The Supporting Alliance in Child and Adolescent Treatment: Enhancing Collaboration Among Therapists, Parents, and Teachers

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Research indicates that the therapeutic alliance between therapist and pediatric patient is most effective in the context of a productive supporting alliance—an alliance encompassing the network of relationships among therapists, parents and teachers. In this essay, we develop a model of the supporting alliance, arguing that the child's primary relationships with various parties (therapists, teachers, and parents) imply a set of secondary relationships among those parties (parent-therapist, therapist-teacher, parent-teacher). We review the literature on these secondary relationships, focusing on their nature and discussing the benefits of and obstacles to establishing productive collaborations in each case. We also describe three sorts of pathology that can afflict the supporting alliance as a whole, and discuss the importance of patient autonomy and therapist-patient confidentiality relative to the supporting alliance. Finally, we identify directions for future research and highlight implications for practice.

KEYWORDS: supporting alliance; system of care; collaboration; parent; teacher; therapeutic alliance

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ENHANCING THE SUPPORTING ALLIANCE AMONG THERAPISTS, PARENTS AND TEACHER IN CHILD AND ADOLESCENT TREATMENT

This essay begins with the notion that the therapist[1] is the ultimate authority in the treatment of a child with a chronic psychiatric, emotional or developmental disorder. There is some truth to this idea: the therapist has formal responsibility for setting key parameters of a child's treatment. He or she may conduct psychodynamic, cognitive-focused or behavioral therapies, and/or select and prescribe psychopharmacological treatment. It is perhaps more revealing, however, to examine how this idea (that the therapist is the ultimate treatment authority) is *false.*

The following four propositions point to ways in which the therapist is *not* the ultimate authority in the treatment of a pediatric patient with a mental health disorder. The word "authority" implies both control and expertise. The first two propositions refer to "authority as control"; they are not, we expect, controversial.

1. The vast majority of interpersonal interactions, including many that have consequences for the child's therapy and some that are explicitly therapeutic in nature, are not controlled or managed by the therapist.
2. In the case of psychopharmacology, the pharmacotherapist is responsible for selecting medications, but rarely controls or supervises their delivery.

The third and fourth propositions refer to a different idea of authority: "authority as expertise." These are perhaps more controversial, though in our view they are equally self-evident.

3. The therapist often has comparatively limited contact with the child and little direct access to information about the child's daily life.
4. The therapist's perspective on the appropriate goals of therapy has no clear moral priority over other perspectives, including those of the child, the child's family and the society in which the child lives.

Taken together, these four propositions suggest that the therapist's *direct* authority over a child's therapy is highly attenuated. Her influence is one among many. She must make decisions with imperfect information and may need to advance her goals for the child's treatment in competition

[1] We use the term "therapist" to refer to the person in the role of the primary mental health provider. This person could be a child psychiatrist, psychologist, social worker, other therapist, or primary care provider. When we are discussing a particular therapeutic function (e.g., prescribing medication) that pertains to a subset of therapists, we use more specific language: prescriber, doctor, or pharmacotherapist.

with the goals of others. To increase her authority (control) over the child's treatment, she must act in concert with the various significant others in the child's life; to increase her authority (expertise) over the child's treatment, she must rely on those significant others for information. The logical conclusion of this argument is striking: effective collaboration increases rather than decreases a therapist's authority. But what constitutes effective collaboration?

In this essay, we develop and explore a model for effective collaboration—a model that we call the *supporting alliance*. This model builds on earlier work in which one of us (Joshi, 2006) outlined the importance of a *dual alliance* model incorporating both therapist-patient and therapist-parent collaboration. Here, we offer a broader vision of the collaboration that supports successful pediatric mental health treatment, be it psychotherapy, behavior therapy or pharmacotherapy. In particular, we stress the need to examine the *de facto* therapeutic role of educational institutions. This emphasis may surprise some of our readers, but we see it as a long-overdue acknowledgment of the fact that schools are now the nation's largest provider of mental health services (Rones & Hoagwood, 2000). We do not dispute the essential role of the *therapeutic alliance* between therapist and patient, a relationship that is at the core of any successful psychotherapeutic intervention. Instead, we argue that the therapeutic alliance is most effective when it exists in the context of a productive supporting alliance—an alliance encompassing the network of relationships that link clinical, educational and family settings. We are not the first to make such an argument (Ulrey, Hudler, Marshall, & Wuori, 1987), but the idea has received very little empirical or theoretical attention.

We present our case in four parts. First, we develop a schematic model of the supporting alliance, arguing that the child's *primary* relationships with various parties (therapists, teachers and parents) imply a set of *secondary* relationships among those parties (parent-therapist, therapist-teacher, parent-teacher). Second, we discuss the literature on those secondary relationships, focusing on the nature of each relationship, as well as the benefits and obstacles associated with each relationship. In the third section, we discuss three sorts of pathology that can afflict supporting alliance as a whole:

1. drain, in which those secondary relationships represent a non-productive tax on the resources of therapists, teachers and parents;
2. distortion, in which the strength of one part of the supporting alliance warps other constituent relationships; and
3. co-optation, in which one participant in the supporting alliance is

asked or chooses to adopt the role of another, and cedes her own perspective on the child's growth and wellbeing.

In the fourth and final section, we address two defining issues that shape the functioning of the supporting alliance: patient autonomy and therapist-patient confidentiality. We have deliberately reserved these critical issues for last, as we expect our arguments in earlier sections to raise many questions about both, and we acknowledge that our own discussion can only provide partial answers. Here as elsewhere in the essay, we intend to start a conversation rather than end one. Throughout the essay, we supplement our research review with illustrative clinical cases. In our conclusion, we identify directions for future research and highlight implications for practice.

