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THERAPEUTIC ALLIANCE IN  
PSYCHODYNAMIC CHILD PSYCHOTHERAPY:  
GROWTH TRAJECTORIES AND RELATIONS WITH OUTCOME

DENİZ ÖZSOY  
115637004

SİBEL HALFON, FACULTY MEMBER, PhD

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Therapeutic Alliance in Psychodynamic Child Psychotherapy:  
Growth Trajectories and Relations with Outcome

Psikodinamik Çocuk Terapisinde Terapötik İttifak:  
Büyüme Eğrileri ve Sağaltım ile İlişkileri

Deniz Özsoy  
115637004

Thesis Advisor: Sibel Halfon, Dr. Öğr. Üyesi :  
İstanbul Bilgi Üniversitesi

Jury Member: Alev Çavdar Sideris, Dr. Öğr. Üyesi :  
İstanbul Bilgi Üniversitesi

Jury Member: Yasemin Sohtorik İlkmen, Dr. Öğr. Üyesi :  
Yeditepe Üniversitesi

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## ABSTRACT

Therapeutic alliance is the emotional and collaborative relationship between patient and therapist. The concept has attracted substantial theoretical and empirical interest in adult and youth psychotherapy literature as it carries a potential for promoting therapeutic growth. However, the research on therapeutic alliance in psychodynamic child treatment is considerably scarce and newly developing. This study examines the child characteristics of therapeutic alliance, development of therapeutic alliance throughout the process and the association between alliance and treatment outcome in psychodynamic child therapy. In order to measure the quality of therapeutic alliance, 179 therapy sessions from the beginning, middle and end phases of the treatment of 49 children with behavioral problems, who completed psychodynamic therapy with good outcome, were coded with the Therapy Process Observational Coding System-Alliance scale (TPOCS-A). To assess treatment outcome, as in improvement in symptoms and level of psychosocial functionality, the Child Behavior Checklist (CBCL) internalizing and externalizing problem scores and Children's Global Assessment Scale (CGAS) ratings were collected pre- and post-treatment. Hierarchical linear modeling results portrayed a U-shaped quadratic growth trajectory of therapeutic alliance. Girls showed higher alliance scores than boys. Internalizing problems and psychosocial functioning were positively related; whereas externalizing problems were negatively related to therapeutic alliance. No significant associations were found between therapeutic alliance and treatment outcome. These results provide preliminary findings on the growth trajectory and idiographic characteristics of therapeutic alliance over the course of psychodynamic child treatment.

*Keywords:* therapeutic alliance, psychodynamic therapy, child psychotherapy, process research, outcome research

## ÖZET

Terapötik ittifak, hasta ile terapist arasındaki duygu ve işbirliğine dayalı ilişkidir. Terapötik ittifak kavramı, terapötik gelişime olan olası katkısından dolayı, hem yetişkin hem de genç ve çocuk psikoterapi literatüründe teorik ve ampirik açıdan oldukça ilgi çekmiştir. Ancak, psikodinamik çocuk terapisinde terapötik ittifak üzerine olan araştırmalar epey sınırlıdır ve gelişmektedir. Bu çalışma, psikodinamik çocuk terapisinde terapötik ittifakın çocuklara dair özelliklerini, terapi süreci boyunca gelişimini ve sağaltım ile ilişkisini incelemektedir. Terapötik ittifak düzeyini ölçmek için, davranış problemi olan ve psikodinamik terapi sürecini iyi sonuç elde ederek tamamlamış olan 49 çocuğun 179 terapi seansı baş, orta ve son kısımlar olmak üzere, Gözleme Dayalı Terapötik İttifak Aracı ile kodlanmıştır. Sağaltımı, yani semptomların ve psikososyal işlevsellik düzeyinin gelişimini değerlendirmek için Çocuk Davranış Değerlendirme Ölçeği içe ve dışa yönelim problem puanları ile Çocukların Global İşlevsellik Skalası puanları sürecin başında ve sonunda toplanmıştır. Hiyerarşik doğrusal modelleme sonuçlarından elde edilen bulgulara göre, terapötik ittifak U şeklinde kuadratik bir büyüme eğrisi göstermiştir. Kızların terapötik ittifak puanları erkeklere kıyasla daha yüksek olmuştur. Terapi sürecinde, içe yönelim problemleri ve psikososyal işlevsellik terapötik ittifak ile olumlu yönde bir ilişki göstermiş; dışa yönelim problemleri ise terapötik ittifak ile olumsuz yönde bir ilişki göstermiştir. Terapötik ittifak ile sağaltım arasında anlamlı bir ilişki bulunamamıştır. Bu sonuçlar, psikodinamik çocuk terapisinde terapötik ittifakın büyüme eğrisi ve danışanlara özgü özelliklerine dair ön bulgular sunmaktadır.

*Anahtar Kelimeler:* terapötik ittifak, psikodinamik terapi, çocuk psikoterapisi, süreç araştırması, sonuç araştırması

## **CHAPTER 1**

### **INTRODUCTION**

In a psychotherapy session, a wide range of interactions takes place between the patient and the therapist (Schneider, Midgley, & Duncan, 2010). The affective and collaborative nature of these interactions is called therapeutic alliance (Kazdin, Marciano, & Whitley, 2005). It is the emotional bond of the dyad, in addition to their mutual work on the tasks and goals of the therapy (Bordin, 1979). The concept is rooted in psychoanalytic theory (Freud, 1913) and it has drawn great theoretical and empirical attention since then. As exploring the effective ingredients of psychotherapy has been intriguing for theorists and researchers for many years, therapeutic alliance has been one of the most remarkable candidates that may contribute to a successful psychological treatment (Martin, Garske, & Davis, 2000).

The interest in the beneficial impacts of therapeutic alliance has led researchers to develop various alliance measures and conduct a large number of studies, particularly in adult field (Green, 2009). These studies have been produced primarily in psychotherapy outcome and process research. In outcome research, end results of psychotherapy are analyzed (Orlinsky & Howard, 1986). The most recent meta-analysis (Horvath, Del Re, Flückiger, & Symonds, 2011) of adult psychotherapy outcome studies has shown that strong therapeutic alliance has a robust and consistent association with positive treatment outcomes. In process research, features of psychotherapy process, which includes everything that happens between and within the patient and the therapist, are examined (Orlinsky & Howard, 1986). As therapeutic alliance has a dynamic nature, various studies have been conducted in order to investigate its trajectories throughout the therapy process, and to identify the alliance pattern that facilitates optimal therapeutic gains (Ardito & Rabellino, 2011).

Although there is a substantial body of research in adult literature, studies on therapeutic alliance with child patients are relatively scarce, newly developing and

requires more attention (Shirk, Karver, & Brown, 2011). The most recent and comprehensive meta-analysis of youth alliance studies (McLeod, 2011) found a significant yet, compared to adults, less reliable link between therapeutic alliance and clinical outcomes of youth psychotherapy. McLeod (2011) indicated that more research is needed to be done in order to establish the consistency of the findings on the role therapeutic alliance plays in youth psychotherapy. Moreover, as various therapeutic alliance trajectories have been discovered in the adult process research, there is considerably limited empirical knowledge on the changes in therapeutic alliance over the course of youth treatment (Bickman et al., 2012).

In addition to its empirical value, studying therapeutic alliance between child and therapist is clinically useful and meaningful for several reasons. First of all, unlike adults, children are brought to therapy by their parents; thus they commonly participate in the process involuntarily (Chethik, 2003). Therefore, it is specifically important to form therapeutic alliance with children as it engages the child in the process and promotes further therapeutic work (Shirk & Karver, 2003). Therapeutic alliance may be an instrument for collaborative work (A. Freud, 1946) or it may facilitate growth in child on its own as it provides an experience of a secure bond (Axline, 1947). Latter aspect of therapeutic alliance is particularly relevant for non-behavioral child therapies such as the treatment approach of the current study, psychodynamic child therapy. By any means, there is a high potential for therapeutic alliance to contribute to the clinical improvement of children (McLeod & Weisz, 2005). For instance, as children with externalizing problems have particular difficulty in interpersonal processes (Garcia & Weisz, 2002), they may benefit from a well-established therapeutic alliance. In order to provide an effective treatment for children, it is essential to gain more knowledge on their therapeutic alliance with their therapists, as in what contributes to its formation, how it grows throughout a successful treatment and whether it ensues therapeutic change. Hence, in the current study, child characteristics of therapeutic alliance, changes in therapeutic alliance

over the course of therapy and the link between alliance and treatment outcome will be explored.

In the following literature review, theoretical background, operational definitions, outcome and process studies and measurements of therapeutic alliance will be presented. Theoretical literature includes adult psychotherapies, as the concept in child literature is derived from the adult field. Moreover, it is grounded in the psychodynamic literature, since the concept originates in psychoanalytic theory and the current study is based on psychodynamic child therapy. Empirical literature includes adult studies and measures because the large body of work done with adult patients supports the relatively small research on children. The child empirical literature involves solely the child-therapist alliance studies and measures, as the main focus of the current study is treatment outcome: According to literature, therapeutic alliance with children predicts symptom reduction, whereas alliance with parents prevents premature termination (Hawley & Weisz, 2005). Subsequently, purpose of the current study will be explained.

## **1.1. PSYCHODYNAMIC BACKGROUND OF THERAPEUTIC ALLIANCE**

### **1.1.1. Therapeutic Alliance in Adult Psychotherapy**

The concept of therapeutic alliance, its definition and knowledge of its contributions to psychological treatment have evolved theoretically and empirically in the last century, primarily in adult psychotherapy literature. It originates in psychoanalytic theory and development of the construct dates back to the writings of Freud in 1910s. In *On Beginning the Treatment*, Freud (1913) argued that strong rapport with a patient, which is one of the vital elements of a successful analysis, is built through establishment of an effective transference. Analyst's serious interest, sympathetic understanding and removal of patient's initial resistances pave the way for the patient to form an attachment and unconsciously link the analyst with "one of

the imagos of the people by whom he was accustomed to be treated with affection" (pp. 139-140). In his earlier papers, therapeutic alliance was portrayed as only based on positive transference, the unconscious distortions of the real relationship (Freud, 1912/1958, 1913). However later in *Analysis Terminable and Interminable*, Freud (1937/1964) revised his understanding of therapeutic alliance and asserted that a good relationship between an analyst and a patient develops as a result of both positive transference and positive relations that are based on reality.

Zetzel (1956) further elaborated the work of Freud (1937/1964) and coined the term "therapeutic alliance" that refers to the real aspect of patient-therapist relationship. She theorized that, when the analyst makes an interpretation of transference, therapeutic relationship helps the patient to differentiate between the fragments of past relationships and the actual, current relationship between himself and the analyst. Moreover, she indicated that, as a successful analysis is based on strong therapeutic alliance, existence of healthy parts of patient's ego functions is a prerequisite for the formation of therapeutic alliance (Zetzel, 1956). Greenson (1965), who was influenced by the work of Zetzel (1956), pointed out the error analysts make in analyzing what actually is an unestablished therapeutic alliance as a negative transference. Therefore he split reactions of patients in two: transference neurosis, which is "the experiencing of feelings, drives, attitudes, fantasies, and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood" and working alliance, which is "nonneurotic, rational rapport which the patient has with his analyst"; "the patient's capacity to work purposefully in the treatment situation" (Greenson, 1965, pp. 156-157). He claimed that it is important to establish and sustain working alliance as much as transference neurosis in order to accomplish a successful treatment. In addition, contrary to stances of the analysts in his time period, he discussed that avoiding an aloof and distant attitude, showing understanding, compassion and consideration for the patient help the analyst to establish working alliance (Greenson, 1965).

In 1976, based on the concept of Zetzel (1956), Luborsky introduced two types of therapeutic alliance that evolve consecutively throughout therapy process. In the early period of therapy, when the patient perceives the therapist as warm, supportive, helpful and the treatment as effective it is called Type 1 alliance. In the later period, Type 2 alliance forms when the patient and the therapist share a sense of working collaboratively to attain the treatment goals that are agreed upon mutually. He suggested that establishing both types of alliance promotes therapeutic growth in psychodynamic therapy (Luborsky, 1976). Bordin (1979), who was influenced by the work of Greenson (1965), used his term "working alliance" and introduced a broad pantheoretical definition that can be used with any therapy approach. He formulated three components of working alliance: goals, tasks and bonds. The concept of *goals* refer to the mutual agreement and collaboration of patient and therapist on treatment goals; *tasks* relate to equal efforts of patient and therapist in carrying out the tasks that the treatment demands and *bonds* pertain to deep, strong relationship of patient and therapist that is based on mutual trust. He proposed that such three means promote strong working alliance that adds to the efficacy of therapy (Bordin, 1979).

In contrast to Zetzel (1956) and the follower theorists that viewed therapeutic alliance and transference as separate concepts, some others perceived patient-therapist relationship solely as a transference interaction. Brenner (1979) strictly claimed that what has been called as therapeutic or working alliance is simply a part of transference that "neither deserve a special name nor require special treatment" (pp. 156). In the same manner, Curtis (1979) argued that warm or supportive attitudes of the therapist would only gratify the transference needs of the patient and lessen the transference interpretation that therapist ought to make. Moreover, he asserted that collaborative attitudes of the patient must be interpreted, which may actually be a disguised form of infantile wishes of parental approval (Curtis, 1979).

On the other hand, Gelso and Carter (1985) agreed with the ones that endorse the formation of a real relationship between therapist and patient alongside of transference relationship; and introduced a threefold quality to therapeutic

relationship: the working alliance, the transference relationship and the real relationship. They indicated that three components are interrelated and experienced as one, rather than distinct entities. Ingredients of working alliance are some of the essential motives that bring both parties to therapy; transference aspects of the relationship give the interaction a form and depth; strength and positive valence of the real relationship boost working alliance; and working alliance strengthens the real relationship and opens the patient a space to work through his transference reactions without fully harming the relationship or the treatment process (Gelso & Carter, 1985).

Although there had been an ongoing debate in psychodynamic literature on whether therapeutic relationship has a real, current and collaborative element or not; Gaston (1990) concluded that most theorists agree upon a concept that consists of current and real aspects as well as distorted parts that are rooted in the past. Beyond the controversy, in the most recent conceptual work, definition of therapeutic alliance is based on its conscious relationship processes and collaborative features (Horvath et al., 2011).

Gaston (1990) bridged theoretical work and research and hypothesized three roles of alliance in therapeutic change: "(a) the alliance as being therapeutic in and of itself; (b) the alliance as being a prerequisite for therapist interventions to be effective; and (c) the alliance as interacting with various types of therapist interventions" (Gaston, 1990, pp. 148). The theory of alliance as being curative itself has its origins in the work of Rogers (1957). He stated that for positive change to take place, therapist's "genuineness", "empathic understanding" and "unconditional positive regard" of the patient are necessary and sufficient (Rogers, 1957, pp. 96). As another advocate of the theory, Bowlby (1988) referred to therapeutic alliance as a secure base where empathic, responsive and trusted therapist promotes exploration of the patient's inner world. He suggested that secure attachment relationship facilitates change in the patient (Bowlby, 1988). In contrast, Bordin (1979) argued that, rather than being curative itself, therapeutic alliance adds to the improvement of patient, by

means of letting the patient accept, trust and follow the treatment process. In line with Bordin, majority of psychodynamic theorists view therapeutic alliance as a necessary but not sufficient element for successful therapeutic change to take place (Gaston, 1990).

Lastly, Meissner (2007) introduced the ingredients of therapeutic alliance that are fundamental to build and sustain an effective psychotherapy with adults. These are therapeutic framework, which consists of time, frequency, setting, payment and boundaries of therapy; participation, which is for both parties to meet their responsibilities as patient or therapist; empathy, which is the capability of both participants to understand and respond to each other; trust, which is for patient to feel secure and believe in therapist and the process; autonomy, which is the opposite of patient to be highly dependent, suggestible, eager to please, or willing to gain approval from therapist; initiative, which represents patient to lead the therapy session, to make meanings with or independent from the therapist; freedom is for both patient and therapist to participate in the therapy process with their own free will; neutrality and abstinence, which refer to therapist's objective, observational and non-judgmental therapeutic stance; and ethical considerations such as confidentiality of therapist and truthfulness of both participants (Meissner, 2007).

### **1.1.2. Therapeutic Alliance in Child Psychotherapy**

Parallel with adult literature, literature on therapeutic alliance between child patient and therapist has a long history. In *The Psycho-analytical Treatment of Children*, Anna Freud (1946) discussed that child's "affectionate attachment" to analyst is a "prerequisite for all later work" in child analyses (pp. 31). She perceived the affective aspect of therapeutic alliance, which includes child's positive feelings for the analyst, as less mature level of alliance that calls forth the more mature level of alliance, which is to work on child's problems (Sandler, Kennedy, & Tyson, 1980). She referred to therapeutic relationship as a catalyst for successful interventions to

take place; she advised an establishment period of affectionate relationship prior to analyst's initial interpretations (A. Freud, 1946). Therefore, she pointed out two qualities of therapeutic alliance: affective, relationship-based aspects and collaborative, work-based aspects.

Contrary to the view of therapeutic relationship as a mediator to successful therapeutic work, Axline (1947) argued that it is the relationship that facilitates therapeutic change, serves as an opportunity for growth of the child. In her book *Play Therapy*, she described the curative nature of the relationship as follows: The empathic, warm, nonjudgmental and stable therapist sets adequate limits, engages sensitively in the affective and expressive experience of child; thus provides a safe haven to child. Child, who feels secure, respected, accepted and understood in the relationship, begins to discover his inner world, to reveal his true self and to grow as a mature, independent individual (Axline, 1947). Aforementioned, Rogers (1957) contributed to this perspective. He identified the "unconditional positive regard" of therapist with "a mother's love for her child", which he designated as a sufficient ingredient for therapeutic change alongside her empathy and genuineness (pp. 101). Whether the affective quality of therapeutic alliance is perceived as "a means to an end" or "an end in itself", establishment of a strong therapeutic relationship is considered as a crucial part of child psychotherapy, throughout the history (Shirk & Saiz, 1992, pp. 716).

There are numerous theorists that further investigated the nature and therapeutic benefits of the relationship that develops between therapist and child. According to the pioneers of attachment theory, Ainsworth (1978) and Bowlby (1979), when child's primary caregiver, who is generally the mother, is available, supportive, sensitive and responsive to child's needs, he lives in a secure and confident mode of being. He explores the world with an assurance of a safe base where he can return to when needed. On the other hand, when the caregiver is incapable of serving as such a secure base to the child, child endures a generalized discomfort and insecurity throughout his life; cannot engage in exploratory

experiences or does so with full of anxiety (Ainsworth, 1978; Bowlby 1979). In therapy, therapist forms an emotional bond with child; establishes and maintains a new attachment relationship by virtue of being consistently available, supportive, sensitive and responsive to child. She provides a holding environment where child feels contained, loved, protected and cared about in a way that evokes the healthy maternal-child interactions (Winnicott, 1971). Therefore, if the child is devoid of secure attachment figures, he repairs his early attachment experiences, and within his therapeutic relationship, fulfills his current need of a safe base (Fitton, 2012). Bowlby (1975) underlined the fact that therapist is a temporary attachment figure who should delicately maintain an equilibrium of being the internal representation of the primary caregiver and the external real person at the same time. This temporary attachment helps child to successfully go through individuation-separation process, strengthen self-regulatory capabilities, build interpersonal skills, and establish new, healthy and permanent attachments to others (Diamond et al., 2003).

