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Article in *Journal of Consulting and Clinical Psychology* · June 2005

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Therapist Alliance-Building Behavior Within a Cognitive–Behavioral Treatment for Anxiety in Youth

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Explored the specific behavior of therapists contributing to a child client's perception of a therapeutic alliance with youth ($n = 56$) who received a manualized cognitive–behavioral treatment for anxiety disorders. The first 3 sessions were coded for 11 therapist behaviors hypothesized to predict ratings of alliance. Child, therapist, and observer alliance ratings were gathered after the 3rd and 7th therapy sessions. "Collaboration" positively predicted early child ratings of alliance, and "finding common ground" and "pushing the child to talk" negatively predicted early child ratings of alliance. Although no coded therapist behaviors predicted early therapist ratings of alliance, "collaboration" and "not being overly formal" positively predicted therapist alliance ratings by Session 7. Child, observer, and therapist ratings of alliance were significantly correlated. Results are discussed with regard to the identified behavior of the therapist as a step toward the identification of empirically supported strategies for building a stronger child–therapist alliance.

Research suggests that the quality of the therapeutic alliance is a modest predictor of treatment outcome (Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). The early alliance (i.e., assessed at the third or fourth session) is particularly predictive of outcome (Horvath, 1994; O'Malley, Suh, & Strupp, 1983), and attrition from therapy has been predicted with measures of the quality of the relationship assessed as early as the end of the first session (Crits-Christoph, 1998; Horvath & Symonds, 1991; Robbins, Turner, & Alexander, 2003). The relationships have been found to be consistent across therapies (e.g., cognitive–behavioral, psychodynamic), perspectives (e.g., client, therapist, observer), and client diagnoses (Shirk & Karver, 2003). Additionally, a strong alliance may facilitate client engagement in therapy tasks (Chu et al., 2004).

Given that the construct of a therapeutic alliance was originally developed with adults, how might it translate to child clients? A variety of relationship variables, including involvement, bond, and the therapist's warmth have been suggested (Shirk & Karver, 2003), and although these variables are moderately associated (Estrada & Russell, 1999; Shirk & Saiz, 1992), they may represent different facets of the one construct (Shirk & Karver, 2003). Research examining the therapeutic relationship has traditionally

focused on the closeness or liking between client and therapist, whereas the therapeutic alliance has traditionally focused on the larger context between client and therapist. The therapeutic relationship is part of a therapeutic alliance, which also encompasses such facets as agreement on the goals of therapy, the tasks of therapy undertaken to meet those goals, and the bond between client and therapist (Luborsky, 1994). Child-process research has yet to unite around a single construct: A review of the literature must consider studies of different relational variables, including the therapeutic relationship and the therapeutic alliance.

Researchers have emphasized the importance and the challenge of developing an alliance with youths (Creed & Diamond, 2001; Kendall, 2000; Shirk & Karver, 2003; Shirk & Saiz, 1992). Children may be brought by parents or referred by outsiders for problems that they think do not require treatment, do not exist, or cannot be controlled (DiGiuseppe, Linscott, & Jilton, 1996; Shirk & Russell, 1998). These facts contrast to adults who are often in treatment by choice. Furthermore, children's normative shift toward increasing autonomy may make the creation and maintenance of a therapeutic alliance different than with adults (DiGiuseppe et al., 1996; Steinberg, 1990). Church (1994) found that adolescents whose therapists used techniques that were respectful of this developing individuation (e.g., collaboration, emphasizing confidentiality) reported the highest degree of treatment satisfaction, openness about the alliance, and seeking the therapist's advice. Furthermore, the assumption must not be made that the relationship between a therapist and a youth client mirrors that of the relationship between a therapist and an adult client. For example, Safran, Muran, and Samstag (1994) found that in adults, techniques to address disruptions in the alliance, such as addressing the client's negative feelings toward the therapist, were associated with improved alliance. In contrast, DiGiuseppe et al. (1996) found that when used with adolescents, these techniques were negatively correlated with the strength of the alliance.

The first two meta-analyses of the alliance literature (Horvath & Symonds, 1991; Martin et al., 2000) were unable to consider client

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This research was supported by National Institute of Mental Health Grant MH64484-01 to Philip C. Kendall and the Presidential Fellowship Award from Temple University to Torrey A. Creed. We thank Deanna Bonewicz, Brandi Ellis, Loran Kundra, Jamal Laidley, and Charlene Artillio for their help with this research. We also thank the clients and staff of the Temple University Child and Adolescent Anxiety Disorders Clinic whose tapes served as the source of data.