I. THE SUPPORTING ALLIANCE

Primary and Secondary Relationships

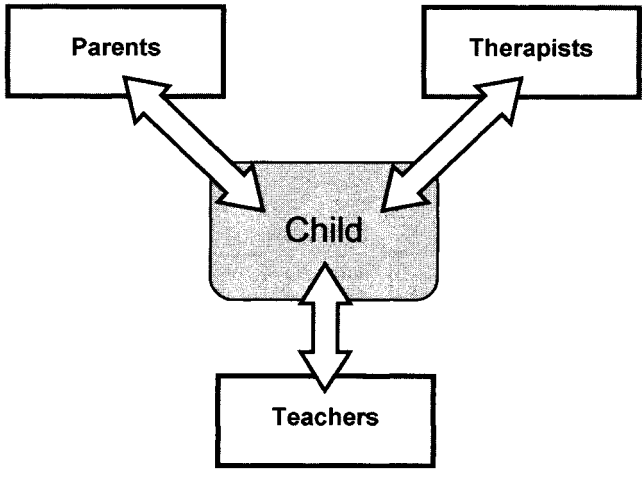
Our model begins with a hypothetical school-aged child who is undergoing treatment for a chronic psychiatric, emotional, or developmental disorder. This child is connected to various significant others in a complex psychosocial network. Some of these significant others are actively involved in the child's therapy, broadly conceived as promotion of the child's growth, development, and improvement *apropos* the disorder or disability.

Each relationship between a child and one of these actively involved significant others can be thought of as a *primary therapeutic relationship.* Our hypothetical child has primary therapeutic relationships with his family caretakers (we use the term "parent" here for simplicity's sake, acknowledging that this role is often filled by a nonparent adult) and with the clinical personnel who are formally charged with stewardship of his mental health. He is also likely to have a primary therapeutic relationship with one or more teachers[2] who guide his growth and development in school settings.

This picture is incomplete in two important ways. First, it focuses on relationships among key individuals and omits the larger systems within which the relationships are embedded. Each primary therapeutic relationship is part of a larger social system: in the parent's case, it is the family system; in the therapist's, it is the clinical system; and in the teacher's, it is the educational system. These systems are populated with various other people who influence the child's therapy. Recently, there has been increas-

[2] We use the term "teacher" here and throughout the paper, though the educators who play this role have may different titles depending on the institutional context.

Figure 1
THE THREE PRIMARY THERAPEUTIC RELATIONSHIPS.



ing clinical and theoretical attention to each of these systems, which have been discussed under rubrics such as the family systems perspective (Patternson & Garwick, 1994), integrated care teams (Aitken & Tylee, 2001), and collaborative instructional teams (Walther-Thomas, Korink, McLaughlin, & Williams, 2000). Considered *en masse*, these groups are said to form the child's *system of care.*

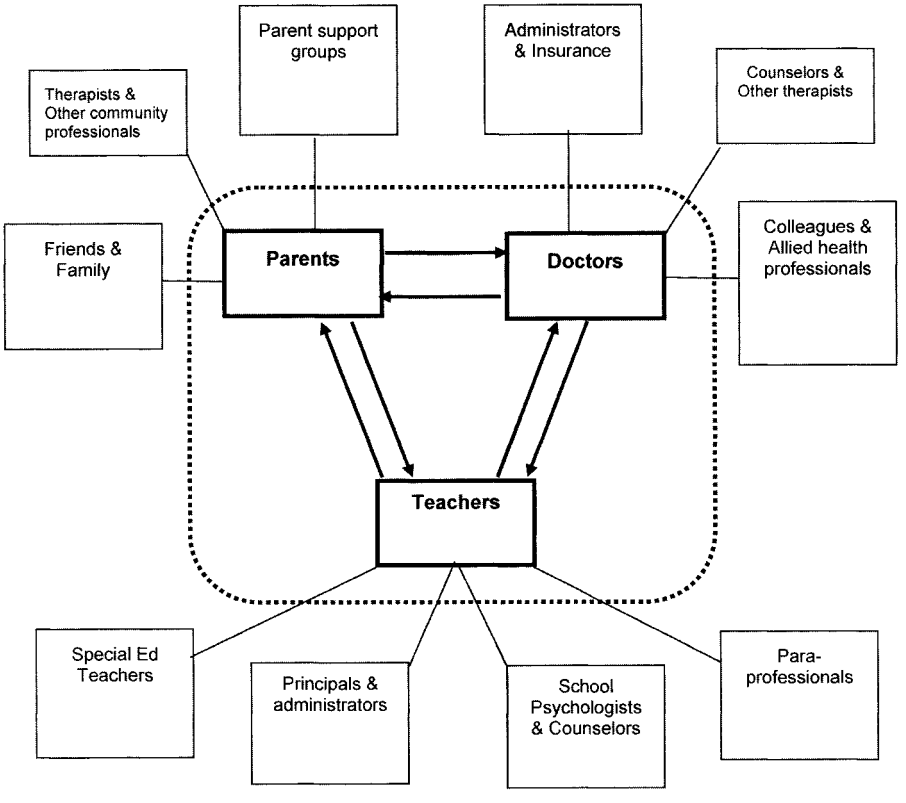
Also missing from Figure 1 are the relationships *among* the significant others in the child's life. These relationships—the connections between individuals who each have a primary therapeutic relationship with the child—can be thought of as *secondary*[3] therapeutic relationships. Although these relationships are not always actualized, they are almost always possible in some form. Whereas the primary therapeutic relationships are the focus of ample attention in various empirical and theoretical literatures, these secondary relationships have received comparatively little study, and their influence upon each other has received almost none.