Furthermore, Gardner (1993) introduced several agents embedded in therapeutic relationship that generate change such as, child spending quality time alone with another, receiving therapist's focused attention and affection, having a protective but objective adult as an ally in the face of conflict with his parents, being spoken to in a developmentally appropriate yet adult-like manner and experiencing the therapist as an adult who can be fun, humorous and comfortably regressive. He indicated that child may benefit from these qualities of the therapeutic relationship especially if he is deprived of them in his relationships with significant others (Gardner, 1993).

It is inevitable to count play in the therapeutic relationship of child and therapist. Play, the native language of children, has been a component of child psychotherapy techniques since the practices of Melanie Klein and Anna Freud in 1930s. In psychodynamic child psychotherapy, child uses play in order to explore and express his feelings, thoughts, needs, wishes and fantasies which are at times conflicting or burdening to the child. Along with verbalization, child communicates

his inner world to therapist through play, and therapist understands and interprets the meaning of the play to child who then feels understood and gains insight about himself. Therapeutic change takes place through these communications of play that enable child's affective expression, resolution of conflicts, mastery over burdening events and rehearsal of expressing diverse ideas and behaviors (Russ, 2004). Moreover, as the therapist understands child's language of play, the communication contributes to construction of a therapeutic relationship that promotes healthy interpersonal representations and functioning (Russ, 2004).

As play is one of the major modes of communication for child, his relationships involve his play relationships to a great extent. Child's play relationships are rooted in his early childhood, in the plays with his parents. Winnicott (1968) states that play, thus the play relationship, developmentally emerges in the transitional space between baby and mother. The good enough mother creates this space in between inner psychic reality and outer world where the baby and the mother play together, share mutual pleasure and trust, and within their play interactions form an intimate bond with each other. For child, to be able to play is to be healthy, and play itself promotes growth (Winnicott, 1968). Therefore, the quality of his play relationships is closely linked with the well-being of child. In the same manner, Chethik (2001) hypothesized that; a child's therapeutic alliance with his therapist is associated with the early play relationship with his parents. He conceptualized therapeutic alliance as child's libidinal attachment to therapist; in which child experiences therapist as a new object that provides him an opportunity to relive and repair his early play relationships. Within the relationship, child uses the therapist as a dependable and constant object in order to play, create, explore and express variety of feelings with the confidence in therapist's capability to understand and regulate whatever is to come out of child's internal world (Chethik, 2001).

Chethik (2001) proposed that play relationship of child and therapist consists of two parts: therapeutic alliance and transference relationship. Between the dyad, transference relationship emerges when the child displaces another object onto

therapist and plays out the feelings, themes and conflicts attached to the certain object. Therapeutic alliance, on the other hand, represents the real relationship between the two players. It is child's experience of therapist as his partner in pretend, whom he safely discloses, narrates and discovers his inner life with, and by whom he feels supported, accepted, welcomed and valued. It includes the child's actual positive emotions toward his therapist, the trusting, loving and caring bond between the two. Chethik (2001) underlined the fact that aforementioned qualities of therapist and therapy atmosphere facilitate the successful establishment of therapeutic alliance and the appropriate interpretations of transference relationship, which are both curative components of play relationship.

In addition to play relationship, during the periods of therapy hour that the two are not engaged in a play activity but are simply interacting, similar to adults, child exhibits transference reactions and demonstrates pathological patterns of relating, especially when the relationship with therapist deepens (Gardner, 1993). For instance, child may treat the therapist in a hostile manner or push the boundaries of therapist and therapy setting. Unlike his other relationships, in the therapeutic relationship, therapist does not fulfill the pathological relational expectations of child but introduces a healthier way of behaving and relating to others. Furthermore, Gardner (1993) claimed that, strongly established therapeutic bond plays a pivotal role in successfully working through the negative transference acts of child.

Chused (1999) drew attention to cases where it is difficult for therapist to work through the intense transference reactions of child. For instance, when child verbally attacks to therapist, it may lead to enactments of therapist such as reacting in a defensive, retaliating or conciliatory manner. Conversely, overly deferential, compliant and pleasing behaviors of child may also challenge therapist's therapeutic abstinence. In another case, instead of therapist's attuned listening, understanding and reflecting, child may require a more concrete way of experiencing therapist as an available other, through action rather than words, such as via hugging. The neutral therapeutic stance of therapist may be perceived as cold or rejecting by child. Such

instances possibly create an uncomfortable therapy atmosphere, disrupt the therapy process and deteriorate the therapeutic relationship. He underlined that it is specifically difficult with certain children to establish or sustain therapeutic alliance by means of listening, understanding and naming child's conflicts and distressing emotions. These children include the ones who are traumatized, who have ingrained deprivations, stiff defenses, immature ego functioning, who do not have developed object constancy, self and other differentiation, reality testing, or those with learning disabilities. He suggested therapists that the most crucial thing to do in the face of a relational rupture is to understand how the child perceives the therapist at that moment, to assess the intolerable emotions child feels as the result of his experience of the therapist, to explore what the child's reactions portray transferentially and to respond in an authentic way that the child can hear and also can feel heard, understood and accepted (Chused, 1999).

As Anna Freud (1946) depicted, therapeutic alliance with children has both relationship-based and work-based aspects. Although it is difficult to segregate the two, thus far, emotional relationship component had been predominantly portrayed. According to Shirk and Saiz (1992), psychodynamic literature on therapeutic alliance with children has focused mainly on the bond, the therapeutic relationship between child and therapist. However, with the emergence of cognitive and behavioral therapies for children, placing an emphasis on child's collaboration in specific treatment tasks, agreement on treatment goals and involvement in therapy process has increased (Shirk & Saiz, 1992).

Engaging children in therapy process is particularly important, due to the fact that unlike adults, children are brought to therapy by their parents. Frequently, children question why they are in treatment, and they do not feel motivated to participate in therapy; which make it difficult for therapists to form therapeutic alliance with children. Chethik (2003) stated that, children often perceive the stranger who is named therapist within the new setting called therapy as an anxiety-provoking occurrence. They come to therapy in a resistant manner due to their immature ego

functioning and unawareness of their internal difficulties. It is therapist's mission to support the child to recognize his internal difficulties and thereby establish therapeutic alliance in the initial sessions (Chethik, 2003). Schowalter (1976) claimed that, children who are aware of their distress and seek a relief from anxiety are more apt to establish therapeutic alliance compared to those who do not suffer consciously, who present symptoms that are related to rigid defenses against anxiety and whose anxiety increases due to the nature of therapy throughout the early period of treatment. He added that, therapist contributes to creating therapeutic alliance in the early period by correctly interpreting child's affects and defenses, noticing first impressions of child that evoke discomforting feelings in herself and resolving countertransference issues (Schowalter, 1976).

In contrast to cognitive and behavioral psychotherapies, which have specific therapeutic procedures to follow and structured therapeutic tasks to perform, in psychodynamic child therapy the tasks are not structured nor directed, therefore the respective responsibilities of child and therapist are subtler. Primarily, therapist is in charge of fixating and sustaining the time, frequency, duration and place of therapy sessions, which all promote a sense of safety in child (Chethik, 2003). Child is expected to come to sessions and produce material (Chethik, 2003); to choose any means, such as toys, art and craft materials or solely words; to express, explore and elaborate his inner life through play or only through verbalization. Reciprocally, therapist affectively engages in child's experience; emphasizes child's feelings and defenses, comments on recurrent patterns of child and discovers the meanings embedded in child's expressions (Chethik, 2003). In order to make meaning, child's active collaboration is needed; child and therapist work together with equal effort to understand, untangle and link the feelings, impulses, wishes, needs and experiences that arise within the therapy hour (Chazan, 2002). This contribution of child to therapeutic work is possible with a formed therapeutic alliance, which comprises of observing rather than experiencing ego of the child (Greenson, 1965). Moreover,

when the child refuses to collaborate, it is therapist's duty to persistently work with child's resistances (Chethik, 2003).

Another task of child is to abide by the therapy rules, which are not to harm self, therapist or room materials, not to take the room materials, such as toys, outside of the therapy room, and not to leave the room, except to go to the bathroom, until the therapy hour is over. Therapist, on the other hand, is responsible of setting limits and reminding child of the rules when needed. In accordance with Axelman (2006), therapist has a vital and delicate work of setting limits and simultaneously tolerating child's strong affects, impulses, demands and defiances. In the face of aggressive acts of child, therapist survives child's destruction by not retaliating or retreating but by keeping a tolerant attitude and setting clear and definite limits. The limits conveyed by therapist paves the way for child to discover the limits of self and other, the boundaries of the relationship between the dyad, and therefore to engage in a mutual partnership with the other (Axelman, 2006). Boundaries of child, therapist and therapy setting enhance therapeutic alliance and enable the child to unfold his inner world safely and freely (Chethik, 2003).

Concisely, a relationship that contains mutual trust, understanding, caring and liking and a collaboration in unraveling child's inner world constitute therapeutic alliance between therapist and child in psychodynamic child psychotherapy. Theoretical literature repeatedly reveals the importance of cultivating therapeutic alliance throughout therapy process in order to promote a fruitful treatment for children.

## **1.2. EMPIRICAL LITERATURE ON THERAPEUTIC ALLIANCE**

### **1.2.1. Operational Definitions of Therapeutic Alliance**

In theoretical and empirical adult literature, there has been diversity in labeling and defining the concept of therapeutic alliance. It has been labeled as

“therapeutic alliance”, “working alliance”, “helping alliance”, “treatment alliance” and so on (Barber & Muran, 2010). Aforestated, Zetzel (1956) coined the term “therapeutic alliance” and conceptualized it as the real aspect of patient-therapist relationship, as the development of a therapeutic bond between patient and therapist. Greenson (1965) named it “working alliance”, which he defined as patient working purposefully with therapist in order to achieve mutually agreed goals. Luborsky (1976) called it “helping alliance” that consists of two types: patient experiencing therapist as warm and supportive, and patient and therapist working together on mutually agreed problems. Dare, Dreher, Holder and Sandler (1992) labeled it “treatment alliance” which is patient’s awareness of and agreement on his difficulties, his willingness to work on the difficulties and his cooperation with therapist in the therapeutic work, particularly through its periods that are hard to endure. Hartley and Strupp (1983) formulized it as an interpersonal process that has five components: a pact, an affective bond, insight, interventions of therapist and self-relatedness of patient. Gaston (1990) defined the four elements in it: capability of patient to use the part of the ego that allies with therapist to work collaboratively, development of an emotional bond between patient and therapist, mutual agreement on tasks and goals of the treatment, and therapist’s attentive, responsive and understanding stance. Bordin (1979) introduced a pantheoretical, tripartite model for it: goals, tasks and bonds. “Goals” refer to mutually confirmed and valued objectives that patient and therapist pursue. “Tasks” represent the therapeutic work responsibilities of patient and therapist that are found to be effective and relevant by both parties. “Bond” addresses positive emotional tie between patient and therapist that involves mutual acceptance, confidence and trust.

In order to evaluate therapeutic alliance between adult patient and therapist in empirical studies, multitude of measures have been developed. Measures differ in conceptualization of therapeutic alliance; thereby assess slightly different aspects of the construct. As a result, theoretical framework of the measure that is used in a study determines the study’s operational definition of therapeutic alliance. Although they

differ in conceptualization, measures, thus the studies share two core aspects: the interpersonal relationship between therapist and patient, and their mutual investment in the ends and means of the treatment (Gelo, Pritz, & Rieken, 2015).

The operational definitions of therapeutic alliance in child empirical literature are derived from adult literature. The theoretical framework of the measures that have been developed to assess therapeutic alliance between child and therapist are based on the conceptualizations of Greenson (1965), Luborsky (1976), Bordin (1979) or Hartley and Strupp (1983). Diverging from adult conceptualizations, child therapeutic alliance does not include a dimension related to mutual agreement on goals due to involvement of parents as informants and children's developmental incompetency in constructing and contracting for the goals (DiGiuseppe, Linscott, & Jilton, 1996). In child empirical literature, the concept consists of two components: affective relationship, which is the emotional bond between child and therapist; and collaborative relationship, which is the mutual work of child and therapist on therapeutic tasks (Shirk et al., 2011). Part of the literature suggested that the two components serve as separate but correlated therapeutic alliance dimensions (e.g. Estrada & Russell, 1999; McLeod & Weisz, 2005; Shirk & Saiz, 1992). However, other studies proposed a single factor solution for the construct (e.g. DiGiuseppe et al., 1996; Faw, Hogue, Johnson, Diamond, & Liddle, 2005; Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006).

Parallel with the child literature, in the present study, operational definition of therapeutic alliance is the affective bond between child and therapist, which involves their trust in, positive emotions for each other, in addition to their collaborative work, which includes their equal effort on the therapeutic tasks (McLeod, 2005).

## **1.2.2. Therapeutic Alliance in Adult Empirical Literature**

### **1.2.2.1. Outcome Research**

#### **1.2.2.1.1. Relation Between Alliance and Outcome**

Since 1970s, there has been a vast increase in empirical research on the relationship between therapeutic alliance and outcome of adult psychotherapy. Psychodynamic theories on therapeutic alliance, Bordin's introduction of a pantheoretical definition of the concept, the measures that had been developed to assess the construct and the Dodo Bird verdict (Luborsky, Singer, Luborsky, 1975) have aroused great interest in the influences of therapeutic alliance on treatment outcome (Gelo et al., 2015).

The Dodo Bird verdict proposed that all types of psychotherapies lead to the same outcomes despite their different techniques (Luborsky et al., 1975). This statement influenced the research on common factors, the therapeutic factors that every psychotherapy approach share in common regardless of their specific techniques, and the impact of these factors on treatment outcome. In the group of common factors, therapeutic alliance has been one of the most appealing factors to explore among researchers (Gelo et al., 2015). In order to investigate the link between therapeutic alliance and treatment outcome, a large amount of studies have been conducted. Several meta-analyses (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000) of the studies reported that there is a moderate but consistent relationship between therapeutic alliance and adult psychological treatment outcome across types of treatment (e.g. psychodynamic, cognitive-behavioral, interpersonal therapy), lengths of treatment (e.g. less than 10 sessions, more than 50 sessions), types of presenting problem (e.g. depression, anxiety, eating disorders), timings of alliance measurement (early, middle, late, averaged), types of alliance measure (e.g. Working Alliance Inventory, Vanderbilt

Therapeutic Alliance Scale), types of outcome measures (e.g. Beck's Depression Inventory, Symptom Checklist), and raters of alliance and outcome measures (patient, therapist, independent observer); that strong alliance is associated with better outcomes of psychotherapy.

The most recent and comprehensive meta-analysis (Horvath et al., 2011) synthesized 201 empirical studies on the relation of therapeutic alliance to adult individual psychotherapy outcome that had been conducted between 1973 and 2009. The results of the meta-analysis had an effect size of .28 that is statistically significant, portraying a moderate but considerably reliable relationship between therapeutic alliance and treatment outcome (Horvath et al., 2011). Most of the research studies on the relationship between therapeutic alliance and outcome have consistently found an association between the two variables. The findings of several outcome studies on adult psychotherapies are presented below chronologically.

Luborsky, Crits-Christoph, Alexander, Margolis and Cohen (1983) examined the observer ratings of therapeutic alliance in early and late psychodynamic sessions of patients with non-psychotic symptoms. According to results of the study, therapeutic alliance in the beginning and end of the therapy process was moderately consistent, and scores of therapeutic alliance from both phases of therapy predicted outcome significantly (Luborsky et al., 1983). In the study of Krupnick and colleagues (1996), to assess therapeutic alliance, observers rated early, middle and late therapy sessions of interpersonal psychotherapy, cognitive behavior therapy and active or placebo pharmacotherapy for patients with major depressive disorder. Therapeutic alliance was evaluated with early scores and average scores of three phases; both measures were significantly correlated with outcome of each type of treatment (Krupnick et al., 1996).

Barber and colleagues (1999) conducted a study among cocaine dependent patients treated in cognitive-behavioral therapy, psychodynamic therapy or pharmacotherapy. They investigated the therapist and patient reports of therapeutic alliance, and the relationship between alliance scores and first and last month

assessments of outcome. The authors observed that patient reports of therapeutic alliance predicted drug-based outcomes only at the first month, but predicted depression-based outcomes at the termination phase as well. Moreover, patient reports of therapeutic alliance were found to be more predictive of outcome than therapist reports (Barber et al., 1999). In the study of Hilliard, Henry and Strupp (2000), therapist, patient and observers' early therapeutic alliance ratings of psychodynamic therapy sessions were evaluated. As the observer scores of early therapeutic alliance were associated with decrease in patient's introjective behaviors, therapist ratings of early alliance were related to symptom reduction and better global outcomes, and patient self-reports of early alliance were solely linked to better global outcome ratings (Hilliard et al., 2000).

In their study, Klein and colleagues (2003) investigated the early therapeutic alliance ratings of chronically depressed patients who were in cognitive-behavioral analysis system of psychotherapy, alone or with medication. Their findings showed that early therapeutic alliance significantly predicted successive decrease in depressive symptoms (Klein et al., 2003). Zuroff and Blatt (2006) examined the early perceptions of patients with depressive symptoms of therapeutic alliance. They observed that patients' early perceptions of therapeutic relationship as positive predicted the subsequent rate of decrease in maladjustment symptoms and increase in adaptive capacities and global functioning across cognitive-behavioral therapy and interpersonal therapy (Zuroff & Blatt, 2006). Johansson and Jansson (2010) analyzed the therapeutic alliance and symptom ratings of patients who were diagnosed with mood, anxiety or eating disorders and who received routine psychiatric outpatient treatment that was based on pharmacological and psychodynamic grounds. The data was collected at the beginning and termination of treatment and the results revealed that although initial therapeutic alliance was not associated with symptom reduction, late assessment of therapeutic alliance significantly explained 15% of the variance of the treatment outcome. Authors stated that improvement of therapeutic alliance was significantly related to positive outcomes (Johansson & Jansson, 2010).

