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Philadelphia College of Osteopathic Medicine

Department of Psychology

THE THERAPEUTIC RELATIONSHIP AND ALLIANCE-BUILDING BEHAVIORS:

TREATMENT IMPLICATIONS FOR CHILDHOOD SOCIAL PHOBIA

William La Valle

Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of

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Abstract

The importance of alliance in therapy has been well documented. This study explored specific therapist behaviors and their relationship to child perceived alliance and outcome in a randomized controlled trial of a cognitive-behavioral treatment for youth anxiety disorders. Participants included 42 youth (male = 24; female = 18; Caucasian = 37; African American = 4; Hispanic = 1) between the ages of 7 and 13 years who met criteria for a principal anxiety diagnosis. The study examined the sample as a whole, as well as focused specifically on youth diagnosed with social phobia. Videos of the first session of treatment were coded for the presence of 11 therapist behaviors (seven positive and four negative) using the Therapist Alliance Building Behaviors Scale (TABBS). The results indicated that negative-valance therapist behaviors predicted perceived alliance in children who had a principal anxiety diagnosis other than social phobia. Findings suggest that avoiding negative behaviors may have more of an effect on alliance than engaging in positive behaviors with some populations. Future research should continue to identify therapist behaviors that might contribute to or rupture a working alliance in the youth population.

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Chapter 1: Introduction

Cognitive behavioral therapy (CBT) is an evidence-based treatment that has been proved effective in the youth population (Barrett, Duffy, Dadds, & Rapee, 2001; Legerstee et al., 2010). Techniques within many of the CBT treatment protocols, such as systematic desensitization, relaxation training, and the downward arrow, are effective in reducing anxiety-related symptoms (Silverman, Pina, & Viswesvaran, 2008).

However, as with any treatment modality, extraneous factors can influence treatment outcome. Identifying and understanding these factors are essential for a successful outcome. External factors occur outside of treatment (treatment adherence, environmental factors) and internal factors occur in session (therapeutic alliance, openness, and honesty); both may affect a client's response to treatment. Attempting to identify nonspecific therapeutic factors (i.e., working alliance) is essential to understanding all aspects of the treatment process (Ilardi & Craighead, 1994).

Of the many factors that may affect treatment outcome, therapeutic alliance has become an emerging topic of research interest, especially within the context of anxiety disorders (Chu & Kendall, 2009). Research has identified alliance as a significant factor that can impact treatment. Recent research has found significant relationships between alliance and treatment outcome across multiple populations, including youth (Chiu, McLeod, Har, & Wood, 2008; Creed & Kendall, 2005; Green 2006; Horvath, Del Re, Fluckiger, & Symonds, 2011).

Although research in psychology widely accepts that alliance plays some part in treatment, the role that alliance plays has been highly debated throughout studies. The

conceptualization of the therapeutic alliance is vital to understanding its impact on treatment. How the alliance is conceptualized also has been debated throughout the years. Perhaps the most widely accepted conceptualizations are those grounded in Bordin's (1979) model, which suggests three key components of a successful alliance: tasks, goals, and bonds. The conceptualization suggests that a successful alliance is formed when these three components have been facilitated. A successful alliance is contingent on the interdependent relationship between the therapist and client.

The majority of research thus far has focused on exploring the relationship between alliance and anxiety disorders in general. Research is limited in understanding alliance in the context of more specific anxiety disorders, such as social phobia. However, emerging studies suggest the importance of comparing the specific anxiety disorders to each other, as the underlying cognitions associated with each may be differentially affected by alliance, some more than others (Alden & Taylor, 2004). For example, clients with social phobia often struggle with forming new relationships and learning to trust others (Eng, Heimberg, Hart, Schneier, & Leibowitz, 2001). Problems related to forming relationships create challenges for the therapist that she or he may not face when treating other anxiety disorders. Understanding how a successful working relationship is formed and the role alliance plays in negating many of these challenges could be vital to the successful treatment of clients struggling with social anxiety. Further research is needed to examine the relationship between alliance and the treatment of the population with social anxiety, in order to provide further insight into how treatment should be approached.