The supporting alliance, represented in Figure 2, is the sum of the secondary therapeutic relationships. As the figure shows, it does not represent the child's entire system of care but rather highlights a part of that system. We make certain assumptions about the supporting alliance. First, we assume that each of the three relationships in the supporting

[3] "Secondary" not because they are unimportant, but because they are one degree removed from the child whose wellbeing is the focus of therapy.

Figure 2

THE SUPPORTING ALLIANCE, INDICATED BY THE DOTTED LINE, WITHIN THE BROADER SYSTEM OF CARE.



alliance affects the others in proportion with its strength—thus, for example, the closer a parent's relationship is with the child's therapist, the more this relationship will affect the parent's collaboration with the child's teacher. Second, we assume that each significant other (parent, therapist, teacher) has a different perspective on the goals and implications of a child's therapy. These perspectives are profoundly shaped by the social system (family, clinical, education) within which the significant other is embedded, and *no one of them is necessarily more correct or valid than the others.* We will discuss and illustrate this point more thoroughly in the third section of the paper, where it becomes most relevant. Finally, we assume that each significant other has a different role in the child's therapy and different psychosocial tools for working with the child.

II. REVIEWING THE RESEARCH

Our schematic model of the supporting alliance provides a convenient structure for reviewing relevant literature. In this section, we discuss each of the secondary relationships (parent-therapist, therapist-teacher, teacher-parent) in turn. We touch on relevant theories and recent empirical work, and offer concrete examples drawn from our collective clinical and research experience. The empirical and theoretical terrain that falls under the umbrella of the supporting alliance is both vast and unevenly explored. Throughout this section, we attempt to be incisive rather than exhaustive: our goal is to explore and vividly illustrative the secondary relationships that comprise the supporting alliance, and to provoke new questions rather than seek definitive answers for old ones.

Parent-Therapist

There is a growing empirical literature on the positive contributions of strong parent-therapist relationships to children's mental health treatment. Alexander and Dore (1999) describe the relationship between parents and therapists as a "facilitative condition which both enhances application of a variety of interventions and is therapeutic in its own right" (p. 262). The quality of the therapist-parent relationship can be a robust predictor of treatment outcome (Horvath & Symonds, 1991). Hawley and Weisz (2005) found that a strong therapist-parent relationship was significantly related to more frequent family participation in psychotherapy, less frequent cancellations and no-shows, and greater therapist concurrence with the decision to end treatment. Conversely, Kazdin and colleagues (1997) found that a poor parent-therapist relationship was predictive of treatment dropout within families of children with externalizing symptoms on the oppositional-defiant-antisocial continuum. Nevas and Farber (2001) found that parents who experience primarily positive attitudes and feelings about their child's therapist feel hopeful, understood, and grateful. Across these and other studies, the outcomes associated with a strongly positive parent-therapist relationship include reduced symptom severity, improved global functioning and service satisfaction, increased treatment participation, and avoidance of premature termination, as well as increased medication adherence (Joshi, 2006).

Research on the parent-therapist relationship either examines the general nature of that relationship (Sperling, 1979, 1997; Alexander & Dore, 1999; DeVet, et al., 2003; Johnson, et al., 1994; DeChillo, et al., 1994; Nevas & Farber, 2001; Hawley & Weisz, 2005; Kazdin, et al., 1997) or focuses more narrowly on particular aspects of the relationship that are

thought to foster therapeutic engagement. The second category of research encompasses studies of parental cognition and attributions (Morrissey-Kane & Prinz, 1999), informed consent (Krener & Mancina, 1994; Towbin, 1995), and the meaning of psychotropic medications to patients and families (Schowalter 1989; Rappoport & Chubinsky 2000; Mintz, 2002; Pruett & Martin, 2003; Joshi, 2006). Most studies have investigated the relationship between parents and mental health providers (psychologists, psychiatrists, social workers, marriage/family therapists), although a small number explore the importance of relationships between parents of children with mental health problems and primary care providers (Beresin, 2001; Coleman, 1995).

Recently, some authors have suggested that the parent-therapist relationship should be treated as a central concern rather than an adjunct to the therapeutic alliance between therapist and patient. Horvath and Greenberg (1994) argue that relatively quick development of a "good enough alliance" (between the therapist and *both* the patient and parents) is crucial for therapy:

> [A]lliance development is a series of windows of opportunity, decreasing in size with each session. . . . [T]he foundation for collaborative work entails adjustments in both the client's and therapist's procedural expectations and goals. The longer the participants find themselves apart on these issues, the more difficult it becomes to develop a collaborative framework. (p. 3)

Pruett, Joshi and Martin (in press) agree, suggesting that therapists should focus on building strong relationships with parents *first*, particularly when the pediatric patient is young. According to their rationale, therapists who prioritize mutual understanding and respect in parent-therapist relationships are less like to perceive parents as prime contributors to the child's pathology or obstacles to the child's therapeutic success. Not surprisingly, research indicates that parents who are perceived (and who perceive themselves) as partners rather than obstacles in a child's therapy invest more deeply and effectively in the therapeutic process (Johnson, et al., 1994; Morrissey-Kane & Prinz, 1999; Alexander and Dore, 1999).

In their exploration of "parents as partners," Alexander and Dore (1999) contrast *traditional practice*, which assumes a "potentially collaborative but inherently unequal relationship between parent and clinician" (p. 257), with *partnership practice,* which assumes that both parents and therapists possess critical information on the nature and course of a child's disorder. Traditional practice can include warm, respectful and supportive relationships between therapists and parents but it de-emphasizes active

collaboration. Partnership practice encourages both affective collaboration, the sense of "we-ness" that sustains collaboration through inevitable give-and-take, and instrumental collaboration, the participation of parents more as equals in choosing and implementing a treatment plan.