In a study (Cronin, Brand, & Mattanah, 2014) that was conducted among patients with dissociative disorders, higher patient and therapist-rated alliance scores were found to be moderately to strongly correlated with lower levels of general distress, dissociation and post-traumatic stress symptoms, and with higher levels of adaptive capacities toward the end of the treatment. Falkenström, Granström and Holmqvist (2014) conducted a study among patients with anxiety, depression, relationship, work-related or psychosomatic problems. The findings of the study revealed that, even when the effects of initial symptom level and early symptom improvement were controlled, patient's rating of therapeutic alliance predicted the outcome of psychological distress (Falkenström et al., 2014). Leuteritz and colleagues (2017) investigated the link between therapeutic alliance and treatment outcome in short-term psychodynamic psychotherapy for breast cancer patients with depressive symptoms. The patient ratings of therapeutic alliance at the end of treatment were significantly correlated with outcome scores of depression (Leuteritz et al., 2017).

Despite the large and diverse evidence for therapeutic alliance and positive treatment outcome relationship, there are some research studies that had demonstrated a non-significant relationship between the two. In the study of Gaston, Marmar, Gallagher and Thompson (1991), authors assessed early and middle therapeutic alliance scores of therapists and elderly depressed adults who received behavioral, cognitive, or brief dynamic therapy. They investigated the association between therapeutic alliance and treatment outcome over and above initial symptoms and symptomatic improvements; however no significant relationship was found. It should be noted that the study had a relatively small sample size (Gaston et al., 1991). Moreover, Feeley, DeRubeis and Gelfand (1999) conducted a study among patients who were treated in cognitive pharmacotherapy alone or with medication for depression. Observers rated therapeutic alliance based on early and late therapy sessions. In accordance with results, alliance did not predict subsequent symptom change; nevertheless a trend in that direction was observed. This study was limited by

small number of participants as well (Feeley et al., 1999). Lastly, Hendriksen, Peen, Van, Barber and Dekker (2014) examined the self-report therapeutic alliance scores of patients with major depressive disorder at middle and end phases of treatment. It was found that therapeutic alliance did not predict consequent symptom change. Authors stated that timing of alliance measures might have led to non-significant results (Hendriksen et al., 2014).

#### **1.2.2.1.2. Therapeutic Alliance as Outcome**

The relationship between therapeutic alliance that is assessed during the process and treatment outcome that is measured at the end of therapy had been presented thus far. Moreover, therapeutic alliance can be a treatment outcome itself; bringing about a strong therapeutic alliance may be a treatment goal. In addition to knowledge on the significant link between therapeutic alliance and treatment outcome, shedding light on the idiographic characteristics of therapeutic alliance is academically and clinically beneficial. Thus, several studies on the patient factors that are associated with a strong therapeutic alliance are presented below.

In a study among patients with depression, over the course of therapy, therapeutic alliance with perfectionistic patients did not develop as much as it did with patients who were low on perfectionism (Zuroff et al., 2000). In another study, reports of participants, who were being treated for bulimia nervosa, revealed that patient expectation of improvement is positively related to therapeutic alliance in early and middle phases of therapy (Constantino, Arnou, Blasey, & Agras, 2005). Another study investigated the patient characteristics of participants with schizophrenia and found that baseline level of interpersonal functioning of patients predicts the early therapeutic alliance ratings of therapists (Couture et al., 2006). In a review, authors portrayed that patients who evaluate their attachment patterns as more secure, evaluate the therapeutic alliance higher (Smith, Msetfi, & Golding, 2010). In a study (Cichocki, 2015) it was observed that when patient is older and his social

network is smaller, early therapeutic alliance rating of the patient is higher. The author attributed this result to "loneliness effect" in which patient is longing for a supportive relationship, or to overestimation of the strength of therapeutic alliance due to patient's misinterpretations of social cues (Cichocki, 2015).

#### **1.2.2.2. Process Research**

Due to the fact that therapeutic alliance between therapist and patient contains human interactions that are dynamic, since 1990s, there has been an increasing research interest in the developmental courses of therapeutic alliance across time (Gelo et al., 2015). Therefore, in addition to the studies that investigated whether or not level of therapeutic alliance has an association with outcome, there have been others that researched how therapeutic alliance changes throughout the therapy process and how its patterns have an impact on outcome.

In process studies, therapeutic alliance has been measured successively or at multiple points over the course of treatment for the purpose of examining its trajectories. Studies revealed various temporal shapes of therapeutic alliance: more or less stable alliance (e.g. Golden & Robbins, 1990; Kramer, de Roten, Beretta, Michel, & Despland, 2009; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998), linear alliance growth (e.g. Hilsenroth, Peters, & Ackerman, 2004; Sexton, Hembre, & Kvarme, 1996), U-shaped quadratic alliance growth (e.g. Gelso & Carter, 1994; Horvath & Luborsky, 1993; Kivlighan & Shaughnessy, 2000), reverse U-shaped quadratic alliance growth (e.g. Smits, Stinckens, Luyckx, & Claes, 2015) and V-shaped alliance patterns defined as frequent rupture-repair cycles (e.g. Stiles et al., 2004; Strauss et al., 2006).

Furthermore, relationship between these patterns and treatment outcome has been investigated. Several studies have reported that linear growth of therapeutic alliance is related to positive therapeutic outcomes. In their study, Klee, Abeles and Muller (1990) found that the patients with more therapeutic improvement were the

ones who gained significant, linear increase in therapeutic alliance over the course of treatment. Moreover, de Roten and colleagues (2004) demonstrated with their study among patients diagnosed with anxiety, depression or personality disorders that linear growth patterns of therapeutic alliance is more predictive of symptom improvement and social adjustment than stable course of alliance. However another study (Kramer, de Roten, Beretta, Michel, & Despland, 2008), that had patients diagnosed with similar disorders as participants, showed that not an increasing pattern but a stable pattern is associated with symptom reduction.

On the contrary, some other evidence portrayed that, rather than a stable alliance or linear alliance growth, positive outcome of therapy is closely linked with a curvilinear pattern through the process with ruptures and repairs in therapeutic relationship. Safran, Muran and Eubanks-Carter (2011) conducted a meta-analysis in order to inspect the importance of alliance rupture-repair processes for therapeutic gains; and they found a significant correlation between rupture-repair episodes of process and positive treatment outcome. In their study among patients with depressive symptoms, Stiles and colleagues (2004) found that the patients who experienced an alliance pattern with ruptures followed by rapid repairs showed more improvement compared to the ones with stable or linear alliance growth. Moreover, Strauss and colleagues (2006) conducted a study with participants who were diagnosed with avoidant personality disorder or obsessive-compulsive personality disorder. It was observed that occurrences of ruptures and their repairs predict more decreases in symptoms of personality disorder and depression (Strauss et al., 2006).

These rupture and repair findings led to the discovery of two crucial phases in the therapy process for a successful treatment with adults. The first phase includes the initial sessions when therapeutic alliance is established. It is important to cultivate adequate levels of collaboration and confidence in the early sessions in order to build a strong base to rest of the treatment (Ardito & Rabellino, 2011). This view was supported by findings, which indicated that adult patients form opinions about the therapeutic relationship early in the process, and their opinions remain more or less

stable throughout the treatment (e.g. Horvath & Luborsky, 1993; Martin et al., 2000). The second phase is when there is an increase in transference reactions and when the therapist challenges the problematic patterns of the patient. As there may be deterioration in the relationship, it is crucial to work through and repair the ruptures that may take place in the second phase (Ardito & Rabellino, 2011). A number of studies (e.g. Bandeau & Wampold, 1991; Safran & Segal, 1990) argued that when the conflictual patterns of the patient arise, in the case of therapist successfully analyzing and working through the conflicts and the patient getting involved in therapist interventions rather than avoiding them strengthens the therapeutic relationship and increases the therapeutic gains.

### **1.2.2.3. Measuring Alliance in Adult Psychotherapy**

More than 30 alliance measures have been developed in order to investigate the role therapeutic alliance plays in psychotherapy with adults (Horvath et al., 2011). There are four main instruments that have been used in majority of alliance studies: Helping Alliance Questionnaire (HAQ; Luborsky et al., 1983), Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989) and California Psychotherapy Alliance Scales (CALPAS; Gaston & Marmar, 1994). HAQ was developed based on Luborsky's (1976) two types of therapeutic alliance and it assesses therapeutic alliance from perspectives of both patient and therapist. VTAS was designed according to Strupp and Binder's (1984) conceptualizations and clinical observers rate the scale by observing tapes of therapy sessions. WAI measures therapeutic alliance based on Bordin (1979)'s tripartite model. CALPAS is developed according to the four components of therapeutic alliance that Gaston (1990) introduced. WAI and CALPAS have patient, therapist and observer forms. Moreover, each of these four measures has an acceptable level of internal consistency (Horvath et al., 2011).

### **1.2.3. Therapeutic Alliance in Child Empirical Literature**

#### **1.2.3.1. Outcome Research**

Hundreds of studies have been conducted in adult psychotherapy literature in order to examine the link between patient-therapist therapeutic alliance and the outcome of therapy. Obtained from the findings of these studies, there is a great evidence for the significant relationship between strong therapeutic alliance and successful treatment outcome in adult psychotherapy (Horvath et al., 2011). In contrast to the adult field, empirical literature on the association between the quality of therapeutic alliance and treatment outcome in child psychotherapy is relatively new and scarce (Maltzman, 2016).

The most recent and comprehensive meta-analysis (McLeod, 2011) included 38 youth alliance-outcome studies conducted between 1992 and 2009 and revealed that there is an association between strong therapeutic alliance and successful treatment outcome in youth psychotherapy as well. However, as the effect size of the meta-analysis was .14, it shows that the association is not as strong as it is in adult psychotherapy, which was .28 in the most recent meta-analysis of adult alliance literature (Horvath et al., 2011). Compared to the adult field, findings of the child alliance-outcome studies revealed more inconsistent and mixed results across several methodological factors (McLeod, Southam-Gerow, & Kendall, 2017). For instance, although the therapeutic alliance-outcome relationship was found to be consistent across various adult patient pre-treatment characteristics, the child alliance meta-analysis portrayed that the relation differs according to child's demographic and clinical characteristics (McLeod, 2011). The child psychotherapy studies on therapeutic alliance and outcome, and the effects of child characteristics on the quality of therapeutic alliance and on the alliance-outcome associations are presented below.

### **1.2.3.1.1. Relation Between Alliance and Outcome**

Gorin (1993) examined the relationship between therapist reports of therapeutic alliance and treatment outcomes in her study with 31 youth diagnosed with adjustment disorder or functional enuresis. Reports were collected at three different times over the course of treatment, and sum of the scores were calculated. Higher therapeutic alliance scores were found to be correlated with the positive changes in impairments. Kendall and colleagues (1997) conducted a study among 94 children aged 9-13, diagnosed with anxiety disorders and randomly assigned to CBT or waitlist control group. The perspectives of children on therapeutic alliance were assessed at post-treatment. No significant association between child-therapist alliance and changes in anxiety symptoms were found. The study of Noser and Bickman (2000) had a sample of 240 youth aged 12-17 in residential treatment who filled out therapeutic alliance forms at the late stage of the process. The results of the study showed that stronger therapeutic alliance was significantly correlated with better outcomes, which were decreases in behavior problems and increases in global functioning.

McLeod and Weisz (2005) conducted a study among 22 children aged 8-14 who were being treated in outpatient community mental health clinics with treatment-as-usual for depressive or anxiety disorders. Randomly selected four sessions from beginning, middle and end of the therapy processes were coded by independent observers and mean of the scores were used for analyses. The findings revealed that a positive child-therapist therapeutic alliance was not associated with a reduction in total internalizing problems or depressive symptoms, but it was significantly linked with a reduction in anxiety symptoms at the end of therapy (McLeod & Weisz, 2005). The same year, Kazdin and colleagues (2005) conducted a study with 185 children aged 3-14, receiving cognitive-behavioral therapy for oppositional, aggressive, and antisocial behavior. Therapeutic alliance was measured at two points, early and late in treatment by child and therapist self-reports and the scores were summed. According

to results of the study, high therapeutic alliance reports of both child and therapist significantly predicted better treatment outcome as in more decreases in externalizing behaviors (Kazdin et al., 2005). The study of Hawley and Weisz (2005) was among 65 youth aged 7-16 who was being treated in community-based outpatient mental health centers. Youth rated therapeutic alliance scores were positively correlated with reduction in symptom severity (Hawley & Weisz, 2005).

Chiu, McLeod, Har and Wood (2009) did therapeutic alliance research with 34 children aged 6-13 who were in cognitive-behavioral therapy for anxiety disorders. The observers coded one early and one late therapy session for therapeutic alliance. The findings showed that early child-therapist alliance predicted reduction of internalizing problems at mid-treatment but not post-treatment (Chiu et al., 2009). Moreover, Liber and colleagues (2010) investigated child-therapist therapeutic alliance with 52 children aged 8-12, who were in cognitive-behavioral therapy for anxiety disorders as well. The independent observers coded an early and a late therapy session and the mean scores of the two points were used for child-therapist alliance. Although therapeutic alliance did not significantly predict outcome, a trend was found for the association between stronger therapeutic alliance and more reduction in internalizing symptoms as the outcome of therapy (Liber et al., 2010).

Kazdin and Durbin (2012) conducted a study among 97 children aged 6-13 who were receiving cognitive-behavior therapy for oppositional, aggressive, and antisocial behavior. They measured therapeutic alliance via therapist and child evaluations at the early and middle phases of treatment; both of the time points gave similar results, thus they summed the ratings to use as the alliance score. Their findings showed that stronger therapeutic alliance was significantly correlated with bigger therapeutic change (Kazdin & Durbin, 2012). In their study, Abrishami and Warren (2013) examined the therapist and youth alliance self-reports' predictability of changes in externalizing behaviors. Reports were collected from 350 youth aged 4-17 at five points over the course of therapy, which was treatment-as-usual. None of the alliance measurement points predicted the outcome; however there was no

variability in the scores of therapeutic alliance. Therefore the results should be interpreted with caution (Abrishami & Warren, 2013). Cummings and colleagues (2013) conducted a study among 488 youth aged 7-17 who were diagnosed with generalized anxiety disorder, social phobia, and/or separation anxiety disorder and treated in cognitive-behavioral therapy, pharmacotherapy, their mixture, or pill placebo. Youth rated therapeutic alliance at the middle and late phases of treatment. The findings showed that only in cognitive-behavioral therapy group, therapeutic alliance predicted outcome as in changes in anxiety symptoms (Cummings et al., 2013).

The study of Zorzella, Muller and Cribbie (2015) had 95 child participants aged 7-12 who experienced various kinds of trauma and received trauma-focused cognitive-behavioral therapy. Children and their therapist rated alliance at three points in treatment. The significant finding was that early strong alliance predicted improvement in the internalizing behaviors at the end of the treatment but not the externalizing behaviors (Zorzella et al., 2015).

Moreover, Kerns, Collier, Lewin and Storch (2017) conducted a study among 64 youth aged 7-16 with autism spectrum disorder and comorbid anxiety symptoms who received modular cognitive-behavioral therapy. Both youth and therapist self-reported on their therapeutic alliance, and the results showed that the alliance strength was significantly correlated with treatment outcome such as reductions in global severity rating and anxiety symptoms (Kerns et al., 2017). McLeod and colleagues (2017) did research with 50 youth aged 7-15 diagnosed with anxiety disorder and received cognitive-behavioral therapy. Therapeutic alliance scores were collected via youth, therapist and observer measures at the early and late phase of treatments, and the mean scores were used. Their results revealed that strong therapeutic alliance in each measure was associated with diminishing anxiety symptoms in children (McLeod et al., 2017).

In accordance with the child-therapist alliance and outcome studies conducted to date, it is difficult to make a final empirical conclusion on the significant link

between alliance and treatment outcome. It is important to note that the studies are predominantly based on cognitive-behavioral therapy and a sample of youth with anxiety symptoms. Moreover, samples of the studies rarely focus solely on children, excluding adolescents.

#### **1.2.3.1.2. Therapeutic Alliance as Outcome**

In addition, the child literature on therapeutic alliance includes studies of child factors that are related to the quality of therapeutic alliance as well as to the alliance-outcome associations. There are some studies that indicate quality of alliance varies according to child's pre-treatment characteristics such as clinical problems, gender and age. Research has shown that children with externalizing problems had more therapeutic relationship problems compared to children with internalizing problems (e.g. Bickman et al., 2004; Garcia & Weisz, 2002). Parallel with this view, in a study (Abrishami & Warren, 2013), children with externalizing problems reported early alliance scores lower than children with internalizing problems. Among the internalizing problems, a study (Chu, Skinner, & Zandberg, 2014) found that pre-treatment anxiety symptoms were positively correlated with early therapeutic alliance where depressive symptoms had no correlation with early alliance. Moreover, in a study (Accurso & Garland, 2015) it was found that therapist reported therapeutic alliance improved throughout the process for children with anxiety symptoms and for girls; however the alliance ratings remained stable for children without anxiety symptoms and for boys. In the case of gender, in another study (Zorzella et al., 2015), early alliance scores of girls were higher than the scores of boys. Age is another variable that appeared to have a correlation with therapeutic alliance. A few studies (e.g. Abrishami & Warren, 2013; DeVet, Kim, Charlot-Swilley, & Ireys, 2003) found a negative correlation between child age and therapeutic alliance; when the child is older, therapeutic alliance is reported to be lower. In another study (Kronmüller et al.,

2002), younger children scored higher on bond aspects of therapeutic alliance, whereas older children scored higher on task and goal dimensions of alliance.

In a study (Kazdin & Durbin, 2012), it was found that pre-treatment intellectual functioning and social competencies of children predicted the quality of therapeutic alliance. In fact in the study, these child factors did not explain the relationship between therapeutic alliance and treatment outcome (Kazdin & Durbin, 2012). According to several studies (e.g. Abrishami & Warren, 2013; Chiu et al., 2009; Kazdin et al., 2005; McLeod, 2005) child characteristics such as age, gender, socioeconomic disadvantage, ethnicity and severity of pre-treatment problems are not reliable moderators in alliance-outcome associations. However, meta-analyses (McLeod, 2011; Shirk et al., 2011) show that child's problem type has a moderator effect; pre-treatment externalizing behaviors of children have higher effect on the alliance-outcome association compared to internalizing behaviors.

### **1.2.3.2. Process Research**

In addition to outcome research in child psychotherapy on the relationship between a single therapeutic alliance value and treatment outcome, in the last decade, process studies on the changes in therapeutic alliance over time and the relationship between the changes in alliance and treatment outcome have been conducted. In the literature it is stated that, as therapeutic alliance is a dynamic entity, examining trajectories of therapeutic alliance may give more reliable findings of its relation to therapy outcome (Bickman et al., 2012). Although various therapeutic alliance trajectories have been found as candidates for successful treatment outcome in adult psychotherapy (e.g. Kivlighan & Shaughnessy, 2000; Stiles et al., 2004), child process literature on therapeutic alliance is newly developing and fairly limited in scope. The studies are presented below.