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age, thereby losing information about how an alliance with children and adults may differ. This may have been due, in part, to the fact that historically less than 3% of child-therapy studies examined treatment processes (Kazdin, Bass, Ayers, & Rodgers, 1990). The literature examined by these two meta-analyses had limitations, including small samples, a lack of manualized treatments, and few randomized clinical trials.

A recent meta-analysis (Shirk & Karver, 2003) addressed some of these limitations by examining relationship variables with 23 child and adolescent studies completed over a 27-year period, in which several important facts regarding the child therapeutic relationship literature came to light. First, although each study measured relationship variables, a lack of standardization was demonstrated by the absence of an identifiable most commonly used measure. The different measures seemed to tap a part of the therapeutic relationship/therapeutic alliance, but in the absence of an agreed-on construct, a group of related constructs were measured. Second, the magnitude of the relationships (e.g., relationship with outcome) across treatment type and modality was similar to that found in the adult literature (Horvath & Symonds, 1991; Martin et al., 2000). Third, the only child characteristic that moderated the association between therapeutic relationship and outcome was the child's presenting problem.

An early study of alliance-building behaviors with children with internalizing disorders (Truax, Altmann, Wright, & Mitchell, 1973) found that different levels of Rogerian relationship variables (i.e., accurate empathy, nonpossessive warmth, genuineness; Rogers, 1951) predicted improvement in internalizing behavior. Children who received more of these relationship-building behaviors showed more improvement than children who received relatively less. None of the children experienced an absence of these therapist behaviors; rather, relatively high or low levels in a limited range were examined. This suggests that for internalizing children, even limited variations in the strength of therapist alliance-building behaviors may have a significant association with outcome.

Braswell, Kendall, Braith, Carey, and Vye (1985) operationalized the alliance/relationship differently, scoring therapist and child in-session behaviors according to a coding system. Child and therapist behaviors indicative of positive involvement in session tasks (e.g., child makes suggestions) were associated with enhanced outcome and the maintenance of gains. Further study of observable in-session behavior rather than self-report may provide more objective information about therapeutic alliances.

In a sample of children with anxiety disorders (Kendall, 1994), a nonsignificant association between the child-rated relationship and outcome has been found, with limited variability in the relationship ratings (all high). There was a significant association between the therapist, but not the child, report of the relationship and outcome in a second sample (Creed & Kendall, 2002; Kendall et al., 1997), suggesting that gathering relationship ratings from multiple reporters is important. At a 3.4 year follow-up (Kendall & Southam-Gerow, 1996), children reported that the relationship had been an important facet of the treatment they had received. Also using a sample of youth with anxiety disorders, Chu and Kendall (2004) reported that child involvement (i.e., active, behavioral, and emotional participation) by the midpoint of a 16-week cognitive-behavioral treatment (CBT) was associated with positive outcomes. Children with large increases in involvement from early to

midtreatment were over 4 times more likely to show diagnostic improvement at the end of treatment. Although it was beyond the scope of that research to examine therapists' behaviors that may contribute to strengthening an alliance, an understanding of the therapists' alliance-building behaviors would have notable clinical implications.

An important factor in this examination of an alliance is the reporter. Therapists, clients, and trained coders each have varying perspectives and research benefits when all perspectives are included. The timing of measurement is also important. Although early measurement of the alliance has been found to be related to outcome, a stronger association was found between later measurement of the alliance and outcome (Shirk & Karver, 2003). However, this stronger association may be confounded by treatment gains—gains may color a client's view of the alliance (Feeley, DeRubeis, & Gelfand, 1999). To reduce the influence of improvement, researchers can focus on early ratings of the relationship/alliance.

The current study examined therapist behaviors that may be related to a strong therapeutic alliance with an anxious child receiving a manualized CBT. A second goal was to determine whether the presence of specific observable therapist behaviors in early sessions would predict later child alliance ratings. We hypothesized that there would be a significant relationship between early therapist behaviors and early alliance ratings, as well as between early therapist behavior and later alliance ratings. A third goal was to consider the different reporters of the therapeutic alliance. Observer, client, and therapist ratings were gathered, with the hypothesis that there would be significant positive correlations.

Method

Participants

Participants ($n = 56$) were children (7–13 years of age; $M = 9.53$, $SD = 1.83$) who received a 16-session manualized CBT at the Child and Adolescent Anxiety Disorders Clinic (CAADC). Participants (male children = 34, female children = 22) were Caucasian ($n = 52$), African American ($n = 3$), and other ($n = 1$), with a current principal diagnosis of generalized anxiety disorder ($n = 27$), social phobia ($n = 18$), or separation anxiety disorder ($n = 11$). Of the 56 participants, 20 were diagnosed with at least one externalizing disorder (attention-deficit/hyperactivity disorder, $n = 16$; oppositional defiant disorder, $n = 8$; conduct disorder, $n = 1$).