Research suggests that partnership practice offers several features that parents want and appreciate in a parent-therapist relationship. For example, DeChillo and colleagues (1994) found that parents and caregivers of children with severe emotional disorders valued both an affective connection and the reciprocal exchange of ideas in their relationships with therapists. In this study, four domains of collaboration accounted for 86% of the variance in parent satisfaction: Supportive Understanding, Accessing Services, Sharing Information, and Utilizing Feedback. It should be noted, however, that Supportive Understanding, which is entirely compatible with traditional practice, accounted for 46% of the variance alone.

Not all therapists, and not all families, will gravitate toward partnership practice. Alexander and Dore (1999) cite four common barriers to partnership: negative beliefs about parents by therapists, lack of therapist knowledge and skill in differentiating and treating a full range of family functioning, racial and cultural differences, and discrepant views of competent parenting. These barriers can emerge in predictable patterns. Therapists who are psychiatrists rather than psychologists or social workers were more likely to believe that parents were substantial contributors to their child's disorder (ibid.). Parents from cultures in which the physician is expected to take on a more directive and paternalistic role are often uncomfortable with partnership practice (cf. DeChillo, et al., 1994). Still, Alexander and Dore (1999) argue that partnership can be just as important with difficult, hard-to-reach, or vulnerable families. The type and severity of family problems should not pose insurmountable barriers to effective partnerships, as long as the therapist acknowledges that families respond differently to stressors, is truly committed to the process and possesses the skills to engage these families.

Partnership seems to be especially important in pharmacotherapy, and may in fact be a necessary pre-condition for successful outpatient treatment of younger children (Pruett, Joshi, & Martin, in press). This is a logical consequence of the fact that parents, rather than therapists, administer or supervise the administration of medication. If parents do not understand and endorse the medication regime, they may consciously or unconsciously weaken the treatment by failing to fill prescriptions, diverging from the medication plan and missing or cancelling sessions. Prescrib-

ing therapists must therefore pay careful attention to the way they include or exclude parents in treatment.

Given the accumulated evidence in support of strong parent-therapist relationships, there is a remarkable shortage of concrete guidance about the formation of such relationships. Joshi (2006), influenced by Havens (2000), offers three guidelines for therapists in helping parents and families "hold it together" during the early phases of alliance formation and treatment:

1. Protect self-esteem. The parent may feel guilty for having caused the illness through bad parenting, poor gene contribution, or both.
2. Emote a measure of understanding and acceptance. Demonstrate that the patient's problem is grasped intellectually, and that the patient's and family's predicament is understood from *their* point of view.
3. Provide a sense of future. Many families have experienced frustration and failure in attempting to find solutions and may have lost hope. Discussion about expectations for treatment that acknowledges fears or even hopelessness may still preserve opportunities for change: "it seems hopeless to you *now*."

Therapist-Teacher

Collaboration between therapists and teachers is associated with successful psychotherapeutic intervention across a wide variety of contexts (Rones & Hoagwood, 2000; Marshall & Wuori, 1985). Therapist-teacher collaboration is a newer idea than either parent-therapist or parent-teacher collaboration. The amount of communication between therapist and teachers varies widely (Mukherjee, Lightfoot, & Sloper, 2002), and the empirical literature, though well regarded, is comparatively thin. In particular, there have been few investigations into the effectiveness of specific collaborative strategies. Despite the paucity of empirical evidence, several models of "best practice" have been proposed.

One of these models (Foy & Earls, 2005) was developed specifically for the assessment and management of children with attention deficit hyperactivity disorder (ADHD). In this model, the school system is responsible for collecting data according to a protocol that includes classroom observation, psychoeducational testing, parent/teacher behavior rating scales and functional assessment. This information is then transferred to the treating therapist. Both the medical center and the school are expected to field teams of personnel who work together to advance the child's well-being, and each of these teams is responsible for designating contact

people who act as points of entry into the clinical and educational systems, respectively.

Although this model offers a blueprint for improving communication between complex systems, it does not address the importance of active collaboration in decision-making or therapeutic action. Another, older model (Marshall, Wuori, & Carlson, 1984; Marshall, Wuori, Hudler, & Carlson, 1987) proposes that a cross-institutional child evaluation team be created to serve as the intermediary between the school district and medical center. Such a team would include clinical and educational personnel, thereby facilitating direct, iterative communication on topics of relevance to both school and medical center. Unless one interprets "evaluation" very broadly, however, this model offers limited scope for collaboration on the substantive work of education and therapy. Furthermore, since both of these models were developed in the particular institutional and clinical contexts, it is unclear whether or not they can be generalized to other disorders and community settings.

The relative novelty of therapist-teacher collaboration is not an altogether bad thing, as there are fewer entrenched practices to overcome. On the other hand, many of the problems therapists and teachers experience stem from the lack of well-known or well-tested tools for collaboration. Teachers, who receive little preparation for working with physicians and medical institutions, report that such collaborations seem frustrating and haphazard (Marshall, Wuori, & Carlson, 1984). Therapists, depending on their specific background, may also receive little or no formal training on this topic, and are often unable to identify an appropriate liaison at the school. Many if not most are unfamiliar with the roles of school staff, especially in the increasingly rare instances when a school doctor is involved. Therapists often delay direct communication with teachers due to concerns about parental consent, but also are reluctant to rely on parents as intermediaries (Mukherjee, Lightfoot, & Sloper, 2002). Both groups report that it is difficult to find time for meetings, a frustration made more acute by the absence of efficient tools and pathways for collaboration (Mukherjee, Lightfoot, & Sloper, 2002).

Despite the difficulties, both teachers and therapists recognize the potential of collaboration. Teachers report that collaborating with physicians provides another point of view, increases their credibility with parents, and streamlines communication about behavioral or academic changes in the student (Marshall, Wuori, & Carlson, 1984; Marshall & Wuori, 1985).