In the study of Chiu and colleagues (2009), independent coders coded 2 early and 2 late cognitive-behavioral therapy sessions of 34 children aged 6-13 with

anxiety symptoms. They calculated the changes in therapeutic alliance throughout the process and found that positive shifts in alliance predicted reduction of anxiety symptoms at the end of treatment (Chiu et al., 2009). Liber and colleagues (2010) conducted a study with 52 children aged 8-12, who were in cognitive-behavioral therapy for anxiety disorders. The independent observers coded an early and a late therapy session and the alliance shift was calculated; a linear increase in therapeutic alliance was observed over the course of treatment, however the shift had no significant correlation with symptom reduction at the end of treatment (Liber et al., 2010).

Kendall and colleagues (2009) explored the shape of therapeutic alliance over time with a longitudinal data of 86 children aged 7-14 diagnosed with anxiety disorders. For the study, at the end of each therapy session children and their therapists filled out therapeutic alliance forms. Across the sessions a concave growth curve of therapeutic alliance, which initially grew fast and then slowed over time with no ruptures, was observed (Kendall et al., 2009). Chu and colleagues (2014) examined the change shape of therapeutic alliance with participants who were 69 youth aged 7-17 receiving cognitive-behavioral therapy for anxiety symptoms. Youth evaluated therapeutic alliance every month and therapists evaluated their alliance at the end of each therapy session. Therapist reports showed a "gradual linear increase in alliance over the first half of treatment followed by a leveling off of alliance in the second half", whereas youth reports did not present systematic growth over time (Chu et al., 2014, pp. 723).

Hudson and colleagues (2014) investigated growth courses of therapeutic alliance and their associations with treatment outcome. Observers coded every cognitive-behavioral therapy session of 151 children aged 6-17 with anxiety disorders. The results portrayed a slight decline in therapeutic alliance over time: Level of alliance had a negative linear slope (Hudson et al., 2014). Hurley, Lambert, Ryzin, Sullivan and Stevens (2013) investigated the therapeutic alliance trajectories with 101 youth aged 10-17 who were receiving skills management treatment for

disruptive behaviors; youth filled out alliance forms every other month of the treatment. The results showed that, throughout the process therapeutic alliance followed a U-shaped pattern: Decreased at first, leveled off in the middle phase and increased toward the end of the treatment (Hurley et al., 2013).

The study of Keeley, Geffken, Ricketts, McNamara and Storch (2011) had a sample of 25 youth aged 7-17 who met the criteria for obsessive-compulsive disorder. They measured therapeutic alliance at the initial, early and termination phases of treatment with therapist and youth self-reports. The results of their study revealed that initial high alliance scores predicted reductions in obsessive-compulsive symptoms at the end of treatment. Moreover, bigger and more positive early alliance changes predicted better therapy outcome (Keeley et al., 2011). Bickman and colleagues (2012) conducted a longitudinal study using a sample of 288 youth. Both youth and therapists reported on therapeutic alliance and symptoms at multiple sessions over the course of treatment. They found that with small positive change, therapeutic alliance improved over time and improvement in therapeutic alliance predicted faster therapeutic change. In contrast, initial therapeutic alliance levels did not predict improvement in symptoms (Bickman et al., 2012). Hurley, Ryzin, Lambert and Stevens (2015) conducted another study with the same sample of their previous study (Hurley et al., 2013). They found that initial therapeutic alliance was positively correlated with decreases in externalizing behaviors as treatment outcome. Moreover, positive trajectories of therapeutic alliance predicted improvements in externalizing behaviors at the middle phase of the treatment but not at the end of the process (Hurley et al., 2015).

Lastly, Goodman, Chung, Fischel and Athey-Lloyd (2017) investigated the 2-year child-centered play therapy process of a 6-year-old child with autism spectrum disorder. The therapy sessions were coded by observers in order to examine therapeutic alliance with in-session ruptures and repairs. The authors have shown that, over the course of treatment, ruptures and repairs in therapeutic relationship subsequently reduced symptoms (Goodman et al., 2017).

### **1.2.3.3. Measuring Alliance in Child Psychotherapy**

In order to assess the quality of therapeutic alliance between child and therapist, various measures have been developed or adapted from adult alliance measures. The measures differ in the type of informants; they have forms for children, therapists or independent observers. However, literature indicates that it may be difficult for children to self-report their own views on the therapeutic alliance due to “developmental differences in self-monitoring, perspective taking, and meta-cognition” (Shirk & Karver, 2003, pp. 462).

One of the measures that are based on child’s evaluation of therapeutic alliance is the Child’s Perception of Therapeutic Relationship (CPTR; Kendall, 1994). It assesses the bond dimension of therapeutic alliance, the affective quality of the therapeutic relationship with 10 5-point Likert scale items. The scale has been used in multiple studies (e.g. Cummings et al., 2013; Kendall et al., 1997). The study of Cummings and colleagues (2013) with 488 youth aged 7-17, who met the criteria for anxiety disorders, reported good internal consistency of the scale. Another child self-report alliance form is Therapeutic Alliance Quality Scale (TAQS; Bickman et al., 2010). It has 5 5-point Likert scale items, which are based on Bordin’s (1979) tripartite model of therapeutic alliance: bond, task, goal. Hurley and colleagues (2013) conducted a study among 145 youth aged 10-17 diagnosed with a disruptive behavior, which portrayed acceptable psychometrics quality of the scale. TAQS have been used in several studies (e.g. Hurley et al., 2015).

One other form that assesses child’s perspective on therapeutic alliance is Working Alliance Inventory for Children and Adolescents (WAI-CA; Figueiredo, Dias, Lima, & Lamela, 2016). It is an adapted version of WAI (Horvath & Greenberg, 1989); therefore it is also based on Bordin’s (1979) tripartite model. The authors shortened and simplified the adult alliance inventory and obtained 36 5-point Likert scale items. They conducted a validation study among 109 children and adolescents aged 7-17, diagnosed with school problems, internalizing and

externalizing disorders; and results presented high internal consistency and good external validity (Figueiredo et al., 2016). Another form that is based on child's perspective is Children's Alliance Questionnaire (CAQ; Roest, Helm, Strijbosch, Brandenburg, & Stams, 2016). The measure is derived from the short version of WAI (WAI-S; Tracey & Kokotovic, 1989), and has separate versions for two age groups. The form for children of age 4-8 has 10 3-point Likert scale items; and the form for children of age 8-14 has 9 5-point Likert scale items. The validation study (Roest et al., 2016) of the questionnaire included 231 children with psychosocial or behavioral problems; and with good reliability and validity scores it showed that the measure can be used with children for assessment of therapeutic alliance. Both of these child self-report forms have not been used in other studies yet.

Moreover, Shirk and Saiz (1992) developed Therapeutic Alliance Scale for Children (TASC) and they also used Bordin's (1979) bond, task and goal dimensions. In fact, they adapted the dimensions in a developmentally applicable way: They included the bond dimension as child's emotional experience of therapist and the task dimension as child's collaboration with the therapeutic tasks, however they excluded the goal dimension of Bordin's conceptualization. They created 12 4-point Likert scale items, same but reworded items, for both child and therapist perspectives. The psychometric properties of both forms of TASC were investigated in the study of Shirk and Saiz (1992), among 62 hospitalized children aged 7-12 with internalizing and externalizing difficulties and their therapists. The study showed moderate internal consistency for child report form and good internal consistency for therapist report form. However, in their study of 65 children, Hawley and Weisz (2005) demonstrated excellent internal consistency for the child form. They also supported the predictive validity (Hawley & Weisz, 2005) of the forms in addition to McLeod and Weisz (2005) who reported their significant convergent validity. TASC is one of the most widely used therapeutic alliance measures for children (McLeod, Doss, & Ollendick, 2013).

In addition to child's and therapist's perceptions of their therapeutic alliance, the construct can be assessed by independent observers via evaluating the interactions of the dyad through recorded therapy sessions. WAI has an observer form (WAI-O; Darchuk et al., 2000) that is used for therapy sessions of adolescents in addition to adults. However, the segmented version of WAI-O (S-WAI-O; Berk, Eubanks-Carter, Muran, & Safran, 2010) has been used in child studies as well (e.g. Goodman et al., 2017). S-WAI-O has 12 7-point Likert scale items, divided as bond and task, and it is used to code every 5-minute segments of a session in order to capture in-session ruptures and repairs. The study of Berk (2013) showed that S-WAI-O is a reliable measure with good convergent and divergent validity. Another observer scale is Child Therapeutic Alliance Scale (CTAS; Grienenberger & Foreman, 1993) which is based on adult alliance scale CALPAS (Gaston & Marmar, 1994). It is developed for psychodynamic play therapy with children. A single case study (Foreman, Gibbins, Grienenberger, & Berry, 2000) of a 10-year-old girl with internalizing and school problems portrayed strong internal consistency and construct validity of CTAS, however it was limited by small amount of data. Moreover, there is Child Psychotherapy Process Scales (CPPS; Estrada & Russell, 1999) to assess therapeutic alliance with observers. It is adapted from Vanderbilt Psychotherapy Process Scale (VPPS; Strupp, Hartley, & Blackwood, 1974) and consists of 33 5-point Likert scale items within child and therapist subscales. In order to test its psychometric properties, Estrada and Russell (1999) conducted a study among 17 children of ages 6-12 and found that CPPS has good internal consistency and strong discriminant validity. CPPS has been used in several studies (e.g. Hudson et al., 2014).

Lastly, McLeod and Weisz (2005) developed Therapy Process Observational Coding System-Alliance scale (TPOCS-A), which is a comprehensive observational coding system of child-therapist therapeutic alliance. The scale has 9 6-point Likert scale items and it is comprised of bond and task subscales in accordance with the child literature on conceptualization of therapeutic alliance. The bond subscale, which measures the emotional aspects of the child-therapist relationship, is based on the

items of CPTR (Kendall, 1994) and TASC (Shirk & Saiz, 1992). The items of the task subscale, which measures the child-therapist collaboration on the therapeutic tasks, are derived from CPPS (Estrada & Russell, 1999) and the Revised Vanderbilt Therapy Alliance Scales (RVTAS; Diamond, Liddle, Hogue, & Dakof, 1999). Psychometric properties of the measure were tested with 22 child aged 8-14 with depressive or anxiety disorder. The results of the study showed excellent internal consistency and moderate test-retest reliability of the measure in addition to its strong convergent validity, when correlated with the TASC (McLeod & Weisz, 2005). TPOCS-A has been used as in several studies, with diverse populations (e.g. Chiu et al., 2009; Fjermestad et al., 2012; Liber et al., 2010).

Out of the measures that have been reviewed, TPOCS-A was selected to be used in the current study for various reasons. Although the opinions of child and therapist on therapeutic alliance are considerably valuable, the literature indicates that in child therapy assessing alliance by a third party observer may be empirically more robust due to aforesaid developmental limitations of the child, possible inflated responses in self-reports and difficulty in interpreting therapeutic alliance based on self-reports when its association with outcome is investigated (Shirk & Karver, 2003). Out of the observational measures, TPOCS-A was the most applicable and convenient candidate for the study. As more than 150 session had been coded, its 9-item scale has been efficient yet sufficient to use. The scale contains all dimensions of therapeutic alliance, bond and task, as conceptualized in child literature (McLeod, 2011), evaluating both child and therapist aspects within the dimensions. The items of the scale have been created from a mixture of reliable and valid child-focused measures (McLeod & Weisz, 2005). Moreover, it has strong psychometric properties and has been used in various process and outcome studies. Although it had not been used in a study of psychodynamic child therapy, its conceptual framework is suitable with psychodynamic approach and according to Kennedy and Midgley (2007), it "could potentially be used in studies of the process of psychoanalytic child psychotherapy" (pp.18).

### **1.3. PURPOSE OF THE STUDY**

The purpose of the current study is to examine the psychodynamic therapy sessions of children with behavioral problems, who completed treatment with good outcome, in order to explore several aspects of therapeutic alliance. First of all, pre-treatment characteristics of children (i.e. age, gender, psychosocial functioning, internalizing and externalizing problems) will be investigated as the predictors of in-session therapeutic alliance. In the second place, growth trajectories of therapeutic alliance will be observed. Lastly, the relationship between therapeutic alliance (i.e. averaged) and treatment outcome (i.e. levels of psychosocial functioning, internalizing and externalizing problems at the end of therapy) will be examined. In order to test these research questions, the alliance observation measure (TPOCS-A; McLeod & Weisz, 2005) that was presented above will be adapted to Turkish.

The findings of this study will contribute to literature by being one of the very few empirical studies on therapeutic alliance with children in psychodynamic therapy. As presented above, most of the studies are conducted with a sample in cognitive-behavioral therapy, the sample infrequently includes only the children and the diagnoses of children are mostly limited to anxiety disorders. Moreover, a validated therapeutic alliance measure to observe child therapy sessions will be adapted to Turkish and used with psychodynamic child therapy for the first time. Furthermore, the findings may enhance our clinical knowledge on the idiographic characteristics and courses of therapeutic alliance that evolves between children and therapists throughout successful psychodynamic therapy processes.

Building on theoretical and empirical literature on therapeutic alliance with children, we set forth a series of exploratory research questions and hypotheses regarding therapeutic alliance development over the course of treatment and association with outcome, operationalized as improvements in behavioral problems and psychosocial functioning. The directions of associations were not indicated in some hypotheses due to limited literature in the area. The study aimed to investigate

whether (1) there is an association between children's age and therapeutic alliance over the course of therapy; (2) girls have higher therapeutic alliance scores over the course of treatment than boys; (3) children with lower externalizing problems, higher internalizing problems and higher psychosocial functioning have higher therapeutic alliance scores throughout the therapy process; (4) therapeutic alliance shows growth over the course of treatment; (5) mean therapeutic alliance is negatively associated with internalizing and externalizing problem scores and positively associated with psychosocial functioning scores that are collected at the end of the therapy.

## **CHAPTER 2**

### **METHOD**

#### **2.1. PARTICIPANTS**

##### **2.1.1. Children**

The data of the study is obtained from Istanbul Bilgi University Psychotherapy Research Laboratory that has the service of low-cost outpatient psychodynamic psychotherapy. A licensed clinical psychologist examined the children and their parents to evaluate whether the children met the research protocol inclusion criteria. The inclusion criteria were that the children aged between 4-10 years old and did not have psychotic symptoms, significant developmental delays, risk of suicide attempts or drug abuse. Out of 84 successively admitted children between Fall 2014 and Spring 2016 who fit the inclusion criteria, 57 gave consent to research and video recording of sessions. Prior to therapy process, the children and their parents were informed thoroughly about the research procedures. The parents provided written informed consent where the children gave oral assent regarding use of their data (questionnaires, videotapes and transcripts of sessions) for research purposes. The study was approved by Istanbul Bilgi University Ethics Committee. Among 57 children, 7 dropped out of treatment before or during the assessment period and one had only mother-child play sessions. Therefore, the final sample of the study consisted of 49 children.

The children were born in Turkey, resided in relatively homogenous urban neighborhoods and belonged to low to middle socioeconomic status (SES). 23% of the children were 4-5 years old, 28% were 6-7 years old, and 49% were 8-10 years old, with almost an equal ratio of males (49%) to females (51%). Their referral reasons were mostly behavioral problems such as rule-breaking and aggressive behaviors (38%), followed by anxiety and depressive problems (36%), and lastly

social problems (26%). In order to evaluate the therapeutic gains of children, standardized behavior problem and psychosocial functioning outcome measures answered by parents and therapists at pre- and post-treatment were used (see Table 2.1, below). To determine whether there was a therapeutic change, a significant difference between pre- and post-treatment scores, paired samples *t*-test analysis was conducted. Moreover, the magnitude of differences between the scores was obtained by using Cohen's *d* (1992) statistic, which defines effect sizes as "small,  $d = 0.2$ ", "medium,  $d = 0.5$ " and "large,  $d = 0.8$ ".

**Table 2.1** Comparison of Pre-Treatment and Post-Treatment Scores for Outcome Measures.

Outcome Measures	Pre-Treatment		Post-Treatment		Change	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>t</i> -Test	Cohen's <i>d</i>
Child Behavior Checklist (CBCL) Total Problems	51.91	20.88	29.55	19.05	6.49**	1.11
Children's Global Assessment Scale (CGAS)	63.59	9.77	74.53	8.41	-7.85**	1.21

\*\* $p < .01$ .

\* $p < .05$ .

The sample was relatively homogeneous as in problem levels, and children were mostly at "borderline" or "clinical" levels of functioning (*mean total problem t-score* = 62.26, *SD* = 8.82) on the Child Behavior Checklist (CBCL; Achenbach, 1991) where *t*-scores over 59 indicate clinical functioning. The results are shown in Table 2.1 for outcome measures organized under reporters. Children showed significant changes in total problems on the CBCL with a large effect size ( $d = 1.11$ ). Similar gains were also observed in psychosocial functioning according to Children's Global Assessment Scale (CGAS; Shaffer et al., 1983) with a large effect size ( $d = 1.21$ )

### **2.1.2. Therapists**

The therapists were 19 clinicians in Istanbul Bilgi University clinical psychology masters program. They were all female and their ages were in between 23 and 34 years old. Every therapist was well-educated in the theoretical background and treatment techniques of psychodynamic child therapy. They all had the same level of experience (1 to 2 years of supervised psychotherapy experience). Therapists treated 4 children on average (range: 1-7). Licensed psychodynamic supervisors with a minimum of 10 years of experience provided 4 hours of supervision per week (i.e. 1 hour of individual and 3 hours of group supervision) to the therapists.

### **2.1.3. Treatment**

The children received psychodynamic child therapy which is the standard treatment practiced at Bilgi University Psychological Counseling Center. Clinical cases were distributed based on the availability of therapists. At the beginning of the treatment process, therapists administered a clinical interview with the parents to gain information about the referral problem, child's developmental history and family background. Following the first session, parents filled out the behavior problem assessment measure. In the second session, the therapists met with the children, introduced the room materials and stated that they are free to play with any toys. Moreover, they informed the children of the therapy rules regarding the duration of sessions and the safety of participants and room materials. Following the assessment period, the therapists evaluated the psychosocial functioning of their patients, prepared a clinical formulation and presented a treatment plan to the child's parents. The regular treatment plan at the counseling center consisted of once a week therapy session of 45 minutes with the child, in conjunction with once a month parent sessions. The duration of the treatment process was open-ended and depended on the progress towards goals, life changes, and decisions of child's parents. On average,

children participated in 30 sessions over a 10-month time period. As the treatment lengths differed, the average number of sessions for 49 children was 31 ( $SD = 11.47$ ).

Despite the fact that treatments were not manualized, the supervisors and therapists followed similar procedures for every clinical case. The main treatment principles can be briefly explained as the therapist inviting the child to express his inner world through play or solely with words; actively listening to the child and affectively engaging in his experience; encouraging the child to reflect on his feelings and thoughts; exploring and linking the wishes, needs, affects, defenses, themes and patterns that arise in play and in the therapeutic relationship; setting therapeutic boundaries while containing the feelings behind the defiant behaviors; and working through child's resistances to collaborate in the therapy process.