The purpose of this study is to examine the effect that alliance plays in the treatment of youth with anxiety disorders and, in particular, with social phobia. Specifically, the study attempts to identify therapist behaviors that facilitate a successful alliance and the relationship these behaviors have to the reduction of anxiety symptoms in this population. The following literature review is presented to support the rationale for conducting the current study, which attempts to further explore how an alliance is created in the youth population, as well as to examine possible relationships between these behaviors and symptom change, particularly in the youth population with social phobia. The literature review outlines research regarding the conceptualization of alliance as well as theories regarding its development or formation. The review also examines research that suggests various methods of measuring alliance, as well as its relationship to outcome. Lastly, the literature review explores why an examination of the aforementioned relationships of alliance and treatment may be of particular importance within the youth population with social phobia.

Conceptualizing the Therapeutic Alliance

Throughout this review, the terms *therapeutic alliance* and *working alliance* are used interchangeably, as they have been referenced in both ways across studies. Early research conceptualized the therapeutic alliance by focusing on the transference between the client and therapist (Safran & Mura, 2006). The alliance was viewed as a by-product of the interpersonal exchanges that take place between the client and therapist. The descriptions used to describe both alliance and transference were very similar and viewed as the emotions that were exchanged between the client and therapist. However, this

conceptualization was later reformulated to separate both transference and treatment

processes from the working alliance. Bordin (1979) made clear distinctions among

transference, treatment, and the alliance. Bordin described the working alliance as

making it possible for the patient to both accept and follow treatment faithfully (Bordin,

1980). This description clearly distinguishes the working alliance as a separate entity

from treatment. Furthermore, it recognizes that alliance can have an impact on treatment.

Bordin's (1979) conceptualization of the therapeutic alliance focuses on the

interdependent processes that take place between the client and therapist. Bordin uses the

term *interdependent* to refer to the exchanges that take place between the client and

therapist that may affect each other's perceptions of alliance. Bordin asserted that this

interdependent relationship is separate from the therapeutic techniques utilized by the

therapist. Research studies have continued to support the alliance as an independent

process, separate from treatment (Elvins & Green, 2008; Frank & Frank, 1991;

Hougaard, 1994).

Bordin (1979) identified the key components that comprise the therapeutic

alliance: *tasks, goals,* and *bonds.* The first component, *tasks*, refers to the behaviors and

cognitions that take place in session. In a successful therapeutic alliance, both the

therapist and the client find the tasks that occur in treatment to be helpful and efficacious.

The second component, *goals,* refers to the mutually agreed upon target outcomes that

the therapist and client are hoping to achieve. The last component, *bonds,* refers to the

personal attachment between the therapist and client, including such issues as trust,

acceptance, and confidence. Bordin's research suggests that if these three components are

successfully addressed, the client and therapist will perceive a positive alliance (Bordin, 1979; Horvath & Greenberg, 1989).

Although conceptualizations of alliance have continued to develop and evolve, most are still grounded in Bordin's (1979) model (Chiu, et al., 2008; Creed & Kendall, 2005; Green, 2006; Horvath et al., 2011). Horvath et al. (2011) extrapolated on Bordin's model by emphasizing the importance of collaboration and consensus between the client and therapist. This idea is vital to understanding current conceptualizations, as it views alliance as a product of conscious processes. Alliance as a conscious process is contrary to previous schools of thoughts in which alliance is viewed as a result of unconscious processes that result from exchanges between the client and therapist (Freud, 1912; Rogers & Wood, 1974). This distinction is important because previous conceptualizations asserted that the alliance could not be consciously formed or changed. However, conceptualizing the alliance as a result of conscious processes implies that the alliance should be able to be formed or changed through efforts of the therapist (i.e., engaging in behaviors that foster alliance; Bordin, 1979; Horvath et al., 2011).