Teacher-Parent

In both the fields of Special and General Education, the collaboration between parents and teachers is considered essential in supporting a child's academic and social development. Family-school connections have been linked with improved academic performance, better attendance, decreased discipline problems and enhanced continuity in expectations (Henderson & Mapp, 2002). School reform projects and teacher preparation programs nationwide emphasize the foundational importance of family participation and the cultivation of positive working relationships (Bingham and Abernathy, 2007; Flannigan, 2007; Jorgensen, Schuh, & Nisbet, 2006; Lamperes, 2006; Mullholland & Blecker, 2008; Rourke & Hartzman, 2008).

Today, parent-teacher collaboration is considered an integral part of a "family-centered" educational approach, an approach that a) emphasizes childrens' strengths, rather than their deficits; b) values family preferences for particular resources; c) includes parents as equitable members of educational teams; and d) honors the cultural, ethnic, racial, and socioeconomic diversity of families (Espe-Sherwindt, 2008; Harry, Kalyanpur, & Day, (1999); Turnbull, Turnbull, Erwin, & Soodak, 2006). This approach represents a significant shift from the previous paradigm, in which parents were considered passive recipients of services who are burdened with unrealistic expectations and require the expert guidance of professionals (Lazar & Solstad,1999; Rainforth, York, & Macdonald, 1992). The parallels to historical trends in therapist-patient and parent-therapist relationships are obvious.

Fortunately, engaging parents as partners in the educative process is now seen as a professional expectation and standard of practice, rather than a choice of individual teachers (Chen & Miles, 2004). This expectation is legally reinforced by the Individuals with Disabilities Education Act (IDEA, 2004), which assigns to parents the legal right to participate as equals in the evaluation of a students' exceptionalities and special needs as well as the planning of Individualized Education Plans (IEPs). During the evaluation and IEP process, and during the provision of services, parents offer vital information about the student's abilities, interests, performance, and history. They also contribute to developing educational priorities, discuss involvement of their child in general education, and help identify the most effective supplementary aides and services. Ideally, parent input influences methods of instruction, differentiation in curriculum, and daily support strategies.

Given the variations in disposition, performance, and behavior that a child with chronic cognitive, emotional, or developmental disorders may exhibit, parents and teachers may engage in *daily* communication as they articulate consistent support strategies and exchange insight regarding the effectiveness of ongoing interventions. Historically, special educators have had a prominent role in fostering and sustaining this communication, acting as case managers and providing oversight for a student's school program. As students with significant mental health disorders are increasingly included in general education classrooms, regular education teachers are taking on new roles in the collaborative process that was once the province of the special educators. General education teachers offer unique perspectives because they often see students over sustained periods of time, across daily routine and transitions. They also have a central role in facilitating peer relationships, and may have the most insight into how children with significant learning, emotional or cognitive disorders are negotiating the curriculum. Co-teaching and team teaching, involving both special and general educators, are now more common and viable options (Friend, 2008).

In practice, both teachers and parents often struggle to fulfill the professional standards and legal requirements of collaboration. Here, too, the parallels with parent-therapist and therapist-teacher collaboration are clear. Despite the high ideals of "family-centered" education, parental opinions, desires, and knowledge about their own children are discounted, ignored, or even resisted by school personnel (Nevin, 2008). In particular, families from diverse cultural and racial backgrounds who have children with significant educational needs often find educators lacking sensitivity and culturally relevant knowledge (Aritles & Ortiz, 2002; Ladson-Billings, 1994). Parents, who are usually the most constant influence in their children's lives, must often act as liaisons among various educational professionals. Although educators are often in the position to "broker" services (Cloniger, 2004), it is still typically the parents who document longitudinal changes in interventions, preserve established positive practices, and advocate for seamless services when professionals enter or exit the family's life.

For their part, teachers (both general and special educators) are at risk of being overwhelmed by the intense time and emotional demands of even a single parent-teacher partnership. The advent of inclusive education and the recent emphasis on collaborative instructional teams have profoundly changed the dynamics of service delivery for children with cognitive, emotional and developmental disorders (Walther-Thomas, Korink,

McLaughlin, & Williams, 2000). Like therapists, teachers must integrate the work of building and sustaining relationships into an already full work schedule. Providing proactive and personalized responses to multiple families adds new challenges in time management and communication. The need for sustained, trusting and respectful collaboration between teachers and parents is widely acknowledged. However, given new systems of service delivery and expanded education and treatment teams, the collaborative enterprise could benefit from new models of interaction and alliance.

III. PATHOLOGIES IN THE SUPPORTING ALLIANCE

In reviewing each of the secondary relationships that comprise the supporting alliance, we alluded to the difficulty of forming and maintaining a productive collaboration. Each relationship offers particular challenges. In addition to these difficulties and challenges, there are problems that emerge at the level of the overall alliance. These problems are not entirely reducible to problems in the separate secondary relationships and deserve separate attention. Although we refer to research, these three pathologies emerge largely from our clinical and research experience. We expect that they will resonate with other practitioners, and describe them in hopes of building a common vocabulary that will enable us to understand and ameliorate problems in the supporting alliance.

Drain

Therapists, teachers, and parents are all familiar with collaborations that exist in name alone—high rhetoric and toothless protocols that require contact but do not entail the exchange of ideas and information, much less shared decision-making. Such relationships are relatively innocuous examples of the most common pathology in the supporting alliance, the unproductive tax on time and effort that we refer to as *drain.*

All collaborations require an investment of time and effort. At best, this investment is rewarded with results that would have been difficult or impossible for the collaborators to achieve alone. At worst, it taxes the attention and enthusiasm of collaborators, and may actually prevent them from effectively performing their own work. This is true for all participants in the supporting alliance: poorly functioning collaboration is a drain on the resources that they would otherwise have available for the child.