## **2.2. MEASURES**

### **2.2.1. Outcome Measures**

The Child Behavior Checklist (CBCL; Achenbach, 1991) is a commonly used scale to determine problematic behaviors in children. There are two different forms for ages 1.5-5 and 6-18. The forms consist of 99 and 112 problem behavior items, respectively, on a three-point scale (0 = "not true", 1 = "somewhat or sometimes true", and 2 = "very true or often true"). Problem behavior items can be computed for composite scales of internalizing (e.g. depression, anxiety), externalizing (e.g. aggression), or total problems. The scales of internalizing and externalizing problems were used in the current study. The internalizing problems scale has high levels of internal consistency (CBCL 1.5-5:  $\alpha = 0.89$ ; CBCL 6-18:  $\alpha = 0.90$ ) and one-week test-retest reliability (CBCL 1.5-5:  $r = 0.77$ ; CBCL 6-18:  $r = 0.91$ ) (Achenbach & Rescorla, 2000). Similarly, the externalizing problems scale has high levels of internal consistency (CBCL 1.5-5:  $\alpha = 0.93$ ; CBCL 6-18:  $\alpha = 0.94$ ) and one-week test-retest reliability (CBCL 1.5-5:  $r = 0.89$ ; CBCL 6-18:  $r = 0.92$ ) (Achenbach &

Rescorla, 2000). The scales have been adapted to Turkish with good internal consistency for internalizing problems ( $\alpha = 0.87$ ) and externalizing problems ( $\alpha = 0.90$ ) (Erol & Şimşek, 2010). Moreover, the adapted scales have one-week test-retest reliability for internalizing problems ( $r = 0.93$ ) and externalizing problems ( $r = 0.93$ ) (Erol & Şimşek, 2010). In the current study, internalizing problems scale had high levels of internal consistency (CBCL 1.5-5:  $\alpha = 0.83$ ; CBCL 6-18:  $\alpha = 0.84$ ) similar to externalizing problems scale, which also had high levels of internal consistency (CBCL 1.5-5:  $\alpha = 0.92$ ; CBCL 6-18:  $\alpha = 0.88$ ).

The Children's Global Assessment Scale (CGAS; Shaffer et al., 1983) is a 1 to 100 numeric scale rated by mental health clinicians to evaluate psychosocial functioning of children younger than 18 years of age. The scale has moderate to excellent inter-rater reliability and good stability over time in addition to good concurrent and discriminant validity (Shaffer et al., 1983).

### **2.2.2. Process Measure**

Therapy Process Observational Coding System-Alliance scale (TPOCS-A; McLeod & Weisz, 2005) is used to assess the quality of therapeutic alliance between child and therapist. After watching videotapes of entire therapy sessions, coders rate the 9-item scale based on the frequency or intensity of the given item within the interaction of child and therapist. The items are as follows: (1) child experiences therapist as supportive and understanding; (2) child acts in a hostile, critical, or defensive manner toward therapist; (3) child demonstrates positive affect toward therapist; (4) child shares his experience with therapist; (5) child appears anxious or uncomfortable interacting with therapist; (6) child and therapist appear anxious or uncomfortable interacting with each other; (7) child uses therapeutic tasks to make changes outside the session; (8) child does not comply with therapeutic tasks; and (9) child and therapist work together equally on therapeutic tasks (McLeod, 2005). The items are rated on a 6-point Likert scale with the anchors of 0 = *not at all* and 5 =

*great deal*. TPOCS-A has shown excellent internal consistency ( $\alpha = 0.95$ ) and acceptable inter-rater reliability ( $ICC > 0.40$ ;  $M = 0.59$ ,  $SD = 0.10$ ); the measure has a convergent validity of 0.53 when correlated with the TASC (McLeod & Weisz, 2005).

For the present study, TPOCS-A was translated into Turkish and its scoring manual was expanded in examples related to psychodynamic child therapy. Addendum to the manual was consulted with Bryce D. McLeod, PhD and Sibel Halfon, PhD. 8 undergraduate psychology and clinical psychology graduate students were trained by the author in a month coding pilot videotapes ( $N = 9$ ) and were certified as they achieved adequate interrater reliability ( $ICC = 0.70$ ). Afterwards, sessions were randomly assigned to pairs of coders who were blind to the study. In order to prevent coder drift, meetings with the coders took place. Moreover, disagreements of pairs were resolved by consultation with the author. 65% of the sessions were double coded by pairs and the mean score was used in the analyses; the sessions were coded with good to excellent ICCs (0.70-1) ( $M = 0.91$ ;  $SD = 0.07$ ).

In the current study, one factor solution of TPOCS-A was extracted accounting for 41.48% of the total variance. Item 7 (i.e. "child uses therapeutic tasks to make changes outside the session") was excluded from the analyses as it showed high skewness and kurtosis values. The rationale behind exclusion of the item is: Children in psychodynamic therapy rarely declare that they use therapeutic tasks unlike children in cognitive-behavioral therapy who are given homework assignments. The measure showed good internal consistency ( $\alpha = 0.73$ ).

### **2.3. PROCEDURE**

The outcome measures were administered at the first and last sessions of the psychotherapy process: Parents filled out CBCL scales and therapists rated CGAS scores. For TPOCS-A ratings, each of the psychotherapy sessions was videotaped and transcribed. In the present sample ( $N = 49$ ), psychotherapy processes of children

ranged between 14 and 58 sessions ( $M = 31$ ,  $SD = 11.47$ ). One session was randomly selected from sessions 1-10, 11-20, 21-30, 31-40, 41-50, 51-60 in each psychotherapy process, with a total of 179 sessions. Videotapes and transcripts of sessions were assigned randomly and entire sessions were watched and scored by coders independently.

## **CHAPTER 3**

### **RESULTS**

#### **3.1. DATA ANALYSIS**

In the data, psychotherapy sessions ( $N = 179$ ) were nested within patients ( $N = 49$ ). Thus, for the purposes of testing child characteristics of therapeutic alliance as well as its growth trajectories, a hierarchical linear modeling (HLM) approach was employed by using HLM Version 7 (Raudenbush, Bryk, & Congdon, 2002). Moreover, in order to test the relationship between therapeutic alliance and treatment outcome, linear regression analyses were conducted by using SPSS software Version 23 (IBM Corp., 2015).

#### **3.2. RESULTS**

##### **3.2.1. Child Characteristics of Alliance and Growth Trajectories**

First of all, in order to test child characteristics, two-level (sessions nested within patients) “empty” hierarchical linear model, where therapeutic alliance was entered as dependent variable with no predictor variables, was used. Three-level (sessions nested within patients nested within therapists) hierarchical linear model was not used as the sample size was too small for a three-level model and as the hypotheses did not include the effects of therapist characteristics on therapeutic alliance. ICC analysis showed that 51% of the variance in therapeutic alliance was explained by between-patient variance. It signifies that the variance in therapeutic alliance is attributable to differences between children. To account for the variance in therapeutic alliance between patients, children’s age, gender, psychosocial functioning and internalizing and externalizing problems were grand mean centered and added as level-2 predictors.

Moreover, in order to observe growth trajectories, a time variable was produced to model the linear and quadratic change of therapeutic alliance over the course of therapy. Time was measured in terms of phases of session numbers: phase 1 for sessions 1-10, phase 2 for sessions 11-20, phase 3 for sessions 21-30, phase 4 for sessions 31-40, phase 5 for sessions 41-50 and phase 6 for sessions 51-60. Quadratic time component was computed by squaring the linear time variable. As children differed in the number of sessions, both time variables were centered at phase 1.

The means, standard deviations, and inter-correlations of the variables are presented in Table 3.1 and the results of the full model are portrayed in Table 3.2. The results show that age was not associated with therapeutic alliance significantly. Throughout the therapy process, girls developed significantly higher levels of therapeutic alliance than boys. Psychosocial functioning was significantly associated with therapeutic alliance, indicating that children with better psychosocial functioning form higher levels of therapeutic alliance over the course of therapy. Internalizing problems had significantly positive association with therapeutic alliance in contrast to externalizing problems that had significantly negative association with alliance. These results suggest that, over the course of treatment, children with more internalizing problems develop higher levels of therapeutic alliance whereas children with more externalizing problems establish lower levels of alliance with their therapists.

**Table 3.1** Descriptive Statistics and Inter-Correlations Between Measures per Sessions.

Variables	<i>M</i>	<i>SD</i>	1	2	3	4	5	6
(1) Age	7.20	2.07	-					
(2) Gender	0.46	0.50	-0.08	-				
(3) Therapeutic Alliance	28.30	5.76	0.29**	-0.30**	-			
(4) Psychosocial Functioning	63.59	9.77	0.18*	0.10	0.22**	-		
(5) Internalizing Problems	14.38	8.44	0.04	-0.02	0.07	0.01	-	
(6) Externalizing Problems	15.51	9.52	-0.38**	0.13*	-0.32**	-0.07	0.36**	-

*Notes.* Gender was dummy coded as (0 = female, 1 = male).

\*\* $p < .01$ .

\* $p < .05$ .

**Table 3.2** Summary of Multilevel Model Predicting Therapeutic Alliance by Age, Gender, Psychosocial Functioning, Internalizing and Externalizing Problems and Time in Treatment.

Intercept and Predictors	Model: Therapeutic Alliance		
	$\beta$	<i>SE</i>	<i>t</i> -Ratio
Intercept ( $\beta_{00}$ )	31.00	0.75	40.96**
Age ( $\beta_{01}$ )	-0.14	0.25	-0.55
Gender ( $\beta_{02}$ )	-3.60	0.93	-3.84**
Psychosocial Functioning ( $\beta_{03}$ )	0.14	0.05	2.82**
Internalizing Problems ( $\beta_{04}$ )	0.16	0.06	2.61**
Externalizing problems ( $\beta_{05}$ )	-0.14	0.05	-2.55**
Time (linear) ( $\beta_{10}$ )	-1.34	0.61	-2.18*
Time <sup>2</sup> (quadratic) ( $\beta_{20}$ )	0.27	0.15	1.78 $\gamma$

\*\* $p < .01$ .

\* $p < .05$ .

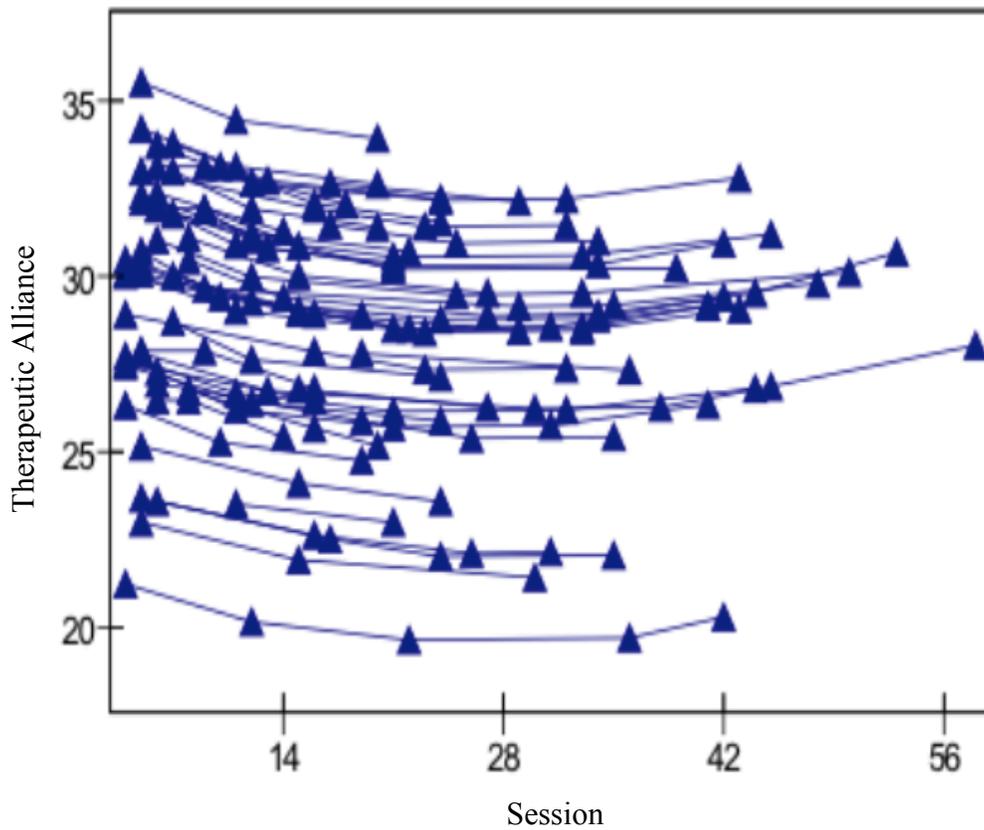
$\gamma p < .08$ .

After controlling for the effect of individual patient characteristics, the main effects of time on therapeutic alliance revealed a significant linear effect with a trend for quadratic growth (U-shaped curve) (see Table 3.2, above). The negative effect of

linear slope indicated that therapeutic alliance initially decreased during treatment; and the positive effect of quadratic slope signified that the decrease was followed by an increase after the 25th session (see Figure 3.1, below).

**Figure 3.1** Growth Trajectories of Therapeutic Alliance over Time When Controlled for Age, Gender, Psychosocial Functioning, Internalizing and Externalizing Problems.

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### 3.2.2. Relation Between Therapeutic Alliance and Outcome

In order to test the relationship between therapeutic alliance and treatment outcomes, linear regression analyses were conducted. Therapeutic alliance score of a child was calculated from the average of each of his coded therapy session. As treatment outcomes, post-treatment scores of psychosocial functioning, internalizing and externalizing problem measures were used, controlling for pre-treatment scores of the measures. Regression analyses showed that mean therapeutic alliance was not significantly associated with post-treatment psychosocial functioning, internalizing problems and externalizing problem scores after controlling for age, gender and pre-treatment scores of the outcome measures (see Table 3.3, below).

**Table 3.3** Linear Regressions with Therapeutic Alliance Scores and Outcome Measures.

Outcome Measures	Therapeutic Alliance		
	$\beta$	<i>SE</i>	<i>t</i> -Ratio
Psychosocial Functioning (CGAS)	0.01	0.26	0.03
Internalizing Problems (CBCL)	0.01	0.20	0.07
Externalizing Problems (CBCL)	0.08	0.23	0.35

\*\* $p < .01$ .

\* $p < .05$ .

## **CHAPTER 4**

### **DISCUSSION**

This study aimed to explore growth trajectory and idiographic characteristics of therapeutic alliance over the course of psychodynamic child treatment, in addition to its relations with outcome. In order to measure the quality of therapeutic alliance, therapy sessions of a group of children with behavioral problems who completed psychodynamic psychotherapy with good outcome were coded with TPOCS-A. To assess treatment outcome, as in symptoms and level of functionality at termination, CBCL internalizing and externalizing problem scores and CGAS ratings were collected pre- and post-treatment. The collected data was analyzed by using hierarchical linear modeling and linear regression analyses. According to the results, therapeutic alliance followed a U-shaped growth trajectory over the course of treatment; average therapeutic alliance scores had no association with treatment outcomes; children with internalizing problems, the ones with better psychosocial functioning and girls had higher levels of therapeutic alliance whereas children with externalizing problems, those with weaker psychosocial functioning and boys showed lower levels of therapeutic alliance; and age had no link with alliance throughout treatment. The findings will be discussed below.

#### **Growth Trajectory of Therapeutic Alliance**

Primarily, growth trajectory of therapeutic alliance across the course of treatment was explored. Child literature has shown that therapeutic alliance changes throughout the therapy process, however the findings have differed in shape of change. As some studies (Chu et al., 2014; Kendall et al., 2009) have found a linear increase of therapeutic alliance, others have observed a negative linear slope (Hudson et al., 2014) or a U-shaped pattern (Hurley et al., 2013) of alliance over time. Therefore a growth was expected, but the shape of the growth trajectory was not

indicated in the hypothesis. Results supported the hypothesis and therapeutic alliance showed growth throughout the therapy process. After controlling for the effect of individual child characteristics such as age, gender and pretreatment problems, therapeutic alliance initially decreased and the decrease was followed by an increase after the 25th session.

The U-shaped change of therapeutic alliance over the course of a successful psychodynamic child treatment may be interpreted as follows: In the initial sessions, child and therapist get acquainted with each other and establish a certain degree of therapeutic alliance as they begin their therapeutic work. The early alliance scores revealed that therapists and children across various pretreatment characteristics were capable of forming alliance at the beginning of treatment. However, in the early relationship-building phase of the process, as the child is warming up to the therapist and the therapy setting, he may tend to be more compliant, forthcoming and cooperative (Kabcenell, 1993). Following the establishment of adequate levels of collaboration and trust, as treatment proceeds, child begins to unfold more of his inner world, to disclose deeper materials that are emotionally meaningful. Over time, the therapeutic relationship deepens as well, that goes hand in hand with child's exacerbated transference reactions and pathological patterns of relating. Meanwhile, therapist explores and interprets the incrementally unraveled material and challenges the pathological relational patterns of child (Gardner, 1993).

The study of Halfon and colleagues (2016) portrays that, in the process of psychodynamic child therapy, child's emotions become disorganized, limited and rigid in the middle phases of therapy, which improve later on toward termination. Moreover, through psychodynamic process, child's symbolic play shows an increase followed by a deceleration whereas his regulation of emotions shows a decrease followed by an escalation (Halfon & Bulut, 2017). Therefore, intensification of the emotional and relational materials, heightened affective arousals and negative transference reactions along with lowered affect regulation may appear as a deterioration in therapeutic alliance toward the middle phases of treatment. Child may

express more negative affect toward therapist; may interact in a more aggressive, regressive, frustrated, anxious, defensive, critical, defiant or hostile manner; may challenge the boundaries of therapist and treatment environment; and may resist to work collaboratively with therapist as psychodynamic work brings forth uncomfortable emotions and confrontations (Axelman, 2006).

In the middle phase, around the 25th session, therapeutic alliance begins to increase. It may be that, different from his other relationships, therapist does not fulfill the pathological relational expectations of child, does not retaliate or retreat but survives his disruptive behaviors, sets adequate limits that promote safety, and contains, processes and reflects back his intense emotions. Thus child uses the therapist to regulate his emotions, to make meaning of his past and current experiences and to work through his resistances (Chethik, 2001). In the realm of a safe and containing therapeutic relationship, child expresses and processes the internal states behind his behavior problems that cannot be expressed easily in his other relationships. Throughout this phase, therapeutic dyad survives the rupture events and successfully repairs the deterioration of alliance, which forges a new phase with strengthened alliance toward the end of treatment (Ellman, 2007). Moreover, this turning point in therapeutic alliance serves the child as an opportunity to meet and practice a healthier way of behaving and relating to others (Horvath, 2000). Therefore, the U-shaped growth trajectory of therapeutic alliance, weakening of the emotional and collaborative relationship at a certain phase of the process followed by its healing, may be therapeutically beneficial in psychodynamic child therapy.