Measures

Anxiety disorders. The Anxiety Disorder Interview Schedule for Children and Parents (ADIS-C/P; Silverman & Albano, 1996) has parent and child interviews to gather information about a child's current symptoms. It also permits the diagnostician to screen for nonanxiety disorders such as conduct disorder, attention-deficit/hyperactivity disorder, and major depressive disorder. The ADIS-C/P has demonstrated strong psychometric qualities, including strong interrater reliability (parent-interview $\kappa = .98$, child-interview $\kappa = .93$; Silverman & Nelles, 1988), strong concurrent validity (Wood, Piacentini, Bergman, McCracken, & Barrios, 2002), and good test-retest reliability (parent-interview $r = .76$; Silverman, Saavedra, & Pina, 2001). The ADIS-C/P has also been shown to be sensitive to changes related to treatment (Kendall et al., 1997; Silverman et al., 1999).

Diagnosticians first scored ADIS-C/P interviews conducted by a reliable diagnostician, and the scores were compared. Diagnosticians in training were then shadowed by trained diagnosticians. To be judged reliable, diagnosticians had to reach agreement with already reliable diagnosticians

on the presence or absence of all diagnoses and be within one severity point rating on a 1–8 Clinician Severity Rating scale. Diagnosticians reached a kappa of .85. To be included, the child had to meet diagnostic criteria for a principal diagnosis of generalized anxiety disorder, social phobia, or separation anxiety disorder.

Child and therapist perception of the therapeutic alliance. Child and therapist perspectives of a therapeutic alliance were measured with revised child and therapist versions of the Therapeutic Alliance Scales for Children (TASC; Shirk & Saiz, 1992). The original TASC measure, a measure of alliance across treatment, was adapted for use in this study to assess the therapeutic alliance at each session (TASC–R). The TASC–R is a 12-item, 4-point scale completed by the child (e.g., “I liked spending time with my therapist,” “I felt like my therapist was on my side and tried to help me”) and the therapist (e.g., “The child liked spending time with you, the therapist,” “The child considered you an ally”). Items are rated on a 4-point scale ranging from 1 (*not at all*) to 4 (*very much*). The total score equals the ratings on the 12 items.

The TASC was originally studied with 62 children in an inpatient treatment setting (Shirk & Saiz, 1992). Two versions of the TASC were developed, with one written for the child and a similar, parallel version written for the therapist. A translated version of the TASC has been used in a German sample, with good reliability (Kronmuller et al., 2003). Test–retest reliability is difficult because the quality of the alliance is expected to fluctuate over time (Safran, 1993; Safran & Muran, 2000). Perception of the alliance is highly subjective, so it is difficult to corroborate the child’s or therapist’s ratings of a subjective experience. Furthermore, although therapist, child, and observer ratings are often correlated, their ratings are not expected to be redundant (Shirk & Karver, 2003). A potential limitation is that children may feel that they should make positive, flattering ratings about therapists (i.e., may create a ceiling effect, as in Kendall, 1994). To reduce this, children were informed that their ratings were confidential. Each child completed the TASC–R away from the therapist and deposited it in a sealed drop box. The therapist completed the TASC–R therapist version independently after each session, and ratings from Sessions 1 to 3 and Session 7 were used in the current analyses. Therapists were blind to all children TASC–R ratings.

Therapist Alliance-Building Behavior Scale (TABBS). The TABBS assessed therapist behaviors hypothesized to be key to a positive therapeutic alliance. The first step in developing the TABBS was a qualitative examination of previous videotaped sessions of the manualized CBT. Care was taken to sample behaviors that would represent the goal, task, and bond facets of the therapeutic relationship (Bordin, 1979). Therapist behaviors in two categories were recorded. Negative valence consisted of therapist behaviors hypothesized to lead to low child ratings of an alliance, and positive valence consisted of those hypothesized to lead to high child ratings. Explicit efforts were made to exclude therapist behaviors specific to this manual to ensure some generalizability beyond the specific treatment; however, generalizability may be limited, given that the behaviors had to occur during the CBT to be included.

The list of therapist behaviors was submitted for review by four individuals with doctoral degrees who had greater than 5 years of experience and who provided opinions on items and item definitions. The final TABBS measure included 7 positive-valence therapist behaviors and 4 negative-valence behaviors. Each was rated on a 4-point scale ranging from 0 (*absent, or present below a typical level*) to 3 (*strong, or present far above a typical level*). The total TABBS score for each item equaled the sum of the scores on that item across Sessions 1, 2, and 3, with the total score ranging from 0 to 9.

