & Smith, 2013).

Closing Remarks

A strong alliance between parents and professionals represents a key process ingredient contributing to positive outcomes of child, parent, and family treatment in general, and home-based parenting support in particular. Previous care experiences, care expectations, and the supervisory alliance impact alliance strength and, ultimately, outcomes of home-based parenting support. Findings of this dissertation underscore the importance of addressing the alliance, both in future research as well as in clinical practice. Although the alliance is certainly not the sole factor that influences care outcomes, it has been suggested that professionals' influence on the alliance strength throughout care is the most direct impact professionals can have on care outcomes (Duncan et al., 2004). Future steps in research and clinical practice should support a professional's ability to develop and maintain a strong alliance with parents. The importance of a strong parent-professional alliance and the need to address the alliance may seem obvious. However, strong alliances are not self-evident, and problems with the alliance can cause detrimental outcomes for parents and children involved in home-based parenting support, as was clearly expressed by a mother in our study:

"As a mother, I really hope that all families involved in home-based parenting support encounter a professional they can develop a good alliance with. Only then it is possible to improve your situation. In my opinion, the first contacts matter most: if there is no click, it is not going to work. And to be honest, during our long history in youth care, my daughter and I encountered just two professionals we had a good alliance with. Only those people were really able to help us to move forward. And without any doubt: every family in youth care deserves this kind of professionals."

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Note. References marked with an asterisk indicate studies included in the systematic review of Chapter 2.

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Summary

Home-based parenting support is the most common service provided in youth care to help parents overcome problems with parenting or child development. Despite the importance of home-based parenting support and the fact that positive outcomes are by no means self-evident, this service type has undergone relatively little empirical examination. As a result, knowledge about factors contributing to positive outcomes of home-based parenting support is limited. Clients and professionals in youth care generally view the alliance between clients and professionals as key to providing effective services. The alliance, defined as a collaborative client-professional relationship that consists of a positive emotional bond and agreement on treatment goals and tasks, has been found to be a consistent predictor of outcomes in adult, youth, and family treatment. Based on research findings in other service sectors, it is plausible that the alliance may also play an important role in promoting positive outcomes of home-based parenting support.

However, the alliance is largely understudied in youth care. Also, most alliance research to date has not involved the client group that is often the main target of youth care services in general, and home-based parenting support in particular: parents. As a consequence, it is yet unclear to what extent the parent-professional alliance predicts outcomes of home-based parenting support, and whether the alliance would thus serve as a relevant focus for quality improvement efforts in this service type. Knowledge about factors contributing to strong parent-professional alliances is also scarce, hindering clear professional guidance on what factors to address when working to develop and maintain a strong parent-professional alliance. The current dissertation therefore aimed to advance knowledge regarding (1) the importance of the parent-professional alliance for care outcomes, and (2) factors that may impact the strength of the parent-professional alliance, and (thereby) outcomes of home-based parenting support.

The importance of a strong parent-professional alliance

As a first step towards a better understanding regarding the importance of the parent-professional alliance, we systematically reviewed studies examining the association between the parent-professional alliance and outcomes of child, parent, and family treatment designed to improve children's psychosocial functioning (Chapter 2). Building on findings of 46 included studies, we investigated the association between the parent-professional alliance and outcomes and factors that may impact the alliance-outcome association. We found that a stronger parent-professional alliance was generally linked with stronger treatment engagement, and improved clinical outcomes for involved children, parents and families, although findings did vary across samples. Several

methodological factors were found to influence the alliance-outcome association. Associations were generally stronger when the alliance was assessed later in treatment or based on change scores (as opposed to alliance assessed early in treatment), for treatment engagement instead of clinical outcomes, and when the same informant reported on alliance and outcome. As studies presented mixed results regarding the role of other methodological factors (alliance source, timing of outcome measurement), and theoretical factors (problem type, child age, parent sex), no clear-cut conclusions could be drawn on how these factors may influence the alliance-outcome association. Together, these findings show that the parent-professional alliance plays an important role in promoting positive outcomes of child-, parent-, and family-focused treatment, emphasizing the need for alliance awareness when working with parents as well as a need for future studies to further and more in depth investigate the parent-professional alliance. We suggest future studies to investigate the strength of the alliance-outcome association in specific types of treatment, combined with the identification of factors influencing alliance strength or the alliance-outcome association. These studies provide professionals with more knowledge on how important the parent-professional alliance may be for outcomes in specific circumstances, and they also provide suggestions on how best to optimize and monitor the parent-professional alliance.