The findings from the American Psychological Association (APA) Task Force on Empirically Supported Relationships have also supported the expanded conceptualization of Bordin's model described in the Horvath et al. (2011) research, recognizing the importance of collaboration and mutual goal setting (Karver, Handelsman, Fields, & Bickman, 2006; Norcross, 2002). The APA Task Force recognized alliance as an essential component of treatment and created a committee dedicated to research in alliance. However, the Task Force failed to include the childhood population in its study.

Thus far, as demonstrated in the research by the APA Task Force, many studies have focused on exploring alliance in the adult population. However, recent studies are beginning to explore alliance in the youth population (Green, 2006) and have also begun to adopt Bordin's conceptualization. For example, Karver et al. (2005) adapted Bordin's model to children and proposed three revised components of alliance: emotional/affective connection (bond), a cognitive connection (agreement on goals), and a behavioral connection (collaboration on tasks; Karver & Caporino, 2010; Karver et al., 2005). This study and other research using conceptualizations grounded in Bordin's model of alliance suggest a number of reasons that alliance may be especially important in the childhood population.

Studies suggest that certain treatment barriers that are found to be more prevalent in the youth population may be assuaged by the formation of a positive alliance. Proschaska, DiClemente, & Norcross (1992) described a model that illustrates a client's readiness to change. This model suggests that people entering therapy may have different attitudes about their willingness or ability to change (pre-contemplative, contemplative, action, and maintenance). Most people who are self-referred to treatment begin therapy in the contemplative or action stages, meaning they are already thinking about change and/or already taking steps towards change. However, the most difficult clients are those who begin treatment in the precontemplative stage. Clients in this stage have not yet begun to think about change and/or may not have identified the need to change. A good example would be clients struggling with substance abuse who have been court ordered to attend treatment (DiGiuseppe, Linscott, & Jilton, 1996). Additionally, children who are

not self- referred also may begin treatment in the precontemplative stage. Research has

suggested several ways in which a positive working alliance can help move the child to

the next stage of change. These include increasing the child's openness to her or his

understanding of treatment and gaining self-awareness (Shirk & Saiz, 1992; Green, 2006;

Karver, Handelsman, Fields, & Bickman, 2005).

Some studies suggest that children have a limited understanding of treatment

(Green, 2006; Shirk & Saiz, 1992). Children may not understand the reason for their

referral or may not recognize that the treatment could be helpful. Thus, developmental

and cognitive limitations of children can pose as treatment barriers (DiGiuseppe et al.,

1996). However, research shows that children who quickly form a positive alliance with

the therapist are often more willing to be open and more receptive to information

presented by the therapist (Elvins & Green, 2008).

Similarly, even if children have a cognitive understanding of therapy, they may

lack self-awareness. Many children who enter treatment are not self-referred and may be

resistant to starting treatment, as they are not cognizant of their own symptoms or how

those symptoms are affecting themselves and others around them (Karver et al., 2005).

However, studies show that a strong working alliance between the child and therapist can

facilitate the child's engagement in treatment. Children who form a strong working

alliance with the therapist increase in self-awareness more rapidly as they are more apt to

engage in the therapeutic process with the therapist (DiGuiseppe et al., 1996; Green,

2006).

In summary, children usually are not self-referred to treatment and possess a

limited understanding of their current needs, often resulting in resistance to treatment.

Their limited understanding can create barriers that impede the child's treatment.

However, understanding Bordin's conceptualization of alliance may help researchers to

understand why alliance may be a key component in eliminating or avoiding these

potential barriers. The key components of Bordin's model empower the client to engage

in treatment as a collaborative process, as the model includes components like agreement

on the goals of therapy, understanding of the tasks of therapy, and development of a bond

between the client and therapist (DiGuiseppe et al., 1996). Many of the aforementioned

barriers to treatment in the childhood population may be lessened through the successful

facilitation of these components.