In adult alliance literature, U-shaped profile of therapeutic alliance is defined as "an initial positive therapeutic alliance followed by a rupture in the alliance for a period of time that is repaired to return to a positive alliance" (Haskayne, Larkin, & Hirschfeld, 2014, pp. 70) and is linked with therapeutic gains. A rupture was defined by Safran (1993) as "a negative shift in the quality of the therapeutic alliance" (pp. 34). According to him, when a rupture is examined, interpreted and resolved, repairment of alliance serves as a curative mechanism for patient; patient begins to

mend his pathological interpersonal patterns by virtue of the constructive interactions therapist fosters (Safran, 1993). Moreover, Ellman (2007) suggested that ruptures in alliance either threatens the treatment or fosters deeper love and trust in the relationship depending on its repairment process. Bordin (1979) asserted that, without ruptures and repairs a successful treatment is not possible and repairing ruptures is the heart of therapy. If no disruptions are experienced in therapeutic relationship, it may indicate that treatment is stuck and "coasting", patient's pathological patterns and conflicts are not being challenged and resolved but are only being repeated, or the patient develops solely positive transference and interacts with therapist in an unrealistic and idealized way without revealing his problems (Horvath & Luborsky, 1993, pp. 568). According to Kabacoff (1993), "It is only by the disruption of the pleasant state of affairs that one can see the workings of the other side of the transference." (pp. 38).

In the meta-analysis of Safran and colleagues (2011) on therapeutic alliance ruptures in adult psychotherapy, it was portrayed that existence of rupture-repair events in therapy processes was positively associated with good outcomes. In adult literature there is considerable evidence for positive treatment outcomes to be more closely related to a process with alliance ruptures followed by their resolutions compared to a process with no ruptures, with only linear growth of alliance (e.g. Gelso & Carter, 1994; Kivlighan & Shaughnessy, 2000; Safran, Crocker, McMinn, & Murray, 1990; Stiles et al., 2004; Strauss et al., 2006). In their study Gelso and Carter (1994) indicated that in a successful psychodynamic therapy process it is expected for an initially strong therapeutic alliance to subsequently worsen, and the deterioration to be followed by a growth. They explained this high-low-high alliance trajectory by an initial phase of optimism about the treatment, followed by a phase full of frustrations and negative reactions, ending with a final phase of positive interactions established on healthier, stronger and more realistic grounds compared to the earlier phases (Gelso & Carter, 1994). Moreover, Kivlighan and Shaughnessy (2000) discussed that toward the middle phases of treatment a decline in the level of

therapeutic alliance is certain as patient's pathology leads to issues in therapeutic relationship. They indicated that a successful therapy process must include interventions aimed at working through patient's relationship problems and helping him to re-engage in the process. They suggested that U-shaped pattern of alliance is related to therapeutic gains as they have found that such a curvilinear change in alliance was linked with improved interpersonal skills (Kivlighan & Shaughnessy, 2000). Furthermore, in their study Stiles and colleagues (2004) explained the rupture-repair sequence that they observed as a productive treatment phase, which provides the patient an opportunity to explore his way of relating to others, and mend its maladaptive aspects in the here-and-now of the therapeutic relationship.

In child alliance literature, there are only two studies that have found U-shaped growth trajectory of therapeutic alliance. One is conducted with skills management treatment for disruptive behaviors (Hurley et al., 2013) and the other is administered in a foster care with treatment parents (Rauktis, Vides de Andrade, Doucette, McDonough, & Reinhart, 2005). However their interpretation of the growth curve was different than the ones for psychodynamic therapy; they indicated that such a change in alliance is a matter of getting used to the treatment setting. Lastly, in their case study of a child-centered play therapy process, Goodman and colleagues (2017) have shown that ruptures and repairs in therapeutic relationship reduced symptoms. As child literature is void of process research on alliance growth trajectories of psychodynamic child therapy, inferences of the current finding have been made predominantly based on the adult psychodynamic literature.

### **Therapeutic Alliance and Treatment Outcome**

Moreover, the relationship between therapeutic alliance and treatment outcome was investigated. The results did not support the hypothesis and no significant association was found between mean therapeutic alliance scores and

internalizing and externalizing problem scores as well as psychosocial functioning ratings that were collected at the end of the therapy.

One of the plausible explanations of this finding may be that a significant link between therapeutic alliance and positive treatment outcome cannot be obtained via mean scores of alliance in psychodynamic child therapies. The current hypothesis was formed based on the previous outcome studies (e.g. Cummings et al., 2013; Kazdin & Durbin, 2012; McLeod & Weisz, 2005), which were majorly conducted with behavioral therapies and used a single therapeutic alliance score such as initial, middle, late alliance or mean of these scores in order to test the alliance-outcome relationship. Cognitive behavioral therapy stresses on therapeutic alliance particularly due to its importance for administering specific technical procedures in the sessions (Shirk et al., 2011). According to the therapy approach, it is substantial to continually promote positive relationship of the dyad, compliance of the child and maintain high levels of alliance throughout the process, in order to work on the therapeutic tasks effectively (Shirk & Saiz, 1992). Therefore, to investigate the contribution of therapeutic alliance to treatment outcome, it is meaningful to examine the correlation between a level of alliance and outcome in these types of therapies.

On the other hand, as we observed in the first finding of the study, clinical use of therapeutic alliance may be different in psychodynamic child therapy. Weakening of alliance throughout the process followed by its strengthening may be more clinically beneficial than sustaining high levels of therapeutic alliance over the course of treatment. As a matter of fact, one of the major aspects that separate psychodynamic treatment from behavioral approaches is its emphasis on expression of negative emotions (Blagys & Hilsenroth, 2002). In their meta-analysis, Shirk and colleagues (2011) have concluded that there is a stronger correlation between high levels of therapeutic alliance and positive treatment outcomes in studies with behavioral therapies compared to non-behavioral ones. Therefore, a hypothesis tailored for psychodynamic therapy, which includes the growth of therapeutic alliance

across time rather than its single score, may be needed in order to attain significant results related to outcome.

However, another explanation may be that the quality of therapeutic alliance influences certain treatment variables different than outcome. Contrary to adult literature, a consistent link has not been established between alliance and outcome in child alliance literature (McLeod et al., 2017). There are several studies (e.g. Abrishami & Warren, 2013; Kendall et al., 1997; Liber et al., 2010) that similarly could not obtain a significant association between therapeutic alliance and outcome. In his meta-analysis, due to its low effect size, McLeod (2011) asserted that previous studies have overestimated the power of alliance-outcome association in child psychotherapy. He indicated that rather than a direct alliance-outcome link, therapeutic alliance may be indirectly contributing to positive treatment outcomes, through other treatment processes (McLeod, 2011). For instance in the study of Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli and Peri (2016), which was conducted with adult patients in psychodynamic therapy, it was found that therapeutic alliance predicted emotional experience, which consecutively predicted psychosocial functioning.

Lastly, this finding may be due to the certain aspects of methodology of the current study. In order to assess therapeutic alliance, an observer-rated alliance measure was used. However in the literature it is indicated that self-report measures of alliance yield associations with outcome more than observer-rated measures (McLeod et al., 2017). Moreover, as observers rated the alliance measure, the outcome measures were filled by therapists and parents. However, there is evidence for alliance-outcome relations to be stronger when both measures are rated by the same evaluator (Kazdin & Durbin, 2012; McLeod, 2011). Furthermore, most of the studies, which have found a significant relationship between alliance and outcome, had a specific, homogenous clinical subsample such as children with anxiety (e.g. Cummings et al., 2013) or disruptive behaviors (e.g. Kazdin & Durbin, 2012). However, the current sample was diverse and heterogeneous, consisting of children

with various behavior problems. Therefore, the significance of alliance-outcome link may have differed depending on children's symptoms; some may have benefitted from therapeutic alliance more than others.

### **Behavior Problems, Psychosocial Functioning and Therapeutic Alliance**

Children's pretreatment behavior problems and psychosocial functioning were potential predictors of therapeutic alliance that is developed over the course of treatment. Results supported the hypothesis that children with lower externalizing problems, higher internalizing problems and higher psychosocial functioning would have higher therapeutic alliance scores throughout the therapy process. The literature is in accordance with this finding; several studies (e.g. Accurso & Garland, 2015; Chu et al., 2014; Zorzella et al., 2015) have shown that internalizing behaviors of children are positively correlated with therapeutic alliance whereas externalizing behaviors have a negative relationship with alliance. Moreover, literature (e.g. Kazdin & Durbin, 2012; Shirk & Karver, 2003) has suggested that higher level of psychosocial functioning is linked with stronger therapeutic alliance.

The difference in the quality of therapeutic alliance between internalizing and externalizing children may be due to the contrast in their characteristics, their styles of interacting with their therapists and the way their therapists perceive them. Children with internalizing behaviors, who have symptoms such as anxiety and depression, portray a shy, inhibited and withdrawn profile (Oldehinkel, Hartman, Winter, Veenstra, & Ormel, 2004). They usually play in a silent and rigid manner; express narrow range of feelings; and use relatively mature defense mechanisms such as rationalization and undoing (Halfon, 2017). These temperaments and characteristics may have made it easier for therapists to bond and work with these children. As they are inhibited, it is difficult for children with internalizing behaviors to facilitate play or talk (Rubin, Coplan, & Bowker, 2009), thus they usually depend on therapist, seek their support and ask for their advice or information. Therefore,

compared to externalizing children, internalizing children may have been more inclined to engage in therapeutic relationship and comply with therapeutic tasks. In literature (Zorzella et al., 2015), it is shown that, the more children face internalizing problems, the more they see the therapist as helpful, supportive and understanding. Also, as children with internalizing problems commonly turn their aggression inward, in therapy sessions it might have been less likely to observe them expressing negative affect toward therapist or going against the rules of treatment. Moreover, it is suggested that high levels of anxiety, which these children experience greatly, is associated with more motivation for treatment, for relieving internal distress, therefore for investing in therapeutic alliance (e.g. Chu et al., 2014; DiGiuseppe et al., 1996).

On the other hand, children with externalizing problems, who exhibit symptoms such as aggressive and rule-breaking behaviors, portray an impulsive, irritable and active profile (Eisenberg et al., 2001; Oldehinkel et al., 2004). They usually express anger, have difficulty in regulating their emotions, their feelings shift abruptly and to cope with their feelings they use polarized defense mechanisms such as projection, splitting and acting out (Halfon, 2017). Hence, they are more inclined to be provocative, to push the boundaries of therapist and therapy setting (Zorzella et al., 2015). In addition, at times, it is hard for them to differentiate between reality and fantasy (Halfon, 2017). Therefore for therapists, it may have been more challenging to feel safe, to connect and work with these children. As psychodynamic work requires pausing the actions, observing and introspecting, it may have been difficult, and even scary, for these children to collaborate with such therapy tasks. Their oppositional, critical or disruptive attitudes may have evoked strong negative countertransference reactions in therapists that made it tough to develop strong therapeutic alliance. In fact in literature, there is evidence for therapists to find establishing alliance with externalizing children more difficult (Bickman et al., 2004; Johansson & Eklund, 2006; Shirk & Karver, 2003); and for externalizing children to

have more relationship problems compared to children with internalizing problems (Bickman et al., 2004; Garcia & Weisz, 2002).

Moreover, the reason for children with better psychosocial functioning to develop stronger therapeutic alliance over the course of treatment may be the similarity in the two concepts. Psychosocial functionality is children's interpersonal functioning and social competence at home, at school and with peers (Shirk & Karver, 2003). According to the meta-analysis of Shirk and Karver (2003), alliance measures were most highly associated with measures of psychosocial functioning in previous studies because of assessing similar relationship-based abilities of children. Furthermore, Kazdin and Durbin (2012) have found that pre-treatment social competencies of children predicted the quality of their therapeutic alliance.

The positive relationship between psychosocial functioning and therapeutic alliance is meaningful and may indicate that children relate to their therapists in a similar way they relate to others. They engage in the therapeutic relationship with similar level of interpersonal skills, sociability and bonding (Kazdin & Durbin, 2012). The more disturbances children experience psychosocially, harder it is to form therapeutic alliance with their therapists. For instance, a child who exhibits antisocial behavior toward peers will most likely act in a hostile manner toward therapist; or a child with isolated behavior at school will appear uncomfortable when interacting with therapist. The study of Kokotovic and Tracey (1990) conducted with adults support this finding by indicating that the quality of past and current relationships of patients influences their ability to engage in therapeutic relationships.

### **Gender, Age and Therapeutic Alliance**

Gender was another pretreatment characteristic of children that could possibly influence therapeutic alliance that evolves across time. The results supported the hypothesis and girls had higher therapeutic alliance scores over the course of treatment than boys. Literature is in accordance with this finding by suggesting that

girls develop stronger therapeutic alliance compared to boys (e.g. Accurso & Garland, 2015; Langer, McLeod, & Weisz, 2011; Zorzella et al., 2015).

One of the potential explanations of this finding may be embedded in their differences in interpersonal interactive styles. There is evidence for girls to spend more time in dyadic interactions whereas for boys to participate in more group interactions (Benenson et al., 1997; Fabes, Martin, & Hanish, 2003). Research has also shown that girls engage in social conversations (Ladd, 1983; Moller, Hymel, & Rubin, 1992) more than boys. Moreover, Maccoby (1990) discussed that, girls identify with relational styles of their mothers, who engage in more intimate and reciprocal interactions whereas boys identify with their fathers, who interact less intimately or reciprocally but more in a humorous, rivalrous and rough-and-tumble manner. Therefore, compared to boys, for girls it may be more familiar and comfortable to participate in close, reciprocal and one-to-one interactions with therapist. For instance, it may have been easier for girls to share their experiences such as talking about their hopes, dreams and opinions or to express their positive feelings toward therapist.

Furthermore, literature suggests that girls self-disclose to their friends (e.g. Lansford & Parker, 1999; Lempers & Clark-Lempers, 1993; Rose, 2002; Zarbatany, McDougal, & Hymel, 2000) and ask their friends for an advice (Gould & Mazzeo, 1982) more than boys. Thus in the therapy sessions, girls may have been observed to express their inner processes such as their thoughts, feelings, needs and wishes, and rely on therapist for support and guidance more than boys. This may indicate that girls are more inclined to engage in treatment; which is in accordance with research claiming that girls make use of psychotherapy more than boys (Weisz, Bahr, Han, Granger, & Morton, 1995).

For therapists as well, it may have been easier to form therapeutic alliance with girls, which is in line with findings from adult literature (e.g. Gibbons et al., 2003). In addition to the aforementioned reasons, gender differences in referral problems may have influenced the results. Research supports that externalizing

behaviors are more common among boys (Zahn-Waxler, 1993). In contrast, girls tend to have more internalizing behaviors, which, as mentioned above, may be less difficult than externalizing behaviors to work with for therapists. Lastly, it should be noticed that all therapists were females. As they were all women, it might have been easier for girls to develop alliance with same-gendered therapists (Langer et al., 2011). There is evidence for girls to find female therapists' relational approach more familiar and engaging compared to boys (Wintersteen, Mesinger, & Diamond, 2005) and for children in general to perceive same-gendered play partners as more compatible (Maccoby, 1990).

Lastly, age was another potential idiographic characteristic of therapeutic alliance and it was investigated whether children's age had an effect on alliance over the course of treatment. However the results did not support the hypothesis and no association was found between age and therapeutic alliance. This finding indicates that, strength of therapeutic alliance that was formed between therapists and children over the course of therapy was not related to children's age. This contrary finding may be due to the age range of the current sample. The predominant research (e.g. Abrishami & Warren, 2013; DeVet et al., 2003) that revealed a significantly negative correlation between child age and therapeutic alliance had a sample including adolescents and indicated that therapeutic alliance decreased as patient age increased because of older aged patients being adolescents. They suggested that engaging adolescents in therapy processes were more difficult than children due to their demands for autonomy (Abrishami & Warren, 2013). However, the current study did not include adolescents. Moreover, Chu and colleagues (2014) found that age does not predict therapeutic alliance, which supports the current finding. They concluded that therapists and youth across age are capable of forming equally firm alliances (Chu et al., 2014).

#### **4.1. IMPLICATIONS FOR CLINICAL PRACTICE**

One of the results of the current study indicates that trajectory of therapeutic alliance over the course of psychodynamic child treatment with good outcome may follow a U-shape. First of all, this preliminary finding may clinically imply that a decline in therapeutic alliance toward the middle phase of treatment (approximately the 25th session) is expected, therapeutically functional and plays a pivotal role in the process. It may mean that child is trusting the therapeutic relationship and revealing his disruptive emotions and pathological patterns of interacting which underlie his behavior problems. In fact, it may signify that treatment is working. In psychodynamic child therapy literature, the importance of expressing disruptive emotions, containing and processing them in the therapeutic relationship is underlined for children with behavior problems (Eresund, 2007; Hoffman, Rice, & Prout, 2015). Therefore it is important for therapists to keep in mind through the treatment process that deterioration of their alliance with their patients toward the middle period is a part of their psychodynamic work.

Secondly, the current finding and previous research (e.g. Ardito & Rabellino, 2011; Safran et al., 2011) show that, it is crucial to survive this phase. If the rupture is not repaired, it may lead to dropout (Muran, Safran, Samstag, & Winston, 2005). In psychodynamic therapy, ruptures and their repairments are viewed as transference and countertransference enactments co-created by patient and therapist within their interactions with each other (Beebe & Lachmann, 2003; Safran & Muran, 2006). If the dyad can mutually attend to and resolve the ruptures, healing of therapeutic relationship can be therapeutically fruitful for child. Thereby, as child may express heightened negative affect toward therapist, challenge the boundaries of treatment and resist to collaborate in the process, it is one of the essential roles of therapist to survive this period, explore what the child's reactions represent transferentially, work with his resistances and provide the safe and containing environment where child can express and work through his matters. Meanwhile, it is important for therapist to

consistently work on her negative countertransference experiences. Moreover, as child may resist coming to therapy in this period, it can be helpful to inform and prepare the parents about this critical period.

Thirdly, adult alliance literature points to the importance of establishing a "good enough" therapeutic alliance in the beginning of treatment (Horvath et al., 2011, pp. 15). It occurs within the first five sessions, provides adequate levels of collaboration and trust, and paves the way for further therapeutic work (Horvath & Luborsky, 1993). Also, it keeps the patient in therapy in later sessions when his transference reactions, negative affects and resistances escalate (Hawley & Weisz, 2005; Kabcenell, 1993). Gelso and Carter (1994) have shown that curvilinear pattern of alliance was associated with a strong early alliance. Therefore, it may be crucial for child and therapist to form satisfactory levels of therapeutic alliance in the initial sessions to bring about child's negative affects and pathological ways of relating as well as to be able to repair the ruptures such difficult emotions and interactions lead to.