Next, we examined whether empirical data supported the hypothesized importance of the parent-professional alliance for outcomes of home-based parenting support in youth care (Chapter 3). Using multi-informant self-report alliance and outcome data from 146 parent-professional dyads collected early (alliance) and late (alliance, outcomes) in home-based parenting support, we investigated the predictive value of early alliance and change in alliance during care on outcomes (i.e., satisfaction with care, change in parent functioning). Regarding the predictive value of early alliance, we found that higher levels of parent-reported alliance predicted higher levels of parent-reported satisfaction with care, and improved parent functioning. A stronger professional-reported alliance predicted higher levels of parent- and professional-reported satisfaction, and improved parent functioning. Although alliance scores were generally high and stable over time, we found that increases in professional-reported alliance predicted higher levels of professional-reported satisfaction and parent functioning. Change in parent-reported alliance was not related to outcomes. These results show that the parent-professional alliance plays a key role in promoting positive outcomes of home-based parenting support. Both parent (i.e., early) and professional (i.e., early, change) alliance reports appear to be valuable sources of information since both predict outcomes, and given the discrepancies (i.e., low correlations) between alliance reports of both informants. Based on these findings, we encourage professionals to monitor the parent- and professional-reported alliance, ask for alliance feedback, and address cases with low or decreasing levels of alliance. For future studies it is important to capture developmental trajectories of alliance and its interplay with parent functioning. Moreover, it is crucial to identify

factors that relate to alliance strength and to a professional's ability to develop and maintain strong alliances with parents and other family members.

Factors that impact the alliance

Given the importance of a professional's ability to develop and maintain a strong alliance with parents for outcomes of home-based parenting support, we investigated factors that might impact the parent-professional alliance in two different studies. First, using questionnaire data from 60 parent-professional dyads collected early and late in care, we examined whether key factors in home-based parenting support were related to early alliance, and predicted change in alliance (Chapter 4). These factors included: voluntary versus mandated service involvement, previous involvement in similar services, parenting stress, child psychosocial problems, and parents' and professionals' care expectations. Results showed that parents' previous involvement in similar services was related to lower levels of early parent-reported alliance, whereas positive care expectations were related to stronger early parent- and professional-reported alliances. Moreover, care expectations predicted change in professional-reported alliance during care; positive parent expectations predicted a decrease in alliance whereas positive professional expectations predicted an increase in professional-reported alliance. Voluntary versus mandated service involvement, parenting stress and child psychosocial problems were not found to influence the alliance. These findings emphasize the need for professionals to discuss previous care experiences and care expectations with parents early in home-based parenting support, as well as a need for future studies to identify other factors that influence alliance strength and alliance-building skills.

In our final study (Chapter 5), we investigated whether the supervisory alliance contributes to strong parent-professional alliances, and (thereby) to positive outcomes of home-based parenting support, using multi-informant self-report supervisory alliance, alliance, and outcome data from 124 parent-professional-supervisor triads collected early and late in care. Results demonstrated that a stronger supervisory alliance was related to a stronger alliance early in care when both were professional-reported. Moreover, both professionals' and supervisors' view on their supervisory alliance were found to predict outcomes of home-based parenting support, above and beyond the predictive value of the alliance on outcomes. A stronger supervisory alliance reported by professionals predicted higher levels of parent- and professional-reported satisfaction with care. A stronger supervisory alliance reported by supervisors predicted parent-reported improvement in parent functioning, and higher levels of professional-reported satisfaction with care. Finally, effects of professional-reported supervisory alliance on professional-reported satisfaction with care were mediated through higher levels of professional-reported alliance. Together, these findings suggest that the supervisory alliance would be a relevant focus for quality improvement efforts in home-

based parenting support, as a strong supervisory alliance may relate to strong alliances and contribute to positive outcomes of home-based parenting support. Future research is needed to help identify factors that contribute to strong supervisory alliances and explain linkages between the supervisory alliance, the alliance, and outcomes. These efforts may likely improve the supervisory alliance, the alliance, and outcomes of home-based parenting support.