The two-decade-old trend towards "mainstreaming" or "inclusive education" (Udvari-Solner & Thousand, 1995; Udvari-Solner, 1997) provides a particularly vivid illustration of drain in the supporting alliance.

Loosely speaking, inclusive education is the placement of children with exceptionalities (previously called "special needs") in general education classrooms for some or all of the school day. General education teachers often lack preparation and support for working with mainstreamed children (e.g., Baker & Zigmond, 1995; McIntosh, Vaughn, Schumm, Haager, & Lee, 1993). In theory, collaboration with doctors and parents helps compensate for this. In practice, however, the emotional and logistical demands of working with doctors and parents exact a toll on the teacher's "finite instructional resources (e.g., time, expertise, support)" (Cook, Cameron, & Tankersly, 2007, p. 231). Teachers themselves point to these collaborations as a source of considerable stress. Teacher stress, in turn, has a predictable negative impact on both performance and retention (Blase, 1986; Luekens, Lyter, & Fox, 2004).

We do not present this situation as an indictment of inclusive education, which often boosts academic achievement for children with exceptionalities (Winzer & Mazurek, 2005). Nor do we feel that the painful realities of inclusive education are an irrefutable argument against collaboration among teachers, parents and therapists. Our point is simply this: collaboration has an inevitable cost, which may be borne unevenly by the participants. It is short-sighted to greet gains in academic achievement as a sign of successful collaboration if they are accompanied by attrition or reluctance to collaborate in the future. The supporting alliance should ideally be supporting in two senses: it should support the growth and development of the child, *and* it should support the empowerment and effectiveness of its participating members.

Distortion

The most common pathology in the supporting alliance, drain, occurs when one or more of the relationships that comprise the alliance do not offer sufficient benefits to balance the cost of maintaining them. This is an easy situation to imagine, and will doubtless be familiar to our readers. It is somewhat more difficult to imagine the problems that arise when a constituent relationship is too close or too strong. In outlining our model of the supporting alliance, though, we proposed that each relationship affects the others in proportion to its strength. It follows that the strength of one relationship could warp the natural dynamic of another. This is what we call *distortion*: an over-emphasis on the relationship between two members of the alliance that makes real collaboration with the third member difficult or impossible. This phenomenon is clearly illustrated in the following, relatively common example:

> The parent of a seven-year-old child with Tourette's Syndrome is dissatisfied with the child's psychopharmacologic treatment regime. She and the pharmacotherapist confer and agree to change the dosage or type of medication that the child receives. One of their critical outcome measures will be the child's behavior in school. Because they wish to avoid biasing their outcome data, they do not tell the child's (general education) teacher that something in the child's treatment is about to change.[4] Under the new medication regime, the child becomes more focused but also moodier and more prone to violent tantrums. The teacher is alarmed to find that her previously effective behavior management strategies seem to have lost their power overnight. As she attempts to compensate for the change, she is forced to divert her plans for the rest of the class and jettison her old learning agenda for the affected child.

This hypothetical case contains some admirable elements, such as the parent and pharmacotherapist working together to shape the child's treatment regime, and their mutual desire to carefully track the resulting change. However, the teacher's exclusion from this process is problematic in three ways. First, it weakens the teacher's capacity to respond appropriately to any anticipated change in the child's behavior, either by taking advantage of positive changes or buffering negative ones. Second, it may actually reduce the teacher's reliability as a reporter of change: in this case, the teacher could be distracted by the child's moodiness and miss the improvement in focus. Finally, it disregards the teacher's responsibility to other students in the class. If she does discover the change in medication, her justifiable annoyance at the real sacrifice that she and her class have unwittingly made will make her wary of future collaborations.

At present, it is difficult to imagine a similar distortion effect arising from a collaboration between teacher and therapist that excludes the parent, but it is easier to see how close teacher-parent collaboration could leave the therapist uninformed about a child's daily behavior or about therapeutically relevant aspects of the child's life at school. Regardless of the locus of distortion, the pattern is the same: close collaboration between two of the three members in the supporting alliance effectively excludes the third, or at least prevents her from doing her job as effectively as she might.

[4] There are obvious confidentiality concerns in this case, and we will address those concerns in the fourth section of this paper.

Co-optation

When defining the terms of the supporting alliance, above, we suggested that parents, therapists, and teachers each have a distinct and valid perspective on the goals of the child's therapy, and different psychosocial tools for working with the child. This implies that there is value in maintaining all three perspectives. It also implies that there would be some loss to the alliance if one member ceded her own goals and adopted those of another—if, for instance, the teacher adopted the parent's goals or the parent adopted the therapist's. We call this phenomenon co-optation.

Probably the most common sort of co-optation occurs when parents accept a therapist's treatment recommendations as law, ceding their own active role in decision-making. For example, parents may accept a pharmacotherapist's decision about appropriate medication for their child, despite what they observe to be a deleterious effect on child and family wellbeing. In this situation, the parent's perspective has been co-opted by the pharmacotherapist. Of course, the reverse situation, in which the therapist's perspective is co-opted by the parents, is also fairly common. When a pharmacotherapist accedes to a parent's desire for medication-based management of a particular set of symptoms, despite the pharmacotherapist's own sense that the particular medication or dosage is not the best course of therapy, her perspective has been co-opted.

The idea that goals can be shared too closely may seem counterintuitive, especially given the recent emphasis on shared goals within the system of care (Ramanujam & Rousseau, 2006). To understanding the negative effects of co-optation, it is important to see how goals and perspectives differ within the supporting alliance and how these different sets of goals can complement each other. Table 1 provides an overview of the differences in perspective among participants in the supporting alliance. To illustrate how these differences might play out, we return to the case of inclusive education.