As a part of their clinical training, information about the two critical phases of therapeutic alliance can be provided to therapists. First about the importance of fostering adequate levels of therapeutic alliance in the beginning of treatment process, and second about the potential deterioration in alliance toward the middle phase, about how to resolve the ruptures. For instance, Safran and colleagues (2011) recommended to therapists to be attuned to the signals of ruptures in therapeutic relationship, to encourage the patient to express negative thoughts and feelings about therapist or therapy, to respond in an accepting and non-defensive manner, to take responsibility for their contribution to the rupture event, to empathize with the experience of the patient, to resolve the alliance rupture with an in-depth examination, and to draw connections between the rupture in the therapeutic relationship and the pathological patterns in other relationships. They added that, in rupture events, transference interpretations should be made carefully as they may lead to further negative reactions (Safran et al., 2011).

Furthermore, the current study shows that therapists and children are capable of forming therapeutic alliance in psychodynamic child therapy processes across a broad range of age, gender and pretreatment problems. Still, the level of therapeutic alliance over the course of treatment varies depending on child's gender, behavior problem and level of functionality. Boys, children with externalizing behavior problems and those with lower levels of psychosocial functioning tend to have weaker therapeutic alliance with their therapists. These children may particularly benefit from interventions aimed at strengthening alliance, promoting social competence and resolving interpersonal problems. In fact literature suggests that developing strong alliance with challenging youth is especially important for their therapeutic gains (Eltz, Shirk, & Sarlin, 1995; Kaufman, Rohde, Seeley, Clarke, & Stice, 2005; Shelef, Diamond, Diamond, & Liddle, 2005; Shirk & Karver, 2003). On the other hand, girls, children with internalizing behavior problems and the ones with higher levels of psychosocial functioning were able to form stronger therapeutic alliance with their therapists. With these children the focus may be on making sure that what appears to be therapeutic alliance is not a treatment compliance (Sandler et al., 1980) that disables child to express negative emotions and transferences. Assessments of children's pretreatment characteristics can provide information about the potential alliance issues of the therapy process and can contribute to therapists' clinical formulation and treatment plan.

#### **4.2. LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH**

Its longitudinal design and use of a validated observational measure of therapeutic alliance are the strengths of the current study. Nonetheless it has limitations requiring attention. First limitation of the study is its relatively small sample size; a larger sample with more time points of therapy sessions would strengthen the methodology. In addition to the observational measure of therapeutic

alliance, using therapist and child ratings of alliance would provide their perspectives about alliance and could improve the methodology.

In process analysis, not including the effect of therapist characteristics on therapeutic alliance due to small sample size and homogenous therapist profile is another limitation of the study; using a three-level hierarchical linear model would enable us to examine contributions of both children and therapists to their therapeutic alliance. In outcome analysis, testing therapeutic alliance with mean scores, employing observational methods, using different sources for alliance (i.e. observer) and outcome (i.e. parent, therapist) measures and the sample of children including diverse, heterogeneous behavior problems may have led to the insignificant alliance-outcome relations found in the study. Also, child behavior problems were only based on parent reports whereas child functionality was solely based on therapist reports; the outcome measures could have been collected from multiple perspectives (i.e. child, therapist, parent). In addition, the symptomatic change that occurred prior to assessment of therapeutic alliance was not controlled, which restrained any conclusions about the predictable value of alliance on treatment outcomes; controlling for symptomatic change by assessing clinical outcomes at multiple time points could provide predictive alliance findings.

Furthermore, this is a naturalistic study of children in psychodynamic therapy, which is short of a control group. Therefore the study is limited in its internal validity. Nevertheless, it has strong external validity, which ensures that its findings reflect the reality of clinical work with children. However, the therapists being all females and novices diminish the generalizability of the findings. Lastly, as children varied in the number of sessions, it may have affected their treatment processes.

Research on therapeutic alliance in psychodynamic child therapy is considerably scarce and further studies are greatly needed. Several recommendations for future research are presented as follows. First one is regarding the study's preliminary finding of alliance growth trajectory. To be able to make an empirically supported clinical meaning of this finding, future research on psychodynamic child

therapies needs to examine the sequence of changes between therapeutic alliance and other variables by using time-series analysis. These other variables may include child's affective experiences in play assessed with the CPTI (Kernberg, Chazan, & Normandin, 1998) or child-therapist interaction structures obtained with the CPQ (Schneider & Jones, 2006). Second, the rupture-repair processes can be investigated on a micro level by coding every 5-minute of the psychodynamic therapy sessions using S-WAI-O (Berk et al., 2010). For instance, with this technique, the longest play segments of the sessions can be coded which can additionally be scored with the CPTI; thus a link between rupture-repair events and emotional experiences of children can be obtained.

Third one is about the association between therapeutic alliance and outcome in psychodynamic child therapies. It is important to examine both growth pattern and level of alliance to test relations with outcome (Kivlighan & Shaughnessy, 2000). In order to investigate the link between growth trajectories of therapeutic alliance and treatment outcome, it is possible for future research to analyze with latent growth modeling the predictability of different growth trajectories (i.e. intercept, slope, quadratic) of positive outcomes. In the case of the relationship between outcome and level of therapeutic alliance, to attain the strongest associations, using parent forms is recommended in previous literature (McLeod, 2011; Shirk & Russell, 1998) due to the important role parents play in children's treatment processes. Moreover, to be able to determine causality between alliance and outcome, behavior problems of children can be periodically measured with Brief Problem Monitor (BPM; Achenbach & Rescorla, 2000); thereby a temporal sequence of therapeutic alliance and outcome can be established. Furthermore, interaction between therapeutic alliance and other treatment processes such as therapist's treatment techniques or child's emotion regulation abilities can be examined in relation to outcome. Also, type of behavior problems can be used as a moderator of alliance-outcome relation as there is evidence for a stronger relation with children with externalizing behavior problems compared to internalizing children (McLeod, 2011; Shirk & Karver, 2003). Lastly, the

relationship between alliance and outcome in psychodynamic child therapy needs to be examined with specific clinical populations (e.g. children with depression, children with disruptive behaviors).

Fourth, it is important for future research to examine the effects of therapist characteristics on therapeutic alliance in psychodynamic child therapy, by using three-level hierarchical linear models. In addition to age, gender and clinical experience, reflective functioning skills can be included as therapist characteristics. Therapist Relationship Interview (TRI; Safran & Muran, 2007) can be used in order to measure reflective functioning of therapists. Fifth, in order to gain deeper understanding of the alliance experiences of children and therapists, their perspectives on therapeutic alliance are needed to be included in further research. Finally, the current study shows that TPOCS-A (McLeod & Weisz, 2005) can be used in future studies in order to code psychodynamic therapy sessions of children.

## **CONCLUSION**

This is one of the first studies to investigate the growth trajectory and idiographic characteristics of therapeutic alliance alongside its relations with outcome in psychodynamic child therapy. The study was able to show evidence that, regardless of pretreatment characteristics of children, therapeutic alliance of therapists and children follow a U-shaped growth trajectory through a process with good outcome. Moreover, over the course of treatment, girls, children with internalizing problems and those with better psychosocial functioning are able to develop stronger therapeutic alliance with their therapists compared to boys, children with externalizing problems and the ones with lower psychosocial functioning. Results of the study provide preliminary findings for research and contribute to our clinical understanding of therapeutic alliance in psychodynamic work with children.

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## Appendix A: Child Behavior Checklist for Ages 1.5-5 (CBCL/1.5-5)

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ÇOCUĞUN;

Cinsiyeti: \_\_\_ ERKEK \_\_\_ KIZ

Yaşı:

Doğum Tarihi: GÜN \_\_\_ AY \_\_\_ YIL \_\_\_

Kreşe, anaokuluna gidiyor mu? \_\_\_ HAYIR \_\_\_ EVET  
(Okulun adı: \_\_\_\_\_)

ANNE BABANIN İŞİ (Ayrıntılı bir biçimde yazınız, örneğin emekli, ilk okul öğretmeni, şoför, oto tamircisi, avukat gibi) EĞİTİMİ (Son bitirilen okula göre eğitim durumunuz)

BABANIN İŞİ: \_\_\_\_\_ EĞİTİMİ: \_\_\_\_\_ YAŞI: \_\_\_\_\_  
ANNENİN İŞİ: \_\_\_\_\_ EĞİTİMİ: \_\_\_\_\_ YAŞI: \_\_\_\_\_

FORMU DOLDURAN:

\_\_\_ Anne

\_\_\_ Baba

\_\_\_ Diğer (Çocukla olan ilişkisi: \_\_\_\_\_)

Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız. Teşekkür ederiz.

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Aşağıda çocukların özelliklerini tanımlayan bir dizi madde bulunmaktadır. Her bir madde çocuğunuzun şu andaki ya da son 6 ay içindeki durumunu belirtmektedir. Bir madde çocuğunuz için çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0 sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri işaretlemeye çalışınız.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- |   |   |   |   |
|---|---|---|---|
| 0 | 1 | 2 | 1. Ağrı ve sızıları vardır (Tıbbi nedenleri olmayan).             |
| 0 | 1 | 2 | 2. Yaşından daha küçük gibi davranır.                             |
| 0 | 1 | 2 | 3. Yeni şeyleri denemekten korkar.                                |
| 0 | 1 | 2 | 4. Başkalarıyla göz göze gelmekten kaçınır.                       |
| 0 | 1 | 2 | 5. Dikkatini uzun süre toplamakta ya da sürdürmekte güçlük çeker. |
| 0 | 1 | 2 | 6. Yerinde rahat oturamaz, huzursuz ve çok hareketlidir.          |
| 0 | 1 | 2 | 7. Eşyalarının yerinin değiştirilmesine katlanamaz.               |

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- 0 1 2 8. Beklemeye tahammülü yoktur, her şeyin anında olmasını ister.
- 0 1 2 9. Yenmeyecek şeyleri ağzına alıp çiğner.
- 0 1 2 10. Yetişkinlerin dizinin dibinden ayrılmaz, onlara çok bağımlıdır.
- 0 1 2 11. Sürekli yardım ister.
- 0 1 2 12. Kabızdır, kakasını kolay yapamaz. (Hasta değilken bile).
- 0 1 2 13. Çok ağlar.
- 0 1 2 14. Hayvanlara eziyet eder.
- 0 1 2 15. Karşı gelir.
- 0 1 2 16. İstekleri anında karşılanmalıdır.
- 0 1 2 17. Eşyalarına zarar verir.
- 0 1 2 18. Ailesine ait eşyalara zarar verir.
- 0 1 2 19. Hasta değilken bile ishal olur, kakası yumuşaktır.
- 0 1 2 20. Söz dinlemez, kurallara uymaz.
- 0 1 2 21. Yaşam düzenindeki en ufak bir değişiklikten rahatsız olur.
- 0 1 2 22. Tek başına uyumak istemez.
- 0 1 2 23. Kendisiyle konuşulduğunda yanıt vermez.
- 0 1 2 24. İştahsızdır. (Açıklayınız): \_\_\_\_\_
- 0 1 2 25. Diğer çocuklarla anlaşamaz.
- 0 1 2 26. Nasıl eğleneceğini bilmez, büyümüş de küçülmüş gibi davranır.
- 0 1 2 27. Hatalı davranışından dolayı suçluluk duymaz.
- 0 1 2 28. Evden dışarı çıkmak istemez.
- 0 1 2 29. Güçlkle karşılaştığında çabuk vazgeçer.
- 0 1 2 30. Kolay kıskanır.
- 0 1 2 31. Yenilip içilmeyecek şeyleri yer ya da içer (kum, kil, kalem, silgi gibi). (Açıklayınız): \_\_\_\_\_
- 0 1 2 32: Bazı hayvanlardan, ortamlardan ya da yerlerden korkar. (Açıklayınız): \_\_\_\_\_
- 0 1 2 33. Duyguları kolayca incinir.
- 0 1 2 34. Çok sık bir yerlerini incitir, başı kazadan kurtulmaz.
- 0 1 2 35. Çok kavga dövüş eder.
- 0 1 2 36. Her şeye burnunu sokar.
- 0 1 2 37. Anne-babasından ayrıldığında çok tedirgin olur.
- 0 1 2 38. Uykuya dalmakta güçlük çeker.
- 0 1 2 39. Baş ağrıları vardır (tıbbi nedeni olmayan).
- 0 1 2 40: Başkalarına vurur.
- 0 1 2 41. Nefesini tutar.
- 0 1 2 42. Düşünmeden insanlara ya da hayvanlara zarar verir.
- 0 1 2 43. Hiçbir nedeni yokken mutsuz görünür.
- 0 1 2 44. Öfkelidir.
- 0 1 2 45. Midesi bulanır, kendini hasta hisseder. (Tıbbi nedeni olmayan).
- 0 1 2 46. Bir yerleri seyirir, tikleri vardır. (Açıklayınız): \_\_\_\_\_

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- 0 1 2 47. Sinirli ve gergindir.
- 0 1 2 48. Gece kabusları, korkulu rüyalar görür.
- 0 1 2 49. Aşırı yemek yer.
- 0 1 2 50: Aşırı yorgundur.
- 0 1 2 51. Hiçbir neden yokken panik yaşar.
- 0 1 2 52. Kakasını yaparken ağrısı, acısı olur.
- 0 1 2 53. Fiziksel olarak insanlara saldırır, onlara vurur.
- 0 1 2 54. Burnunu karıştırır, cildini ya da vücudunun diğer taraflarını yolar.  
(Açıklayınız): \_\_\_\_\_
- 0 1 2 55. Cinsel organlarıyla çok fazla oynar.
- 0 1 2 56. Hareketlerinde tam kontrollü değildir, sakardır.
- 0 1 2 57. Tıbbi nedeni olmayan, görme bozukluğu dışında göz ile ilgili sorunları vardır. (Açıklayınız): \_\_\_\_\_
- 0 1 2 58. Cezadan anlamaz, ceza davranışını değiştirmez.
- 0 1 2 59. Bir uğraş ya da faaliyetten diğerine çabuk geçer.
- 0 1 2 60. Döküntüleri ya da başka cilt sorunları vardır. (Tıbbi nedeni olmayan).
- 0 1 2 61. Yemek yemeyi reddeder.
- 0 1 2 62. Hareketli, canlı oyunlar oynamayı reddeder.
- 0 1 2 63. Başını ve bedenini tekrar tekrar sallar.
- 0 1 2 64. Gece yatağına gitmemek için direnir.
- 0 1 2 65. Tuvalet eğitimine karşı direnir. (Açıklayınız): \_\_\_\_\_
- 0 1 2 66. Çok bağıırır, çağırır, çığlık atar.
- 0 1 2 67. Sevgiye, şefkate tepkisiz görünür.
- 0 1 2 68. Sıkılğan ve utangaçtır.
- 0 1 2 69. Bencildir, paylaşmaz.
- 0 1 2 70. İnsanlara karşı çok az sevgi, şefkat gösterir.
- 0 1 2 71. Çevresindeki şeylere çok az ilgi gösterir.
- 0 1 2 72. Canının yanmasından, incinmekten pek az korkar.
- 0 1 2 73. Çekingen ve ürkektir.
- 0 1 2 74. Gece ve gündüz çocukların çoğundan daha az uyur.  
(Açıklayınız): \_\_\_\_\_
- 0 1 2 75. Kakasıyla oynar ve onu etrafa bulaştırır.
- 0 1 2 76. Konuşma sorunu vardır. (Açıklayınız): \_\_\_\_\_
- 0 1 2 77. Bir yere boş gözlerle uzun süre bakar ve dalgın görünür.
- 0 1 2 78. Mide-karın ağrısı ve krampları vardır. (Tıbbi nedeni olmayan).
- 0 1 2 79. Üzgünken birden neşeli, neşeli iken birden üzgün olabilir.
- 0 1 2 80. Yadırganan, tuhaf davranışları vardır.  
(Açıklayınız): \_\_\_\_\_
- 0 1 2 81. İnatçı, somurtkan ve rahatsız edicidir.
- 0 1 2 82. Duyguları deęişkendir, bir anı bir anını tutmaz.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- 0 1 2 83. Çok sık küser, surat asar, somurtur.  
0 1 2 84. Uykusunda konuşur, ağlar, bağırır.  
0 1 2 85. Öfke nöbetleri vardır, çok çabuk öfkelenir.  
0 1 2 86. Temiz, titiz ve düzenlidir.  
0 1 2 87. Çok korkak ve kaygılıdır.  
0 1 2 88. İşbirliği yapmaz.  
0 1 2 89. Hareketsiz ve yavaştır, enerjik değildir.  
0 1 2 90. Mutsuz, üzgün, çökkün ve keyifsizdir.  
0 1 2 91. Çok gürültücüdür.  
0 1 2 92. Yeni tanıdığı insanlardan ve durumlardan çok tedirgin olur.  
(Açıklayınız): \_\_\_\_\_  
0 1 2 93. Kusmaları vardır. (Tıbbi nedeni olmayan).  
0 1 2 94. Geceleri sık sık uyanır.  
0 1 2 95. Alıp başını gider.  
0 1 2 96. Çok ilgi ve dikkat ister.  
0 1 2 97. Sızlanır, mızırdanır.  
0 1 2 98. İçe kapanıktır, başkalarıyla birlikte olmak istemez.  
0 1 2 99. Evhamlıdır.  
0 1 2 100. Çocuğunuzun burada değinilmeyen başka sorunu varsa lütfen yazınız: \_\_\_\_\_

## Appendix B: Child Behavior Checklist for Ages 6-18 (CBCL/6-18)

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ÇOCUĞUN;

Cinsiyeti: \_\_\_ ERKEK \_\_\_ KIZ

Yaşı:

Doğum Tarihi: GÜN \_\_\_ AY \_\_\_ YIL \_\_\_

Sınıfı: \_\_\_ Okula devam etmiyor: \_\_\_

ANNE BABANIN İŞİ (Ayrıntılı bir biçimde yazınız, örneğin emekli, ilk okul öğretmeni, şoför, oto tamircisi, avukat gibi) EĞİTİMİ (Son bitirilen okula göre eğitim durumunuz)

BABANIN İŞİ: \_\_\_\_\_ EĞİTİMİ: \_\_\_\_\_ YAŞI: \_\_\_\_\_

ANNENİN İŞİ: \_\_\_\_\_ EĞİTİMİ: \_\_\_\_\_ YAŞI: \_\_\_\_\_

FORMU DOLDURAN:

\_\_\_ Anne

\_\_\_ Baba

\_\_\_ Diğer (Çocukla olan ilişkisi: \_\_\_\_\_)

Çocuğunuzun davranışlarıyla ilgili bu formu lütfen görüşlerinizi yansıtacak biçimde yanıtlayınız. Her bir madde ile ilgili bilgi verebilir ve 2. sayfadaki boşluklara yazabilirsiniz. Lütfen bütün maddeleri işaretlemeye çalışınız. Teşekkür ederiz.

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I. Çocuğunuzun yapmaktan hoşlandığı sporları a, b, c şıklarına yazınız.