Conclusions

As discussed in the General Discussion (Chapter 6), the findings reported in this dissertation clarified that the alliance between parents and professionals represents a key process factor that contributes to positive outcomes of treatments involving parents that are designed to help improve children's development in general, and home-based parenting support in particular. We found that both early alliance and alliance change, as well as parents' and professionals' view on the alliance provide relevant information when aiming to predict care outcomes. Moreover, we concluded that parents' previous care experiences, care expectations, and the supervisory alliance may impact alliance strength and, ultimately, outcomes of home-based parenting support.

These findings underscore the importance of addressing the alliance, both in future research and clinical practice. Next steps in research should contribute to our understanding of when, why, and how the alliance predicts outcomes, and what professionals can do to develop and maintain strong parent-professional alliances. For future studies it is important to capture developmental trajectories of the alliance and other relevant factors (e.g., client functioning, professional competencies, client-professional interactions, intervention characteristics) over the course of care. Moreover, the field would benefit from alliance studies that match the specific dynamics of working with families. Professionals in home-based parenting support are presented with the challenging task to simultaneously develop and maintain strong alliances with multiple people involved in a particular case (e.g., multiple parents, children, other professionals, clinical supervisor, line manager). Smaller-scale studies (e.g., case studies) using a mixed-methods design (e.g., observations, questionnaires, interviews; see Escudero et al., 2008; Friedlander et al., 2012; Sheehan & Friedlander, 2015) may help to shed light on what works in developing and maintaining multiple alliances with parents and others involved in a particular case, and to investigate how these alliances relate to outcomes of home-based parenting support.

In terms of implications for clinical practice, it is important for professionals to be aware of the importance of the alliance in promoting positive outcomes when working with parents. This includes helping professionals realize that their view on the alliance may well not be in line with how parents judge the alliance, that strong alliances are not self-

evident, and that there is no such thing as a 'one size fits all recipe' for strong alliances given the uniqueness of every parents' situation and parent-professional interaction in a specific case. It is thus important that professionals monitor the parent- and professional-reported alliance, ask for alliance feedback, and address cases with low or decreasing levels of alliance. Moreover, given their association with alliance strength, we suggest professionals to discuss parents' previous care experiences, parents' and professionals' care expectations, and the supervisory alliance. Addressing the alliance and factors associated with alliance strength is not only important for professionals and supervisors currently involved in providing home-based parenting support. Efforts from youth care organizations, educators of (future) professionals, and policy makers are needed to increase the likelihood that knowledge regarding the parent-professional alliance is actually used in clinical practice. Together, these efforts will serve (future) professionals in working effectively with parents. More importantly, it will serve the interests of parents and children who rely on home-based parenting support.

Samenvatting | Summary in Dutch

Ambulante gezinshulpverlening is de meest ingezette hulpverleningsvorm binnen de jeugd- en opvoedhulp en richt zich op het ondersteunen van ouders met problemen op het gebied van opvoeding of de ontwikkeling van de kinderen in hun gezin. Ondanks het belang van deze hulpverleningsvorm en het gegeven dat positieve hulpverleningsresultaten niet vanzelfsprekend zijn, bestaat er nog weinig zicht op factoren die bijdragen aan effectieve ambulante gezinshulpverlening. Cliënten en hulpverleners binnen de jeugd- en opvoedhulp zien een goede alliantie tussen cliënt en hulpverlener doorgaans als een belangrijke factor voor het realiseren van positieve hulpverleningsresultaten. Alliantie wordt gedefinieerd als een professionele samenwerkingsrelatie waarin sprake is van een positieve emotionele band of 'klik', en overeenstemming over samenwerkingsdoelen en de werkwijze die nodig is om die doelen te bereiken. Onderzoek gericht op therapie voor volwassenen, jeugdigen en gezinnen heeft uitgewezen dat de alliantie een consistente voorspeller vormt voor hulpverleningsresultaat. Gezien de onderzoeksbevindingen uit andere sectoren ligt het voor de hand dat alliantie ook een belangrijke rol speelt binnen de ambulante gezinshulpverlening.