Positive-valence TABBS items were as follows: (a) Customizing the session: The therapist (T) customizes the session for the child, including (but not limited to) asking for information about the child’s likes and dislikes, then incorporates that information into the session in the form of examples, rewards, and other session tasks; (b) Being playful: T presents individual tasks and therapy as a whole in a playful way. T does not

hesitate to get down on the floor and play with the child and gets involved in fun activities/games with the child as a reward, a therapy task, or to facilitate session material; (c) Providing hope and encouragement: T expresses encouragement about therapy, hope for improvement, and a belief that the child is or will make progress; (d) Collaboration: T presents treatment as a team effort, building a sense of togetherness with words like “we,” “us,” and “let’s.” T has the child help set goals for therapy and presents treatment as a way to address the child’s worries and concerns. T also encourages the child’s participation and involvement, and encourages specific feedback from the child; (e) Validating: T shows respect and understanding for the child’s feelings, thoughts, and behavior in ways that may include responding to the child’s hesitation about therapy or anxious situations, as well as exploring problems in the therapist–child relationship if they appear; (f) Having general conversations: conversations between T and the child without a focus on anxiety or treatment, about a topic of some interest to the child; and (g) Finding common ground: things T does to emphasize common ground with the child so that the child might feel special and connected to the therapist. These can be comments T makes in response to the child, in which the therapist is, in essence, saying “Me, too!” or in which T is telling the child something so that the child may, in essence, say, “Me, too!” (Note: T comments that were overly personal were rated no higher than 1 on a 0–3 scale.)

Negative-valence behaviors included the following: (a) Pushing the child to talk: T pressures the child to talk about anxiety. This does not refer to conversations in which the child willingly discusses anxiety and was not scored unless the therapist continued to ask about anxiety beyond the point in which the child seems interested or comfortable; (b) Being too formal: ways T makes the relationship formal instead of relaxed and comfortable, including (but not limited to) talking to the child in ways that appear aloof, punishing, stuffy, or patronizing; (c) Not following through on promises: instances in which T does not follow through on promises made to the child or disappoints the child’s expectations (e.g., not following through on expected rewards or activities). The expectations may or may not be realistic or have been set up by the therapist; however, if they are realistic or based on things the therapist has said or done, then this would contribute to a higher score in this category; and (d) Talking at an inappropriate level: times that T talks in a way that may alienate the child, including talk at a level above or below that which is appropriate for the child’s age, conversations with family that exclude the child, or talking about the child like he or she is not in the room.

Observer’s Perception of the Therapeutic Alliance

The TABBS—Alliance (TABBS–A) included four items (e.g., “How did you feel about the therapist?” “What do you think the child thought about his or her relationship with the therapist?” “What did you think of the therapist–child relationship?”). Each item was given a 1–5 rating ranging from 1 (*weak relationship*) to 5 (*strong relationship*). The TABBS–A was completed by TABBS coders immediately after viewing each therapy tape.

Procedures

Children were referred to the CAADC by parents, school personnel, and mental health professionals. Families were informed that sessions were audio- and videotaped. Parents signed an informed consent form, and children signed an assent form. Participants were administered the ADIS-C/P as part of a prescreening battery for treatment. For each child, separate diagnosticians conducted the parent and child interviews so that information reported in one interview would not bias the other. Diagnosticians each conducted an approximately equal number of parent and child interviews. Following each interview, the parent and child diagnostician independently assigned diagnoses and then reached the composite diagnoses (generated by integrating the independent diagnostics with the “or” rule; see Silverman & Albano, 1996).

Table 1
Intraclass Correlations, Minimums, Maximums, Means, Standard Deviations, and Correlations of Dependent Variables (n = 56)