Örneğin: Yüzme, futbol, basketbol, voleybol, atletizm, tekvando, jimnastik, bisiklete binme, güreş, balık tutma gibi.

\_\_\_ Hiç yok.

Çocuğunuz her birine ne kadar zaman ayırır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

II. Çocuğunuzun spor dışındaki ilgi alanlarını, uğraş, oyun ve aktivitelerini a, b, c şıklarına yazınız. Örneğin: Bilgisayar, satranç, araba, akvaryum, el işi, kitap, müzik aleti çalmak, şarkı söylemek, resim yapmak gibi. (Radyo dinlemeyi ya da televizyon izlemeyi katmayınız).

\_\_\_ Hiç yok.

Çocuğunuz her birine ne kadar zaman ayırır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

III. Çocuğunuzun üyesi olduğu kuruluş, kulüp ya da takımları a, b, c şıklarına yazınız. Örneğin: Spor, müzik, izcilik, folklor gibi.

\_\_\_ Hiç yok.

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

IV. Çocuğunuzun evde ya da ev dışında yaptığı işleri a, b, c şıklarına yazınız. Örneğin: Gazete alma, bakkala gitme, pazara gitme, bahçe-tarla işleri, hayvancılık, elektrik-su faturası yatırma, çocuk bakımı, sofrayı kurma-kaldırma, bir dükkanda çalışma gibi. Ödeme yapılan ve yapılmayan her şeyi katınız.

\_\_\_ Hiç yok.

Çocuğunuz her birinde ne kadar başarılıdır?

	Normalden az	Normal	Normalden Fazla	Bilmiyorum
a. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- V. a. Çocuğunuzun yaklaşık olarak kaç yakın arkadaşı vardır?  
(Kardeşlerini katmayınız).  
Hiç yok  1  2 ya da 3  4 ya da fazla
- b. Çocuğunuz okul dışı zamanlarda haftada kaç kez arkadaşlarıyla birlikte olur?  
(Kardeşlerini katmayınız).  
1 den az  1 ya da 2  3 ya da daha fazla

VI. Yaşlılarıyla karşılaştırıldığında çocuğunuzun:

- a. Kardeşleriyle arası nasıldır?  
Kötü  Normal Sayılır  Oldukça İyidir  Kardeşi Yoktur
- b. Diğer çocuklarla arası nasıldır?  
Kötü  Normal Sayılır  Oldukça İyidir  Kardeşi Yoktur
- c. Size karşı davranışları nasıldır?  
Kötü  Normal Sayılır  Oldukça İyidir  Kardeşi Yoktur
- d. Kendi başına oyun oynaması ve iş yapması nasıldır?  
Kötü  Normal Sayılır  Oldukça İyidir  Kardeşi Yoktur

VII. 1. Çocuğunuzun okul başarısı nasıldır? Çocuğunuz okula gitmiyorsa lütfen nedenini belirtiniz: \_\_\_\_\_

	Başarısız	Orta	Başarılı	Çok Başarılı
a. Türkçe / Türk Dili Edebiyatı	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Hayat Bilgisi / Sosyal Bilgiler	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Matematik	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Fen Bilgisi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Diğer derslerde nasıldır?

Örneğin: Yabancı dil, bilgisayar. (Beden eğitimi, resim ve müziği katmayınız)

e. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Çocuğunuz özel alt sınıf ya da bir özel eğitim kurumunda okuyor mu?  
O Hayır O Evet – Ne tür bir sınıf ya da okul? \_\_\_\_\_

3. Çocuğunuz hiç sınıfta kaldı mı?  
O Hayır O Evet – Kaçınıcı sınıfta ve nedeni: \_\_\_\_\_

4. Çocuğunuzun okulda ders ya da ders dışı sorunları oldu mu?  
O Hayır O Evet – Açıklayınız: \_\_\_\_\_

Bu sorunlar ne zaman başladı? \_\_\_\_\_  
Sorunlar bitti mi?  
O Hayır O Evet – Ne zaman? \_\_\_\_\_

Çocuğunuzun herhangi bir bedensel hastalığı ya da zihinsel engeli var mıdır?  
O Hayır O Evet – Açıklayınız: \_\_\_\_\_

Çocuğunuzun sizi en çok üzen, kaygılandıran ve öfkelendiren özellikleri nelerdir?

Çocuğunuzun en beğendiğiniz özellikleri nelerdir?

Aşağıda çocukların özelliklerini tanımlayan bir dizi madde bulunmaktadır. Her bir madde çocuğunuzun şu andaki ya da son 6 ay içindeki durumunu belirtmektedir. Bir madde çocuğunuz için çok ya da sıklıkla doğru ise 2, bazen ya da biraz doğru ise 1, hiç doğru değilse 0 sayılarını yuvarlak içine alınız. Lütfen tüm maddeleri işaretlemeye çalışınız.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- |                      |   |   |  |
|----------------------|---|---|--|
| 0                    | 1 | 2 | 1. Yaşından çok çocuksu davranır.  |
| 0                    | 1 | 2 | 2. Anne babanın izni olmadan içki içer.  |
| 0                    | 1 | 2 | 3. Çok tartışan bir çocuktur.  |
| 0                    | 1 | 2 | 4. Başladığı etkinlikleri (oyunu, dersleri, işleri) bitiremez.   |
| 0                    | 1 | 2 | 5. Hoşlandığı ya da zevk aldığı çok az şey vardır.   |
| 0                    | 1 | 2 | 6. Kakasını tuvaletten başka yerlere yapar.  |
| 0                    | 1 | 2 | 7. Bir şeylerle övünür, başkalarına hava atar.   |
| 0                    | 1 | 2 | 8. Bir konuya odaklanamaz, dikkatini uzun süre toplayamaz.   |
| 0                    | 1 | 2 | 9. Kafasından atamadığı, onu rahatsız eden bazı düşünceleri vardır (mikrop bulaşma, simetri takıntısı, okul sorunları, bilgisayar gibi). |
| (Açıklayınız): _____ |   |   |  |
| 0                    | 1 | 2 | 10. Yerinde sakince oturamaz, çok hareketli ve huzursuzdur.  |
| 0                    | 1 | 2 | 11. Gereken gayreti göstermeden, sırtını tamamen büyüklere dayayıp her şeyi onlardan bekler.   |
| 0                    | 1 | 2 | 12. Yalnızlıktan şikayet eder.   |
| 0                    | 1 | 2 | 13. Kafası karışık, zihni bulanıktır.  |
| 0                    | 1 | 2 | 14. Çok ağlar.   |
| 0                    | 1 | 2 | 15. Hayvanlara eziyet eder.  |
| 0                    | 1 | 2 | 16. Başkalarına eziyet eder, kötü davranır, kabadayılık eder.  |
| 0                    | 1 | 2 | 17. Hayal kurar, hayallere dalıp gider.  |
| 0                    | 1 | 2 | 18. Kendine bilerek zarar verdiği ya da intihar girişiminde bulunduğu olmuştur.  |
| 0                    | 1 | 2 | 19. Hep dikkat çekmeye çalışır.  |
| 0                    | 1 | 2 | 20. Eşyalarına zarar verir.  |
| 0                    | 1 | 2 | 21. Ailesine ya da başkalarına ait eşyalara zarar verir.   |
| 0                    | 1 | 2 | 22. Evde söz dinlemez.   |
| 0                    | 1 | 2 | 23. Okulda söz dinlemez.   |
| 0                    | 1 | 2 | 24. İştahsızdır.   |
| 0                    | 1 | 2 | 25. Başka çocuklarla geçinemez.  |
| 0                    | 1 | 2 | 26. Hatalı davranışından dolayı suçluluk duymaz, oralı olmaz, aldırılmaz.  |
| 0                    | 1 | 2 | 27. Kolay kıskanır.  |
| 0                    | 1 | 2 | 28. Ev, okul ya da diğer yerlerde kurallara uymaz, karşı gelir.  |
| 0                    | 1 | 2 | 29. Bazı hayvanlardan, durumlardan (yüksek yerler) ya da ortamlardan (asansör, karanlık gibi) korkar. (Okulu katmayınız).                |

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- 0 1 2 30. Okula gitmekten korkar, okul korkusu vardır.
- 0 1 2 31. Kötü bir şey düşünebileceği ya da yapabileceğinden korkar.
- 0 1 2 32: Kusursuz, dört dörtlük ve her konuda başarılı olması gerektiğine inanır.
- 0 1 2 33. Kimsenin onu sevmediğinden yakınıdır.
- 0 1 2 34. Başkalarının ona karşı olduğu, zarar vermeye, ya da açığını yakalamaya çalıştığı hissine kapılır.
- 0 1 2 35. Kendini değersiz, önemsiz ya da yetersiz hisseder.
- 0 1 2 36. Bir yerlerini kaza ile sık sık incitir.
- 0 1 2 37. Çok kavga çıkarır, kavgaya karışır.
- 0 1 2 38. Çok fazla sataşılır, dalga geçilir.
- 0 1 2 39. Başı belada olan kişilerle dolaşır.
- 0 1 2 40: Olmayan sesler ve konuşmalar işitir.  
(Açıklayınız): \_\_\_\_\_
- 0 1 2 41. Düşünmeden hareket eder, aklıma eseni yapar.
- 0 1 2 42. Başkalarıyla birlikte olmaktansa yalnız olmayı tercih eder.
- 0 1 2 43. Yalan söyler, hile yapar, aldatır.
- 0 1 2 44. Tırnaklarını yer.
- 0 1 2 45. Sinirli ve gergindir.
- 0 1 2 46. Kasları oynar, seğirmeleri ve tikleri vardır.  
(Açıklayınız): \_\_\_\_\_
- 0 1 2 47. Geceleri kabus görür.
- 0 1 2 48. Başka çocuklar tarafından sevilmez.
- 0 1 2 49. Kabızlık çeker.
- 0 1 2 50: Çok korkak ve kaygılıdır.
- 0 1 2 51. Başı döner, gözleri kararır.
- 0 1 2 52. Kendini çok suçlu hisseder.
- 0 1 2 53. Aşırı yer.
- 0 1 2 54. Sebepsiz yere çok yorgun hissettiği olur.
- 0 1 2 55. Fazla kiloludur.
- 0 1 2 56. Sağlık sorunu olmadığı halde;  
a. Ağrı ve sızılardan yakınıdır. (Baş ve karın ağrısı dışında).  
b. Baş ağrılarında yakınıdır (şikayet eder).  
c. Bulantı, kusma duygusu olur  
d. Gözle ilgili şikayetleri olur. (Gözlük, lens kullanma dışında).  
(Açıklayınız): \_\_\_\_\_
- 0 1 2 e. Döküntü, pullanma ya da başka cilt hastalığı olur.
- 0 1 2 f. Mide-karın ağrısından şikayet eder.
- 0 1 2 g. Kusmaları olur.
- 0 1 2 h. Diğer (açıklayınız): \_\_\_\_\_
- 0 1 2 57. İnsanlara vurur, fiziksel saldırıda bulunur.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- 0 1 2 58. Burnunu karıştırır, derisini ya da vücudunu yolar, saç ve kirpiğini koparır. (Açıklayınız): \_\_\_\_\_
- 0 1 2 59. Herkesin içinde cinsel organıyla oynar.
- 0 1 2 60. Cinsel organıyla çok fazla oynar.
- 0 1 2 61. Okul ödevlerini tam ve iyi yapamaz.
- 0 1 2 62. El, kol, bacak hareketlerini ayarlama güçlük çeker, sakardır.
- 0 1 2 63. Kendinden büyük çocuklarla vakit geçirmeyi tercih eder.
- 0 1 2 64. Kendinden küçüklerle vakit geçirmeyi tercih eder.
- 0 1 2 65. Konuşmayı reddeder.
- 0 1 2 66. İstemeyerek de olsa, belli bazı davranışları tekrar tekrar yapar. (Elini defalarca yıkama, kapı kilidini tekrar tekrar kontrol etme gibi). (Açıklayınız): \_\_\_\_\_
- 0 1 2 67. Evden kaçır.
- 0 1 2 68. Çok bağırır.
- 0 1 2 69. Sırlarını kendine saklar, hiç kimseye paylaşmaz.
- 0 1 2 70. Olmayan şeyleri görür. (Açıklayınız): \_\_\_\_\_
- 0 1 2 71. Topluluk içinde rahat değildir, başkalarının kendisi hakkında ne düşünecekleri ve ne söyleyecekleriyle ilgili kaygı duyar.
- 0 1 2 72. Yangın çıkartır.
- 0 1 2 73. Cinsel sorunları vardır. (Açıklayınız): \_\_\_\_\_
- 0 1 2 74. Gösteriş meraklısıdır, maskaralık yapar.
- 0 1 2 75. Çok utangaç ve çekingendir.
- 0 1 2 76. Diğer çocuklardan daha az uyur.
- 0 1 2 77. Gece ve/veya gündüz diğer çocuklardan daha çok uyur. (Açıklayınız): \_\_\_\_\_
- 0 1 2 78. Dikkati kolayca dağılır.
- 0 1 2 79. Konuşma problemi vardır. (Açıklayınız): \_\_\_\_\_
- 0 1 2 80. Boş gözlerle bakar.
- 0 1 2 81. Evden bir şeyler çalar.
- 0 1 2 82. Ev dışındaki başka yerlerden bir şeyler çalar.
- 0 1 2 83. İhtiyacı olmadığı halde birçok şey biriktirir. (Açıklayınız): \_\_\_\_\_
- 0 1 2 84. Tuhaf, alışılmadık davranışları vardır. (Eşyaların belli bir düzende ve sırada olmasını isteme gibi). (Açıklayınız): \_\_\_\_\_
- 0 1 2 85. Tuhaf, alışılmadık düşünceleri vardır (bazı sayıları, sözcükleri tekrarlama ve bunları zihninden atamama gibi). (Açıklayınız): \_\_\_\_\_
- 0 1 2 86. İnatçı ve huysuzdur.
- 0 1 2 87. Ruhsal durumu ya da duyguları çabuk değişir.
- 0 1 2 88. Çok sık küser.

0: Doğru değil (Bildiğiniz kadarıyla) 1: Bazen/Biraz doğru 2: Çok/Sıklıkla doğru

- 0 1 2 89. Şüphelidir, kuşku duyar.  
0 1 2 90. Küfürlü ve açık saçık konuşur.  
0 1 2 91. Kendini öldürmekten söz eder.  
0 1 2 92. Uykuda yürür ve konuşur.  
(Açıklayınız): \_\_\_\_\_  
0 1 2 93. Çok konuşur.  
0 1 2 94. Başkalarına rahat vermez, onlara sataşır, onlarla çok dalga geçer.  
0 1 2 95. Öfke nöbetleri vardır, çabuk öfkelenir.  
0 1 2 96. Cinsel konuları fazlaca düşünür.  
0 1 2 97. İnsanları tehdit eder.  
0 1 2 98. Parmak emer.  
0 1 2 99. Sigara içer, tütün çiğner.  
0 1 2 100. Uyumakta zorlanır.  
(Açıklayınız): \_\_\_\_\_  
0 1 2 101. Okuldan kaçır, dersini asar.  
0 1 2 102. Hareketleri yavaştır, enerjik değildir.  
0 1 2 103. Mutsuz, üzgün ve çökkündür. (Depresyondadır).  
0 1 2 104. Çok gürültücüdür.  
0 1 2 105. Sağlık sorunu olmadığı halde madde kullanır. (İçki ve sigarayı katmayınız). (Açıklayınız): \_\_\_\_\_  
0 1 2 106. Çevresindeki kişi ve eşyalara kasıtlı olarak zarar verir, zorbalık eder.  
0 1 2 107. Gündüz altını ıslatır.  
0 1 2 108. Gece yatağını ıslatır.  
0 1 2 109. Mızırdanır, sızlanır.  
0 1 2 110. Karşı cinsiyetten biri olmayı ister.  
0 1 2 111. İçine kapanıktır, başkalarıyla kaynaşmaz.  
0 1 2 112. Evhamlıdır, her şeyi dert eder.  
0 1 2 113. Çocuğun yukarıdaki listede belirtilmeyen başka sorunu varsa lütfen yazınız: \_\_\_\_\_

## Appendix C: Scoring Sheet for the Therapy Process Observational Coding System-Alliance Scale (TPOCS-A)

### A. Baę Alt Ölçeęi

Ařaęıdaki ölçeęi kullanarak, lütfen çocuk ve terapistin bu seanstaki baęlarına dair deęerlendirmenizi belirtin. Bu ölçekte baę, çocuk ile terapistin iliřkisinde ne kadar 1) Olumlu duygulanım (örn. sevmek, anlamak, önemsemek) ve 2) Karřılıklı güven olduęudur. Lütfen ařaęıdaki her puanlamayı tüm seansı düşünerek yapın. İlgili numarayı sorunun yanında bırakılan boşluęa yazın.

0 1 2 3 4 5  
Hiç Biraz Çok

1. Çocuk ne sıklıkta/yoęunlukta terapistin anlayıřlı ve destekleyici olduęunu belirtti? \_\_\_\_
2. Çocuk ne sıklıkta/yoęunlukta terapistte düşmanca, eleřtirel veya savunmacı bir tutumla davrandı? \_\_\_\_
3. Çocuk ne sıklıkta/yoęunlukta terapistte olumlu duygular ifade etti? \_\_\_\_
4. Çocuk ne sıklıkta deneyimini terapist ile paylařtı? \_\_\_\_
5. Çocuk ne sıklıkta terapist ile etkileřiminde rahatsız görünüyordu? \_\_\_\_
6. Çocuk ve terapist ne sıklıkta birbirleriyle etkileřim halindeyken huzursuz veya rahatsız görünüyorlardı? \_\_\_\_

### B. Görev Alt Ölçeęi

Ařaęıdaki ölçeęi kullanarak, lütfen bu seanstaki terapötik görevlere dair deęerlendirmenizi belirtin. Bu ölçekte terapötik görev, 1) Terapist tarafından uygulanan terapötik müdahaleler (yorum yapmak, soru sormak, terapötik sınır koymak, vb.) ve 2) Çocuęun terapötik müdahaleleri kullanma ve takip etmeye dair (oyun oynamak, duygu ve düşüncelerini ifade etmek, terapistin söyledięini detaylandırmak, konulan sınıra uymak, vb.) isteklilięi. Lütfen ařaęıdaki her puanlamayı tüm seansı düşünerek yapın. İlgili numarayı sorunun yanına yazın.

0 1 2 3 4 5  
Hiç Biraz Çok

7. Çocuk ne sıklıkta/yoęunlukta terapötik görevleri seans dıřında, hayatında deęiřiklik yapmak için kullandı? \_\_\_\_
8. Çocuk ne sıklıkta/yoęunlukta terapötik görevlere uyum göstermedi? \_\_\_\_
9. Çocuk ve terapist ne sıklıkta/yoęunlukta terapötik görevler üzerinde beraber, eřit bir řekilde çalıştılar? \_\_\_\_