In de jeugd- en opvoedhulp is echter nog verrassend weinig onderzoek gedaan naar alliantie. Bovendien richtte eerder alliantieonderzoek zich nauwelijks op een belangrijke doelgroep van de jeugd- en opvoedhulp in zijn algemeenheid, en ambulante gezinshulpverlening in het bijzonder: ouders. Het is daarom nog onduidelijk in hoeverre de ouder-hulpverlener alliantie bijdraagt aan positieve hulpverleningsresultaten, en daarmee dus een relevante focus zou vormen voor kwaliteitsverbetering van ambulante gezinshulpverlening. Ook bestaat er nog nauwelijks zicht op factoren die van invloed zijn op de kwaliteit van de ouder-hulpverlener alliantie, waardoor het hulpverleners ontbreekt aan concrete aanknopingspunten voor het ontwikkelen en behouden van goede allianties met ouders. Doel van dit proefschrift was dan ook om (1) zicht te geven op het belang van de ouder-hulpverlener alliantie voor hulpverleningsresultaat, en (2) op factoren die van invloed zijn op de kwaliteit van ouder-hulpverlener allianties en (daarmee) op het resultaat van ambulante gezinshulpverlening.

Het belang van een goede alliantie tussen ouders en hulpverleners

Om een beeld te krijgen van de bestaande kennis over het belang van de ouder-hulpverlener alliantie, startten we dit proefschrift met een systematische literatuurstudie (Hoofdstuk 2). Op basis van 46 geïncludeerde studies, onderzochten we de samenhang tussen de ouder-hulpverlener alliantie en het resultaat van hulp aan jeugdigen, ouders, en gezinnen, gericht op het verbeteren van het psychosociaal functioneren van jeugdigen.

Daarnaast bekeken we welke factoren van invloed zijn op de samenhang tussen alliantie en hulpverleningsresultaat. We vonden dat een betere ouder-hulpverlener alliantie doorgaans samengaat met verbeterd cliëntfunctioneren (i.e., van jeugdigen, ouders en gezinnen) en een beter verloop van de hulpverlening, hoewel er binnen en tussen studies variatie bestond ten aanzien van de sterkte en richting van dit verband. Verschillende factoren ten aanzien van de gebruikte onderzoeksmethode bleken van invloed op het verband tussen alliantie en resultaat. Zo was de samenhang doorgaans sterker wanneer (1) alliantie later in het hulptraject werd gemeten of wanneer verandering in alliantie in kaart werd gebracht, ten opzichte van alliantie gemeten in de beginfase van hulptrajecten, (2) resultaten betrekking hadden op het hulpverleningsproces in plaats van cliëntfunctioneren, en (3) alliantie en resultaat door dezelfde informant in plaats van door verschillende informanten werden beoordeeld. Omdat bevindingen van studies varieerden ten aanzien van de rol van overige methodologische factoren (beoordelaar van alliantie, moment van resultaatmeting) en cliëntfactoren (aard problematiek, leeftijd jeugdige, geslacht ouders), was het niet mogelijk om duidelijke conclusies te trekken over de invloed van deze factoren op de samenhang tussen alliantie en resultaat. Bevindingen van deze studie wijzen op het belang van een goede ouder-hulpverlener alliantie voor het realiseren van positieve resultaten van hulp aan jeugdigen, ouders en gezinnen. Het is dan ook belangrijk dat hulpverleners zich bewust zijn van dit belang en dat er verdiepend onderzoek komt naar de ouder-hulpverlener alliantie. Dit onderzoek zou zicht moeten geven op de sterkte van de samenhang tussen de ouder-hulpverlener alliantie en hulpverleningsresultaat binnen specifieke hulpverleningsvormen, en op factoren die van invloed zijn op alliantie en diens samenhang met resultaat. Hiermee krijgen hulpverleners beter zicht op het belang van de ouder-hulpverlener alliantie in specifieke omstandigheden, en krijgen zij aanknopingspunten voor het verbeteren en monitoren van de alliantie met ouders.