Alliance-Building Behaviors

According to Bordin's model, the alliance is composed of conscious processes

that comprise the key components of the relationship: tasks, bonds, and goals. These

processes are contingent on the *mutual* and *reciprocal* exchanges that take place between

the client and therapist. Behaviors exhibited by both the therapist and client may

determine the successful formation of an alliance. Research on these behaviors may carry

important treatment implications regarding what constitutes a successful alliance.

Alliance-building behaviors may play a vital role in the development of these key

components of the relationship. Alliance-building behaviors may impact the development

of efficacious in-session activities that promote positive cognitions about therapy (tasks),

develop mutually agreed upon targets of treatment (goals), and develop trust and a positive therapist-client relationship (bonds). The identification of such behaviors may be vital to understanding how an alliance is formed.

Recent research suggests that engaging in certain behaviors in early sessions of treatment results in the successful formation of a positively perceived alliance (e.g., Horvath et al., 2011; Horvath & Greenberg, 1994; Russell, Shirk, & Jungbluth, 2008; Shirk & Karver, 2003). Horvath et al. (2011) demonstrated the importance of establishing a therapeutic alliance in early sessions in an adult population. The study showed that utilizing alliance-building behaviors early in treatment resulted in lower drop-out rates and aided in the facilitation of the key components of an alliance. The identified alliance-building behaviors in this study included adapting the tasks or activities used in therapy to suit the client's needs, expectations, and capacities (tasks); collaborating with the client to formulate mutual goals (goals); and carefully bridging the client's expectations and the therapist's expectations of which goals are believed to be most important (bonds). The study found that engaging in these behaviors contributed to the development of a positive therapeutic alliance.

Findings from this study further revealed that the client's perception of alliance in each individual session was directly impacted by the therapist's behaviors (Horvath et al., 2011). For example, overchallenging clients to deal with difficult issues, misunderstandings, and negative transference contributed to poorer alliance ratings. Conversely, nondefensive responses to the client's negativity contributed to the maintenance of a positive therapeutic relationship. Although fluctuation in perceived

alliance occurred in individual sessions, the largest fluctuation in perceived alliance

occurred as the result of behaviors occurring in the first session. The study hypothesized

that therapists may be able to self-monitor their behaviors (especially in the first session

of treatment), which might enable therapists to consciously facilitate a successful

working alliance with their client.

Other studies have found similar results in the youth population. One recent study

identified therapists' alliance-building behaviors using the Adolescent Alliance Building

Scale (Russell et al., 2008; Shirk & Karver, 2003). A study by Russell et al. (2008)

involved 54 adolescents who were receiving CBT for the treatment of depression.

Researchers coded the first session of treatment in 10-minute segments for specific

therapist behaviors. The therapist behaviors that contributed to the formation of a positive

alliance included eliciting information from a client, attending to the subjective

experience, utilizing praise effectively, formulating meaningful goals, and orienting the

client to the collaborative nature of treatment. This study also identified behaviors that

had a negative impact on the development of an alliance. Those negative behaviors

included: therapist disconnect, failure to acknowledge expressed emotions, and criticizing

or expressing anger toward the client. These behaviors were negatively correlated with

alliance.

Russell et al. (2008) grouped the identified alliance-building behaviors into four

categories based upon their contribution to the overall variance among the therapist's

behaviors contributing to perceived alliance. The first category, experiential socialization,

included those behaviors that involved clear social techniques, such as collaboration, and

accounted for 17% of the total variance in reported alliance perceptions. The second

category, therapist responsiveness, included experiential and cognitive-focused

techniques (eliciting information, cognitive restructuring), accounting for 16.4% of the

total variance. The third category, therapist lapses, included behaviors that negatively

contributed to the overall alliance (negative attitude, criticism), which accounted for 11%

of the variance. The last category, remoralization, consisted of motivational techniques

and accounted for 8% of the variance. Overall, the study surmised that the interaction of

these four clusters of behaviors contributed to overall perceived alliance and suggested

that further research examine the impact they may have on outcome (Russell et al., 2008).