Variable	rICC	Min	Max	<i>M</i>	<i>SD</i>	Child (Sessions 1–3)	Child (Session 7)	Therapist (Sessions 1–3)	Therapist (Session 7)
TABBS									
Playfulness	.90	0	9	3.67	2.39	-.02	.05	.29 ^a	.31 ^a
Pushing the child	.94	0	5	1.59	1.80	-.23	-.24	-.01	.15
Hope-encouragement	.92	0	9	4.11	2.18	.12	.02	.38 ^a	.45 ^a
Formality	.34	0	7	0.95	1.49	-.19	-.23	-.18	-.37 ^b
Collaboration	.86	0	9	4.11	2.22	.25	.05	.42 ^b	.50 ^b
Validating	.88	0	8	4.18	2.11	.05	.06	.21	.30 ^a
Inappropriate talk	.60	0	6	0.74	1.35	.15	-.01	.37 ^b	.41 ^a
Finding common ground	.84	0	9	3.57	2.47	-.16	.04	.12	.20
TASC-R (child)									
Session 1 total score		14	48	37.00	9.32				
Session 2 total score		14	48	38.29	9.37				
Session 3 total score		16	48	39.95	8.54				
TASC-R (therapist)									
Session 1 total score		9	48	32.70	8.58				
Session 2 total score		13	48	34.11	8.81				
Session 3 total score		14	48	35.80	8.72				

Note. rICC = reliability intraclass correlation coefficient; Min = minimum; Max = maximum; TABBS = Therapist Alliance-Building Behavior Scale; TASC-R = Therapeutic Alliance Scales for Children—Revised.

^a Correlation is significant at the .05 level. ^b Correlation is significant at the .01 level.

Eligible children were randomized to one of three 16-session manualized treatments lasting 60 min per session (average one per week). A CAADC staff member, other than the therapist, had the child complete the TASC-R at the end of each session and fold and insert the form in a sealed (confidential) box. A total rating, which summed alliance ratings from the end of the first, second, and third sessions, was used. Ratings from the end of the seventh session were used in analyses of later alliance because, in this CBT, exposure tasks begin at Session 8 (and may influence alliance ratings) and, as treatment moves toward outcome, later alliance ratings may be confounded by improvement (see Feeley et al., 1999).

Seven psychology students were trained to reliability on the TABBS. Coders independently coded the first three therapy sessions for two practice cases. A single-measure intraclass correlation coefficient (ICC) determined whether coders had reached reliability. After the coders were all deemed reliable, they coded the first three therapy sessions of participants for the presence and strength of the therapist behaviors and for their own (observer) perception of the therapeutic alliance. Coders were blind to all ratings of the TASC-R. During data collection, each coder coded three therapy tapes of the same two participants as an unannounced reliability check.

Results

Reliability of Coders

A single-measure reliability ICC (rICC) determined that coders reached adequate reliability at the end of training (rICC = .92, $p < .0001$). An unannounced reliability check performed during data collection evidenced the maintenance of reliability (rICC = .91, $p < .0001$).

Preliminary Analyses

The coded TABBS data were examined to determine whether there were sufficient occurrences. Item 7 of the TABBS (not following through on promises) was excluded from analyses be-

cause there were too few occurrences ($n = 5$ from 168 sessions). Two TABBS items were found not to be reliable (customizing the session, inappropriate talk) and were excluded. The remaining eight TABBS items were reliably coded and used for further analyses. The intraclass correlations, means, standard deviations, minimum scores, and maximum scores for the TABBS total scores (e.g., the sum of each item across all three sessions) are provided in Table 1.¹

Correlations between Session 3 alliance scores and total alliance scores were examined, and strong positive correlations were found for both child ($r = .86$, $p < .001$) and therapist ($r = .89$, $p < .001$). Given the strength of these correlations, the total score was used in analyses of the child report of alliance at Session 3. Given that fluctuations in an alliance are common and expected (Safran & Muran, 2000), a summed score represents the overall state of an alliance, lessening the impact of fluctuations across sessions.

Correlations among the four TABBS-A items were examined, and strong positive correlations were found (see Table 2). Given

¹ On the basis of a correlation matrix of the reliable items (see Table 2) and an examination of the hypothesized valence of the items, a composite variable was formed on the basis of positive correlations of $r = .45$ and higher (all $ps < .01$). The positive behavior composite variable (being playful, hope-encouragement, collaboration, validation, general conversations, finding common ground) was formed by summing total scores from each item. No corresponding negative behavior composite variable was formed because no negative-valence items were significantly correlated. In consideration of multicollinearity, the positive behavior composite variable and the negative-valence variables were entered into regressions. At Session 3, positive behavior did not predict child alliance but positively predicted therapist alliance. At Session 7, positive behavior did not predict child alliance. Therapist alliance was positively predicted by positive behavior and negatively predicted by being overly formal.