In Hoofdstuk 3 bekeken we in hoeverre empirische gegevens het veronderstelde belang van de ouder-hulpverlener alliantie voor het resultaat van ambulante gezinshulpverlening bevestigden. We onderzochten de voorspellende waarde van vroege alliantie en verandering in alliantie voor het hulpverleningsresultaat (tevredenheid met hulp, verandering in functioneren van ouders). Ouders (n = 146) en hun hulpverlener beoordeelden daartoe hun alliantie in de begin- en eindfase van hulptrajecten, en beoordeelden het hulpverleningsresultaat in de eindfase van hulptrajecten. Wat betreft de voorspellende waarde van vroege alliantie vonden we dat een betere alliantie zoals ervaren door ouders voorspellend was voor een positiever oordeel van ouders over het hulpverleningsresultaat. Een betere alliantie zoals ervaren door hulpverleners bleek voorspellend voor betere resultaten zoals beoordeeld door ouders en hulpverleners. Hoewel alliantiescores doorgaans hoog en stabiel waren gedurende het hulptraject, vonden we dat groei in alliantie zoals ervaren door hulpverleners voorspellend was voor betere hulpverleningsresultaten volgens hulpverleners. Verandering in alliantie

zoals ervaren door ouders bleek niet samen te hangen met hulpverleningsresultaat. De resultaten van deze studie laten zien dat de ouder-hulpverlener alliantie een belangrijke rol speelt in het realiseren van positieve resultaten van ambulante gezinshulpverlening. Zowel de alliantie zoals ervaren door ouders (vroege alliantie) als door hulpverleners (vroege alliantie, verandering in alliantie) zijn relevante informatiebronnen gezien hun voorspellende waarde voor hulpverleningsresultaat, en vanwege de beperkte samenhang tussen hoe ouders en hulpverleners hun alliantie ervaren. Gegeven deze bevindingen is het belangrijk dat hulpverleners monitoren hoe ouders en hulpverleners hun alliantie ervaren, ouders om alliantiefeedback vragen, en inzetten op alliantieverbetering in casussen waarin sprake is van minder goede of dalende allianties. Vervolgonderzoek is nodig om meer zicht te krijgen op hoe alliantie zich ontwikkelt tijdens hulpverleningstrajecten en hoe zich dit verhoudt tot ontwikkelingen in het functioneren van ouders. Daarnaast is het zinvol wanneer toekomstig onderzoek zicht geeft op factoren die samenhangen met alliantiekwaliteit en die bijdragen aan het vermogen van hulpverleners om goede allianties met ouders en overige gezinsleden te ontwikkelen en te behouden.

Factoren die van invloed zijn op alliantie

Gezien het belang van een goede ouder-hulpverlener alliantie voor effectieve ambulante gezinshulpverlening, zochten we in twee volgende studies naar factoren die van invloed zijn op alliantiekwaliteit. Allereerst bekeken we in hoeverre verschillende factoren in ambulante gezinshulpverlening samenhangen met alliantiekwaliteit in de beginfase van hulptrajecten, en voorspellend zijn voor verandering in alliantie gedurende de hulp (Hoofdstuk 4). Deze factoren betroffen: vrijwillig versus gedwongen hulpverleningskader, het eerder gelijksoortige hulp hebben ontvangen, opvoedingsstress van ouders, psychosociale problemen van kinderen, en verwachtingen van ouders en hulpverleners ten aanzien van het verloop en resultaat van ambulante gezinshulp. Hierbij maakten we gebruik van vragenlijstgegevens van 60 ouders en hun hulpverlener, verzameld in de beginfase (factoren, alliantie) en eindfase (alliantie) van hulptrajecten. We vonden dat wanneer ouders al eerder gelijksoortige hulp ontvingen, zij in de beginfase van hulptrajecten minder positief waren over de alliantie met hun hulpverlener. Positieve verwachtingen van ouders en hulpverleners bleken samen te hangen met betere allianties in de beginfase van hulptrajecten, zoals ervaren door ouders en hulpverleners. Verwachtingen ten aanzien van de hulp bleken bovendien van invloed op verandering in alliantie gedurende de hulp; positieve verwachtingen van ouders voorspelden een verminderde alliantie, positieve verwachtingen voorspelden daarentegen toegenomen alliantiekwaliteit zoals ervaren door hulpverleners. We vonden geen verband tussen hulpverleningskader, opvoedingsstress van ouders en psychosociaal functioneren van kinderen en alliantiekwaliteit. Deze bevindingen wijzen op het belang voor hulpverleners om eerdere ervaringen met hulpverlening en verwachtingen te bespreken met ouders

in de beginfase van hulptrajecten, en vragen daarnaast om vervolgonderzoek naar andere factoren die van invloed zijn op alliantiekwaliteit en alliantievaardigheden van hulpverleners.