Additionally, the identified alliance-building behaviors in the first session of treatment

had the largest effect on perceived alliance in later sessions. This study asserted that

engaging in alliance-building behaviors in early sessions of treatment may predict

perceived alliance in later sessions.

    As the research demonstrating the importance of utilizing alliance-building

behaviors has grown, studies are beginning to examine ways that therapists may be taught

to actively engage in these behaviors. A study by Crits-Christoph et al. (2006) examined

whether therapists could be trained to be cognizant of alliance-building behaviors in order

to directly affect perceived alliance. Using Bordin's (1979) conceptualization of alliance,

Crits-Christoph et al. (2006) trained five therapists in alliance-fostering interventions.

Each therapist treated three patients for depression over 16 weeks. The therapists treated

clients in three phases: using their usual approach to treatment, using the alliance-

fostering approach with supervision, and using the alliance-fostering approach without

supervision. The alliance training taught therapists about Bordin's model of alliance, focusing on how to separate the alliance from treatment. The training also taught therapists how to self-monitor alliance-building behaviors in order to address Bordin's key components of alliance: tasks, goals, and bonds.

The findings demonstrated a fairly large effect ($d = 0.77$) from pretraining to posttraining (Crits-Christoph et al., 2006), as an increase in alliance was found following training. Results were mixed across therapists regarding the degree to which they were able to actively engage in alliance behaviors, suggesting that further research should be done to standardize alliance trainings. The study recommended that future research might accomplish standardizing trainings by understanding which behaviors are most important to building alliance, as well as which of these behaviors can most easily be learned by therapists. The study laid the groundwork for the development of an alliance-building training protocol in future studies.

Overall, studies have suggested that early alliance-building behaviors may play a vital role in contributing to a successful alliance (Crits-Christoph et al., 2006; Horvath et al., 2011; Russell et al., 2008). Furthermore, although research is still limited, studies have begun to suggest that therapists can be trained to utilize specific behaviors to foster alliance. The continued study of behaviors that influence the client's perception of alliance is important.

Measuring Alliance with Children and Adolescents

Research has developed several methods of measuring alliance in the youth population. The way that alliance is measured depends largely on the way it is conceptualized by the researcher. Researchers have not yet reached a consensus on the most effective way of measuring alliance, nor have they reached a consensus on the components of alliance they feel are most important in affecting treatment (Elvins & Green, 2008).

As previously discussed, Bordin's (1979) conceptualization of alliance recognizes the working relationship as independent from treatment interventions (i.e., nonspecific therapeutic factor). Therefore, using this model, alliance should be examined as its own entity in order to understand its development and its relationship to treatment outcome. This section will review methods of measuring alliance and discuss the strengths and limitations of these measures.

One method of evaluating the level of perceived alliance is through self-report measures. These measures, often completed by both the therapist and client, reveal information about their perceptions of the alliance. Horvath and Greenberg (1989) developed one of the first self-report measures, the Working Alliance Inventory (WAI). The WAI was developed from Bordin's (1979) conceptualization of alliance, as it sought to measure alliance independently from treatment. The measure consisted of 36 questions, which together addressed the three key components of alliance: tasks, bonds, and goals. This measure helped to operationalize alliance, and the summation of the

responses determined the level of perceived alliance. However, this measure is

commonly criticized because it focuses solely on the emotional relationship formed

between the client and therapist (bonds) but fails to adequately address the mutual

collaboration and mutual exchange (goals and tasks), which are essential to the

development of a complete alliance, according to Bordin's model (Elvins & Green, 2008;

Hatcher & Barends, 1996).