Table 2
Intercorrelations Between TABBS Items and Between TABBS-A Items

Item	1	2	3	4	5	6	7	8
TABBS								
1. Playfulness	—	.25	.63**	-.41**	.62**	.49**	.51**	.53**
2. Pushing	—	—	.29	.02	.28	.30	.17	.13
3. Hope and encouragement	—	—	—	-.22	.76**	.66**	.69**	.55**
4. Formality	—	—	—	—	-.25	-.17	-.25	-.23
5. Collaboration	—	—	—	—	—	.60**	.58**	.45**
6. Validation	—	—	—	—	—	—	.48**	.52**
7. General conversations	—	—	—	—	—	—	—	.62**
8. Common ground	—	—	—	—	—	—	—	—
TABBS-A								
1. Did you like the therapist?	—	.54**	.65**	.75**				
2. How do you think the therapist viewed the alliance?	—	—	.91**	.89**				
3. How do you think the child viewed the alliance?	—	—	—	.95**				
4. How did you view the alliance?	—	—	—	—				

Note. TABBS = Therapist Alliance-Building Behavior Scale; TABBS-A = TABBS—Alliance.
** $p < .01$.

the strength of correlation, we concluded that the four items appeared to tap the same construct. The item with the highest correlations with the other items (“What did you think of the therapist–child alliance?”) was chosen. This item was totaled in the same way that the TASC–R child and therapist scores were summed so that observer ratings at Session 3 equaled the summed total score of Sessions 1, 2, and 3.

The child and therapist TASC–R ratings were examined with Cronbach’s alpha to assess internal consistency. Child and therapist ratings were found to have acceptable levels of internal consistency at Sessions 1, 2, 3, and 7 (children’s $\alpha = .88$ –.92, therapists’ $\alpha = .94$ –.96).

Demographic Variables

A series of analyses of variance were conducted to examine whether demographics were linked to child ratings of the alliance. There was no significant effect of child’s age in years, $F(6, 42) = 1.34$, $p = .26$; of child’s gender, $F(1, 54) = 0.38$, $p = .54$; of child’s race, $F(2, 53) = 0.36$, $p = .70$; of treatment condition, $F(2, 53) = 0.28$, $p = .75$; or of child’s principal diagnosis, $F(2, 53) = 2.75$, $p = .20$. Because there were nonsignificant findings, none of these variables were entered into the next step of the analyses.

Therapist Behaviors as a Predictor of Child Ratings of the Therapeutic Alliance

A linear regression assessed the degree to which therapist behaviors significantly predicted early child ratings of a therapeutic alliance (see Table 3). Item scores for the eight therapist behavior codes were each summed across the sessions, resulting in a total score for each item. Each total score was then entered into the linear regression. Three behaviors were found to be significant predictors of child perception of the therapeutic alliance at Session 3. Specifically, “collaboration” between therapist and child was

predictive of higher child ratings of an alliance;² “finding common ground” with the child was predictive of lower child ratings of an alliance; and “pushing the child to talk” about anxiety beyond his or her comfort level was predictive of lower child ratings of an alliance.

A linear regression examined the degree to which therapist behaviors significantly predicted later (Session 7) child ratings of a therapeutic alliance. Total scores for each of the eight therapist behaviors were entered with Session 7 child alliance scores. “Pushing the child to talk” remained predictive of lower child ratings of an alliance at Session 7 (see Table 4).

Therapist Behaviors as a Predictor of Therapist Ratings of a Therapeutic Alliance

A linear regression assessed the degree to which coded therapist behaviors significantly predicted early therapist ratings of an alliance. Total scores for the eight therapist behavior codes were entered into a linear regression, but there were no therapist behaviors that were significant predictors of therapist perception of the therapeutic alliance at Session 3 (see Table 4).

A linear regression examined the degree to which therapist behaviors significantly predicted therapist ratings of a therapeutic alliance at Session 7. Total scores for each of the eight therapist behaviors were entered. At Session 7, “being overly formal” significantly negatively predicted therapist ratings of the alliance, and “collaboration” significantly positively predicted therapist ratings of an alliance (see Table 4).

² “Collaboration” also significantly positively predicted observer ratings of the relationship at Session 3 ($B = 1.12$, $SE B = 0.56$, $\beta = .32$, $p < .05$).

Table 3
Summary of Linear Regression Analysis for Specific Therapist Behavior Predicting Child Ratings of the Therapeutic Alliance at Session 3 and Session 7 (n = 56)

Variable	B	SE B	β
Session 3			
1. Playfulness	-5.56	4.24	-.23
2. Pushing	-6.98	3.08	-.29*
3. Hope-encouragement	-0.38	5.64	-.02
4. Formality	-4.69	3.18	-.20
5. Collaboration	10.85	4.75	.45*
6. Validating	0.98	4.07	.04
7. General conversations	5.91	4.40	.25
8. Finding common ground	-9.75	4.01	-.41*
Session 7			
1. Playfulness	-0.48	1.46	-.07
2. Pushing	-0.18	0.08	-1.70*
3. Hope-encouragement	-0.22	1.83	-.03
4. Formality	-1.68	1.10	-.25
5. Collaboration	0.87	1.70	.13
6. Validating	1.12	1.45	.16
7. General conversations	-1.09	1.55	-.16
8. Finding common ground	0.39	1.41	.06

Note. R^2 for Session 3 = .33, $p = .01$; R^2 for Session 7 = .14, $p = .55$.
 * $p < .05$.