Parents are often acutely aware of the difference between academic materials presented in special education and general education classrooms. With their children's long-term independence and success foremost in their minds, they may struggle against what they perceive to be the unacceptable academic compromises of special education. They may also see inclusion as an important step towards achieving a "normal" life for their children, both academically and socially.

Teachers often see special education and general education as nonexclusive categories that can be combined in various ways to serve a child's

Table 1 DIFFERENT PERSPECTIVES WITHIN THE SUPPORTING ALLIANCE

	Primary interests	Unique contextual expertise	Timescale
Parent	Child's long-term happiness and independence, family well-being	The child's temperament, character and history; the particular symptomatic manifestations of the disorder; the family relational context	Highly variable daily contact over many settings and many years; encompassing life of child
Teacher	Child's academic and social capacity, successful integration with & progress through educational system	Learning environments and interventions; development in classroom context; peer social interaction; school programs and requirements	Focused and frequent interaction in academic and school-social contexts for a limited time (1+ years)
Therapist	Child's immediate health and safety, long-term success in reducing, mitigating or eliminating symptoms	Formal diagnosis and definition of the disorder, including etiology and progression; case formulation; therapeutic interventions and their probable outcomes	Focused though comparatively infrequent interaction – both narrower (crisis) and broader (time-lapse growth); may work with child for a few months or for many years

best interest. Based on their experience with other children, and their first-hand knowledge of classroom realities, they form their own opinions about a child's realistic chances of social and academic success in a general education classroom.

Therapists may see themselves as having no formal role in setting the child's educational trajectory, but their diagnostic authority has real re-

percussions for academic placement. Conversely, a child's academic placement has a large impact on the child's everyday circumstances, effectively transforming both the challenges of psychotherapeutic/psychopharmacological intervention and the domain in which such interventions play out. Where a parent or teacher might see the child's therapy as affecting his success at school, the therapist is likely to see the child's schooling as affecting the success of her therapy.

In asserting that each of these perspectives is valuable, our point is simply that a parent's long-term goals should not be ignored in light of school-based constraints, that educational intervention is not merely an adjunct to therapy, and that therapeutic goals should not be abandoned altogether in service of family harmony. The different perspectives and goals that co-exist within the supporting alliance should serve as checks and balances upon each other. Yet this is not their only function. Successful therapy abets the goals of education, high-quality education facilitates the goals of therapy, and both contribute to the long-term happiness and independence of the child. Different goals can lead to mutually satisfactory outcomes. The supporting alliance requires harmony of purpose, rather than unity of purpose.

IV. DEFINING ISSUES: AUTONOMY AND CONFIDENTIALITY

More Than Mere Silence

If we have done an adequate job describing the supporting alliance so far, our description *should* have provoked at least two important questions about the role of the supporting alliance in therapeutic practice. First, how can the communication and collaboration that we espouse be reconciled with the ethical and practical demands of therapist-patient (and therapist-family) confidentiality? Second, now that we have brought the supporting alliance into the foreground, where does the *patient* fit in? In particular, what is the proper relationship of the patient's therapeutic goals to the therapeutic goals of the alliance and its members?

Consider the example we used to illustrate distortion in the supporting alliance, in which the parent and doctor of a seven-year-old child choose not to inform the teacher about a change in the child's medication regime. We suggested several negative consequences of this arrangement—but, consequences notwithstanding, would informing the teacher represent a legal or ethical breach of confidentiality? Sharing information of this sort requires the consent of the family and, in many cases, the assent of the patient (more on this issue below). Families and patients are justifiably

protective of the details of therapy, and both the ethical and legal doctrines of confidentiality support their right to withhold those details.

At the risk of stating the obvious, however, the strictures of confidentiality are subject to the will of the patient and family—not vice versa. In addition to preserving privacy, confidentiality should serve therapeutic ends. There is nothing new in the idea that patients, therapists and family members must strike a balance between privacy, on one hand, and the real benefits that may come with open communication, on the other. In the case of the supporting alliance, particularly where a child's teacher is concerned, it may at times be inappropriate to reveal the exact nature of the child's condition, the type of medication, or some other detail of diagnosis and therapy. These limitations should mark the *beginning* of communication, not the end. Once the "no-go" areas of confidentiality are established, the next challenge is how best to use the remaining territory.

In the example of the seven-year-old child, above, the parents may be willing to share partial information with the teacher, preserving the teacher's capacity to act in the best interests of the child and the class. This is more possible than it may initially seem because teachers are accustomed to working with incomplete information. Important contextual details about a child's home life, for example, are often communicated to them in oblique or coded form. In this case, it might be possible to alert the teacher to a *general* change in treatment, or warn her (assuming well-known side-effects) of the likelihood of more extreme mood swings. If even this is not possible, a simple cue to "batten down the hatches" might be enough to enable watchfulness and flexibility in classroom planning.

In the supporting alliance, confidentiality does not mean silence. It simply helps define the conversations that are possible. For the alliance to work, discussions about confidentiality must have two components. First, they must address what can *not* be communicated. Second, proceeding directly from that, they must ask what *can* be communicated, and how it can be used to strengthen collaboration.

Patient Autonomy

There is, of course, a level of confidentiality that concerns only the therapist and patient; this is information that even the parents may not possess. In the example above, we deliberately featured a *young* child to reduce the surface relevance of this issue. Therapist-patient confidentiality, though always a central feature of that relationship, is a dynamic entity whose boundaries shift as the patient grows older and/or increasingly autonomous. In adolescence, as patients assume greater responsibility for

their own care, therapists can help parents avoid intrusive, controlling styles and attitudes around both therapy and medication, while still encouraging proper supervision and monitoring of pharmacotherapy. Here, too, the balance between communication and silence must be negotiated with the goals of therapy—and the goals of the patient—foremost in mind.