In addition to finding a measure that addresses all of the essential components of

alliance, DiGiuseppe et al. (1996) also asserted the importance of developing self-report

measures specifically designed for use with the youth population. However, very few

measures have been designed specifically for children. Rather, most measures utilized in

studies with children are adaptations of adult measures. Some studies have made attempts

to simplify the reading level of the measure, such as with the WAI (DiGiuseppe et al.,

1996). One of the few measures developed specifically for youth was the Family

Engagement Questionnaire (Kroll & Green, 1997). However, this measure focused

mainly on child and parent engagement and did not adequately address all of the key

components of Bordin's (1979) model of alliance.

The first self-report measure that was grounded in Bordin's (1979) model of

alliance and developed specifically for a youth population was the Therapeutic Alliance

Scales for Children (TASC; Shirk & Saiz, 1992). The researchers constructed items that

addressed the three components of alliance: tasks, goals, and bonds. They created three

subscales on a self-report measure that included the child's affective experience of

therapy in a positive bond, the negative affective response to therapy subscales, and

collaboration of tasks of therapy. The researchers reported adequate internal consistency

and moderate convergence between the therapists' and children's versions of the scale.

These findings emphasized the relevance of all three components of Bordin's (1979)

model and suggested the importance of measuring all three of Bordin's proposed

components in order to obtain an accurate representation of perceived alliance

(DiGiuseppe et al., 1996; Shirk & Saiz, 1992). This study provided a framework for the

development of child self-report measures of alliance.

A more recently developed measure is the Therapeutic Alliance Scale for

Children-Revised (TASC-R; Creed & Kendall, 2005). The measure is a modified version

of the Therapeutic Alliance Scales for Children (TASC; Shirk & Saiz, 1992). This

version was shortened in order to make its completion easier at the end of every session,

which allows for ongoing feedback. The modified version (TASC-R) is a 12-item, 4-

point Likert scale completed by both the child (i.e., "I liked spending time with my

therapist"; I felt like my therapist was on my side and tried to help me") and the therapist

("The child liked spending time with you, the therapist"; "The child considered you an

ally"; Creed & Kendall, 2005). The summation of ratings about the alliance reported by

the child and therapist is translated into a single "overall score."

An advantage of using a self-report measure of alliance, such as the TASC-R, is

that it allows for direct feedback. Since perceptions of alliance are subjective, self-report

measures allow one to gather information directly from the client and therapist about

their experience of the relationship (Kendall et al., 2009). The TASC-R attempts to

operationalize alliance into an objective measure to eliminate any subjective

interpretation. However, studies have shown that solely using a self-report measure is often prone to Type I statistical errors since therapist and patient ratings are often intercorrelated (Shirk & Karver, 2003).

In order to avoid Type I errors, converging self-report scales with another measure may be important to obtain a more accurate representation of alliance. Observational measures, used in conjunction with self-report measures, can be an effective means of measuring alliance. In addition to gathering feedback about the perceived alliance from self-report measures, identifying and measuring alliance-building behaviors may also be important. As discussed previously, the identification of alliance-building behaviors (or lack thereof) may provide pertinent information about the perceived alliance. For example, if a client perceives a negative alliance, the therapist might be helped by understanding what behaviors could have contributed to this perception.

Observational methods are perhaps the most effective way to identify and measure behaviors during treatment sessions. The Alliance Observation Coding System (Karver, Shirk, Day, Field, & Handelsman, 2003) allows researchers to observe and identify behaviors during exchanges between the therapist and client. The coders identify behaviors such as disclosing information, reacting to questions, and making comforting statements. This measure was developed with an adolescent population.