Multiple Ratings of Alliance

At Session 3, observer ratings of a therapist-child alliance were significantly correlated with child ratings of an alliance, $r(54) = .57, p < .001$, and with therapist ratings of an alliance, $r(54) = .34, p = .01$. Child ratings of a therapist-child alliance at Session 3 were significantly correlated with therapist ratings of an alliance, $r(54) = .37, p < .01$. At Session 7, child and therapist alliance ratings were not significantly correlated, $r(54) = .25, ns$. Observer ratings were not gathered at Session 7.

Discussion

This study identified specific therapist behaviors that were predictive of child clients', therapists', and observers' perception of a therapeutic alliance. The occurrence of "collaboration" predicted early child ratings of a stronger alliance, and "pushing the child to talk" and "emphasizing common ground" predicted early child ratings of a weaker alliance. "Pushing the child to talk" continued to predict lower child ratings of an alliance at Session 7. Although none of these behaviors predicted early therapist alliance ratings, later therapist alliance was predicted by "collaboration" (positively) and "being overly formal" (negatively). Other therapist behaviors were not predictive of child ratings of an alliance, including being playful, providing hope and encouragement, and general conversations.

These findings indicate a link between specific therapist behaviors and subsequent ratings of an alliance by multiple reporters. Given that the literature suggests that an alliance may be related to engagement in (a) therapy tasks (Chu et al., 2004; Kendall & Ollendick, 2004), (b) treatment outcome (e.g., Martin et al., 2000; Shirk & Karver, 2003), as well as (c) retention in treatment (Crits-Christoph, 1998; Robbins et al., 2003), an understanding of

the ways in which therapist behaviors may contribute to the quality of an alliance is important. Although directionality cannot be determined from these findings, knowing the associations between therapist behaviors (i.e., collaboration, pushing a child to talk, emphasizing commonalities) and alliance can help to inform clinical practice.

Collaboration predicted child perception of a stronger alliance after 3 sessions. The present ratings of therapist collaborative behaviors (e.g., therapist building togetherness with the child client) resemble child involvement (e.g., child makes suggestions) identified in earlier research (e.g., Braswell et al., 1985). Collaboration has also been described as an important facet of cognitive therapy for adult depression. Accordingly, approaching treatment as a collaborative enterprise merits both clinical application and additional research attention.

There are several possible explanations regarding collaboration. Perhaps therapist collaboration helped shape treatment interactions (e.g., deciding on goals) and influenced a child's view of an alliance. Another possible explanation is that a child who formed a strong alliance was already prone to actively participating in therapy in a collaborative manner. This explanation would be supported if there were pretreatment child characteristics that predicted collaboration, but such characteristics have not yet been identified. Therapist ratings of an early alliance were not predicted by the presence of collaboration, but collaboration did predict higher therapist ratings of an alliance at Session 7. Perhaps children were more sensitive to variations in therapists' effort to collaborate, leading them to rate the early alliance higher.

Pushing the child to talk about anxiety when the child was not yet ready was a significant negative predictor of child alliance. Perhaps pushing, wherein therapy was too dictated by the therapist's schedule of topics, detracted from the child's view of an alliance. Alternatively, perhaps children with a weaker sense of

Table 4
Summary of Linear Regression Analysis for Specific Therapist Behavior Predicting Therapist Ratings of the Therapeutic Alliance at Session 3 and Session 7 (n = 56)

Variable	B	SE B	β
Session 3			
1. Playfulness	1.24	4.37	.05
2. Pushing	-3.08	3.37	-.13
3. Hope-encouragement	2.44	5.63	.10
4. Formality	-1.82	3.31	-.08
5. Collaboration	7.69	4.97	.32
6. Validating	-0.40	4.47	-.02
7. General conversations	7.25	4.56	.31
8. Finding common ground	-7.21	4.30	-.31
Session 7			
1. Playfulness	-1.18	1.33	-.16
2. Pushing	0.39	1.02	.05
3. Hope-encouragement	1.19	1.71	.15
4. Formality	-2.52	1.00	-.33*
5. Collaboration	3.00	1.51	.38*
6. Validating	-0.11	1.35	-.01
7. General conversations	1.85	1.38	.24
8. Finding common ground	-1.67	1.30	-.22