In Hoofdstuk 5 onderzochten we in hoeverre de alliantie tussen hulpverleners en hun leidinggevende bijdraagt aan goede ouder-hulpverlener allianties, en (daarmee) aan positieve resultaten van ambulante gezinshulpverlening. Om deze vragen te beantwoorden gebruikten we vragenlijstgegevens van 124 ouders, hun hulpverlener en de leidinggevende van de hulpverlener, zoals verzameld in de beginfase (alliantie hulpverlener-leidinggevende, alliantie ouder-hulpverlener) en eindfase (alliantie ouder-hulpverlener, hulpverleningsresultaat) van hulptrajecten. Een betere hulpverlener-leidinggevende alliantie bleek samen te hangen met een betere ouder-hulpverlener alliantie in de beginfase van hulptrajecten, wanneer beide alliantievormen werden beoordeeld door hulpverleners. Daarnaast vonden we dat een betere hulpverlener-leidinggevende alliantie voorspellend was voor betere hulpverleningsresultaten, aanvullend op de effecten van de ouder-hulpverlener alliantie op hulpverleningsresultaat. Een betere hulpverlener-leidinggevende alliantie volgens hulpverleners, voorspelde een hogere mate van tevredenheid met de hulp zoals beoordeeld door ouders en hulpverleners. Een betere hulpverlener-leidinggevende alliantie volgens leidinggevenden, voorspelde meer vooruitgang in het functioneren van ouders zoals beoordeeld door ouders, en een hogere mate van tevredenheid met de hulp zoals beoordeeld door hulpverleners. Tot slot bleek dat de effecten van de hulpverlener-leidinggevende alliantie op tevredenheid met de hulp gemedieerd werden door betere ouder-hulpverlener allianties, wanneer hulpverleners beide alliantievormen en hulpverleningsresultaat beoordeelden. Deze resultaten wijzen erop dat dat de hulpverlener-leidinggevende alliantie een relevante focus vormt voor kwaliteitsverbetering van ambulante gezinshulp, gezien de samenhang met ouder-hulpverlener allianties en het positieve effect op hulpverleningsresultaten. Daarnaast is vervolgonderzoek nodig dat zicht geeft op factoren die bijdragen aan goede hulpverlener-leidinggevende allianties en op de mechanismen die de samenhang tussen beide alliantievormen en hulpverleningsresultaat kunnen verklaren. Met deze kennis is het mogelijk om gericht te werken aan verbeterde allianties (hulpverlener-leidinggevende, ouder-hulpverlener) en hulpverleningsresultaat.

Conclusies

In de Algemene Discussie van dit proefschrift (Hoofdstuk 6) concludeerden we dat een goede alliantie tussen ouders en hulpverleners een belangrijke factor is in het realiseren van positieve hulpverleningsresultaten binnen de hulp aan jeugdigen, ouders en gezinnen in zijn algemeenheid, en ambulante gezinshulpverlening in het bijzonder. Verschillende alliantiemetingen (vroege alliantie, verandering in alliantie, alliantie zoals ervaren door ouders en hulpverlener) bleken relevant te zijn bij het voorspellen van

hulpverleningsresultaat. Ook constateerden we dat eerdere hulpverleningservaringen van ouders, verwachtingen ten aanzien van de geboden hulp, en de alliantie tussen hulpverleners en leidinggevenden van invloed kunnen zijn op alliantiekwaliteit en (daarmee) op het resultaat van ambulante gezinshulpverlening.