An examination of the concerns posed by therapist-patient confidentiality illustrates the relevance of patient agency within the supporting alliance. Unless carefully qualified, the supporting alliance could be interpreted as a paternalistic framework for facilitating the collusion of adults who collectively "know what is best for the child." To counter this interpretation, we point to the terms in which we initially defined the supporting alliance: the sum of the secondary therapeutic relationships—the relationships between the child's significant others, each of whom has a primary therapeutic relationship with the child. The adjectives "primary" and "secondary" describe *both* the social remove of those relationships from the epicenter of therapy *and* the inevitable precedence of one set of relationships over another. The primary relationships define the universe of possibilities for the secondary relationships.

The patient's/child's goals and desires shape the supporting alliance through his primary relationships with therapist, teacher and parent. Yet the goals that emerge in each primary therapeutic relationship are not *simply* or *purely* the child's goals. Just as the different participants in the supporting alliance have unique perspectives on the purposes of therapy, they each have access to a different subset and a different expression[5] of the child's goals. Therapist, teacher and parent will each have a unique interpretation of those goals, based on evidence and expertise that is uniquely available to them. Ideally, each one advocates for the child's goals from a different perspective, and through the fusion of those three perspectives a more complete and nuanced picture may emerge.

V. CONCLUSIONS AND RECOMMENDATIONS

In the preceding pages, we have suggested that the potential and actual collaborations between therapists, teachers and parents can be thought of as a *supporting alliance*: a social structure that supports the growth and

[5] These are not necessarily the goals that pertain to their formal areas of expertise. A child may well discuss his family goals with the doctor, his school goals with a parent and his treatment goals with the teacher.

development of a child. We have reviewed the empirical and theoretical literature relevant to each branch of this alliance and outlined three problems that limit the effectiveness of the supporting alliance. We have addressed how the supporting alliance impinges upon confidentiality and patient autonomy, and argued that the resulting tensions are manageable.

There is no shortage of models for collaboration and teamwork around the care and treatment of children with chronic disorders. Perhaps the most obvious novelty of the supporting alliance model is the degree to which we have insisted on the teacher's role. Any number of objections could be raised to granting teachers such a position of parity in collaboration. Three particular objections are more or less guaranteed to emerge: training, transience, and programmatic constraint. In short, it is commonly argued that teachers are not appropriately trained to take an active role in a child's therapeutic program, that they are transient presences in the child's life, and that they have limited ability to act within the constraints of the educational system.

Each of these objections is valid. On the other hand, all of them could be leveled against therapists as well. A child with a mental health or developmental disorder is likely to see multiple therapists in his childhood. Some will have no particular expertise on his specific condition; others, such as the primary care provider, may have no mental health expertise at all. Most of them will pass out of the child's life within a small number of years. All of them will be formidably constrained by various clinical systems (particularly the health insurance system). Furthermore, few therapists see a child for nearly as many hours as that child's teachers, and, with the exception of school-based practitioners, therapists almost never see the child interact with peers. Although therapists from various disciplines bring a great deal to pediatric psychotherapy, they too may be ill-trained, transient and constrained in their ability to act. Both therapists and teachers bring strengths and weaknesses to the supporting alliance; both should act in the humility of that knowledge.

What, other than overdue attention to the teacher's role, does this model of the supporting alliance contribute to clinical practice? First, it offers a vocabulary for describing and examining the relationships that influence pediatric therapies. Second, it draws attention to the problems that can arise in those relationships, both individually and at the level of the entire system. Third, it provides a regulative ideal of collaborative practice—a model to which parents, teachers and doctors can aspire.

What this model does *not* do is reveal how best to achieve productive

multi-party collaboration. This is a formidable challenge. If anything, our model has simplified this challenge by ignoring the considerable difficulties of collaboration *within* our categories of therapist, teacher and parent. To give just one example, Sabo and Rand (2000) have written about the barriers to collaboration between psychotherapist and psychopharmacologist. As the authors argue, in order to surmount

> . . .their natural competition to deliver the most effective treatment, [the psychotherapist and psychopharmacologist ought] to discover the value of their relationship as a source of added insight and emotional support to each other. . . a good rule of thumb being to let the other know when you've noticed something positive in the work she is doing with the patient. This begins to offset the self-doubt that often masquerades as quiet contempt or downright arrogance. The relationship is built by establishing a genuine basis for respect. (p. 51-52)

There are some research-based recommendations in the literature concerning each of the constituent relationships in the supporting alliance, but no truly clear indications of how to harmonize these relationships and avoid the systemic pathologies described above. The added value of the supporting alliance is, we believe, more than the sum of its parts, and cultivating a healthy alliance will require more than tending to each of the constituent relationships individually. Research on multi-party collaboration, in the context of the supporting alliance, could bear ample fruit. Such research might answer questions such as these:

1. Given that a child's doctors and teachers change, what mechanisms are available to establish productive collaboration quickly and avoid the problem of drain?
2. How do members of the supporting alliance negotiate the challenge of balancing confidentiality with communication?
3. Would it be possible or useful to develop basic plans for collaboration that could be minimally modified to fit different circumstances?
4. What are the measurable indicators of health and stress in the supporting alliance?
5. Parents, doctors and teachers are embedded within complex social systems; how do these systems abet and endanger the supporting alliance?

We would also recommend a systematic examination of the role that a child's peer group can play in the supporting alliance. Apart from parents, teachers and doctors, the significant others in a child's life tend to be other children. We have not included them in our picture of the supporting

alliance because they have almost never been considered active partners in pediatric psychotherapy. Although such partnerships may be difficult to conceptualize, there can be little question that both parents and teachers work with and through a child's peers to foster the child's growth and development. The nature and consequences of that work seem well worth studying.

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