Note. R^2 for Session 3 = .28; $p = .05$; R^2 for Session 7 = .39, $p < .01$.
 * $p < .05$.

alliance were less engaged in therapy, leading the therapist to perceive the need for an extra push. Because of the correlational nature of the data, the directionality is unclear. However, it is of interest that pushing was not predictive of therapist ratings of an alliance at either time point—especially given its consistent predictiveness of children's alliance ratings. Although therapists may not sense their pushing (perhaps seeing it as encouragement), it appears to be noticed, and disliked, by child clients with anxiety. Future research is needed into the merits or demerits of, and potential optimal timing for, therapist behaviors that either encourage or push a child client.

A second therapist behavior that negatively predicted early child alliance was "finding common ground." Although the direction of the relationship was unexpected, a reexamination of the therapist behaviors coded as "finding common ground" suggests an explanation. Perhaps conversations in which the therapist tried to emphasize commonalities were taken by the child as naïve, if not disingenuous, efforts to connect with the child (e.g., "Don't worry about being a few minutes late. I know it can be hard to find parking. I had a hard time today, too." "You're the goalie for your hockey team? I played hockey for years!" "I get nervous sometimes too."). If the child thinks the therapist is trying too hard, then the statements can be taken as insincere. Alternatively, perhaps a relatively weak alliance elicited increased the therapist's effort to relate to the child by increased efforts to try to find common ground. It should be noted that timing may be critical. Early efforts to find common ground predicted a less favorable early alliance, but finding common ground was neither associated with later child alliance, nor did it predict therapist or observer ratings of an alliance at any time point. Rushing to find common ground may not be preferred, whereas commonalities that surface over time, in a more natural manner, may not be undermining of an alliance.

There are potential clinical implications from the correlations among observer, therapist, and child ratings of an alliance. Research findings have been inconsistent regarding observer ratings when client age is not considered (Horvath & Symonds, 1991; Martin et al., 2000). Shirk and Karver (2003) found that child reports of the alliance were less predictive than therapist reports. Observer ratings were not considered. In the current study, we found that child, therapist, and observer ratings of the alliance were positively correlated. The correlation between the observer TABBS-A alliance rating and both child and therapist TASC-R alliance ratings provides some validation for the TASC-R. This TASC-R concurrent validity adds to the child alliance literature, which has suffered from a lack of a commonly used measure of child alliance.

This study examined alliance within a manualized treatment that was considered to have efficacy (Ollendick & King, 2000) on the basis of randomized clinical trials (e.g., Kendall et al., 1997), buttressing the merits of studying process variables within treatments known to have beneficial outcomes. The use of a standardized treatment (with adherence checks) and a fairly homogenous sample (with regard to child diagnosis) permitted a focused analysis of how therapist behaviors are related to an alliance. Note that the present results speak to alliance within an effective treatment, not to alliance as an effective treatment.

Potential limitations merit consideration. For example, the present findings included a restricted range of child reports of an alliance. However, the strong positive correlation between ob-

server and client ratings suggests that the restricted range may not have been inaccurate (i.e., not a bias, but a reflection of true strong alliances across cases). Indeed, meta-analyses have indicated that although child reports typically show "very limited variability" (Shirk & Karver, 2003, p. 460), child reports of an alliance are nevertheless predictive. A potential limitation related to the TABBS was that the codes came mainly from videotapes of CBT. Although care was taken not to select therapist behaviors specific to one treatment, only behaviors that occurred during CBT could be coded, potentially limiting generalizability of the findings. Additional research is needed to extend the current findings beyond CBT into other areas in which alliance may be considered a necessary, but not sufficient, part of the change process. Consideration should also be given to the degree to which an alliance is a mechanism of change: Therapist behaviors in an alliance theorized to be necessary and sufficient may have different implications than when an alliance is theorized to be necessary but not sufficient.

A direction for future research concerns the potential moderating effect of the child's motivation for treatment and level of engagement during sessions. A therapist may use different alliance-building behavior to engage an unmotivated child than a child who is already motivated. Study of these interactions will help to understand the bidirectional nature of an alliance. Given that alliance can have an impact on treatment attrition (Crits-Christoph, 1998; Robbins et al., 2003) and that alliance has been suggested as influencing engagement in the tasks of therapy (Kendall & Ollendick, 2004), it would be of interest to study therapist actions that correct a weak alliance.

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Received July 12, 2003

Revision received March 15, 2004

Accepted April 6, 2004 ■