De bevindingen benadrukken het belang van aandacht voor de alliantie, zowel in vervolgonderzoek als in de hulpverleningspraktijk. Voor toekomstig onderzoek is het van belang zicht te geven op factoren die alliantiekwaliteit en de samenhang tussen alliantie en resultaat beïnvloeden en kunnen verklaren, en te verhelderen wat hulpverleners kunnen doen om goede allianties met ouders te ontwikkelen en behouden. Daartoe is het zinvol om te bekijken hoe alliantie en andere relevante factoren (bv. cliëntfunctioneren, competenties van hulpverleners, cliënt-hulpverlener interacties, interventiefactoren) zich ontwikkelen in de loop van hulpverleningstrajecten. Daarnaast is het van belang dat toekomstig alliantieonderzoek aansluit bij de systemische context van ambulante gezinshulpverlening, waarin hulpverleners doorgaans samenwerken met verschillende partijen (bv. meerdere ouders, jeugdigen, andere hulpverleners, inhoudelijk en operationeel leidinggevenden). Kennis over factoren die bijdragen aan het vermogen van hulpverleners om meervoudige allianties te realiseren met ouders en andere samenwerkingspartners is wenselijk. Kleinschalige studies (bv. casestudies) met een mixed-method design (bv. observaties, vragenlijsten, interviews) kunnen daarbij helpend zijn.

Als het gaat om implicaties voor de hulpverleningspraktijk, is het belangrijk dat hulpverleners zich bewust zijn van het belang van een goede ouder-hulpverlener alliantie. Daarbij hoort het besef dat ouders en hulpverleners doorgaans niet op één lijn zitten in hoe zij hun alliantie ervaren, dat goede allianties niet vanzelfsprekend zijn en dat er geen ‘kant en klaar recept’ bestaat voor goede allianties, gezien de unieke omstandigheden en ouder-hulpverlener interacties in elke casus. Het is dus van groot belang dat hulpverleners de alliantie zoals ervaren door ouders en hulpverleners monitoren, om alliantiefeedback vragen, en inzetten op alliantieverbetering in casussen waarin sprake is van minder goede of dalende allianties. Daarnaast is het zinvol om eerdere hulpverleningservaringen van ouders, verwachtingen ten aanzien van de hulp en de hulpverlener-leidinggevende alliantie te bespreken met betrokkenen, gezien hun samenhang met alliantiekwaliteit. Deze thema’s verdienen niet alleen aandacht van huidige hulpverleners en organisaties en beleidsmakers die deze hulpverleners ondersteunen, maar dienen ook een structurele plek te krijgen in de opleiding van (toekomstige) hulpverleners. Deze vervolgstappen bieden kansen voor (toekomstige) hulpverleners om effectiever samen te werken met ouders. En belangrijker nog: hulpverleners die in staat zijn om goede allianties met ouders te realiseren en te behouden, hebben een waardevolle vaardigheid in handen om de situatie van gezinnen die zijn aangewezen op ambulante gezinshulpverlening te verbeteren.

Curriculum Vitae

Marieke de Greef was born on March 12th, 1986 in Eindhoven, the Netherlands. After completing secondary education at Commanderij College in Gemert in 2004, she studied Pedagogical and Educational Sciences at Radboud University in Nijmegen, the Netherlands. Here she obtained her bachelor's degree in 2007, and graduated from the Research Master Behavioural Science in 2009. As part of the Research Master program she completed research internships at the Developmental Psychopathology department (Radboud University), and Professor Thomas Dishion's Child and Family Center in Eugene, Oregon, United States (Oregon University). Given her interest in clinical work and research in youth care, she obtained a second master's degree in Pedagogical Sciences (Radboud University), involving clinical and research internships at the foster care department of youth care organization Oosterpoort. After graduating Cum Laude in 2010, she worked as a child and family psychologist in youth care (Oosterpoort: 2010-2012, Combinatie Jeugdzorg: 2012-2015). In 2011 Marieke joined the Key Factors in Youth Care research group at HAN University of Applied Sciences. In this position, she contributed to the development and execution of the 'Stronger Together' research and exchange program on alliance (2011-2015), and provided (invitational and curricular) lectures in bachelor and master courses in social work, educational and behavioural science. Building on one of the studies in the 'Stronger Together' research program, she started her Ph.D. project in 2015. In the next four years, she discussed her work with clients, (future) professionals, and policy makers in youth care, and presented her work at national (e.g., Jeugd in Onderzoek, 2015-2018) and international conferences (EUSARF 2016, 2018). In 2017 she had the opportunity to spend three months at Virginia Commonwealth University in Richmond, Virginia, United States where she collaborated with Dr. Bryce McLeod and his team. Currently, Marieke continues her research and teaching at HAN University of Applied Sciences, and she works as a child and family psychologist at Karakter Child and Adolescent Psychiatry University Center.

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