Research by Creed and Kendall (2005) also explored an observational method of identifying behaviors in treatment that foster a successful alliance. The measure utilized

was an alliance-building inventory called the Therapeutic Alliance Building Behaviors

Scale (TABBS). The TABBS measures behaviors that research has suggested contribute

to the development of the key components of a therapeutic alliance: tasks, goals, and

bonds. The coders utilize the measure by viewing the treatment sessions and rating the

therapist's alliance-building behaviors on a 4-point scale. The first behavior, *customizing

the session*, occurs when the therapist tailors the session to the specific client. The

therapist is also rated on *being playful*, which involves presenting tasks and therapy in an

age-appropriate and playful manner. The next behavior, *providing hope and

encouragement,* is evident when the therapist sets a positive tone to the session. The

therapist is also rated on how well she or he *collaborates* with the client, setting mutual

goals and agreeing on points of treatment. The next behavior, *validating* the client's

thoughts and beliefs, occurs when she or he shows respect for and understanding of the

client's feelings. Additionally, the therapist is coded on how well she or he incorporates

general conversations into the session, which aid in the facilitation of a comforting and

safe environment. Lastly, the therapist is rated on how well she or he finds *common

ground* with the client, emphasizing and utilizing communality to promote a positive

alliance (Creed & Kendall, 2005). These behaviors are positively correlated with many

of the key components of alliance.

The TABBS also identifies negative-valence behaviors, which are those behaviors

that are negatively correlated with perceived alliance. The first behavior, *pushing the

child to talk*, occurs when the therapist pressures the client to talk beyond her or his level

of comfort. Another behavior is evident when the therapist is *being too formal* and

appears to make the environment uncomfortable for the client. Also, *not following through on promises* may disappoint the client's expectations, leading to a negative alliance. The last negative-valence behavior is evident when the therapist *talks at an inappropriate level,* such as failing to use age-appropriate language or engaging in conversations that exclude the client while she or he is in the same room. The summation of the coder's ratings of the therapist's positive- and negative-valence behaviors shows how well the therapist used behaviors to foster an alliance, which allows the researcher to hypothesize perceived alliance.

Measuring alliance-building behaviors is a way to predict perceived alliance in later sessions. A limitation of this method is that the behaviors are based on the coders' subjective perceptions of the treatment session interactions. However, tools like the TABBS are useful in predicting alliance, particularly in the childhood population. Because of their cognitive development, children may not be as cognizant as adults of their perceptions of alliance. A third-party coder, however, may be able to identify exchanges between the therapist and client that predict alliance.

In summary, alliance can be measured directly through self-report measures, allowing for direct feedback about the client's and therapist's perceptions of alliance. A more indirect method is to identify behaviors that have been shown to facilitate a positive alliance. This method is useful in predicting alliance in later sessions.

Alliance and Outcome

Although independent from actual interventions, studies have begun to suggest an important relationship between the development of a successful working alliance and treatment outcome (Green, 2006; Martin, Garske, & Davis, 2000; Norcross, 2002). This working relationship, driven by components of the exchanges that take place between the client and therapist, may have a significant effect on a client's progress throughout treatment.

Thus far, a large amount of research on the relationship between alliance and outcome has focused on the adult population. Studies within this population have found significant relationships between alliance and treatment outcome in adults (Green, 2006; Norcross, 2002). A meta-analysis by Martin et al. (2000) found a positive relationship between treatment outcome and working alliance across 79 studies. Specifically, the meta-analysis revealed a moderate and stable relationship between alliance and outcome across the studies.

The relationship between outcome and alliance has continued to be illustrated in more recent studies. For example, Webb et al. (2011) conducted a study to examine the impact that therapeutic alliance has on the treatment of depressive symptoms. The study used recorded CBT treatment sessions that were coded to rate the quality of the therapeutic alliance during the third and third from last sessions. The study utilized 105 adult participants. Results from the study demonstrated that a strong therapeutic alliance was associated with fewer reported symptoms of depression following CBT.

Despite significant findings of studies examining alliance in the adult population, research has not been as expansive within the childhood population, and some studies have revealed mixed findings regarding the role alliance may play in affecting treatment outcome in youth. Liber et al. (2010) conducted a study to examine the role alliance and adherence may play in mediating treatment outcome. The participants in the study were 52 children (ages 8 – 12 years) undergoing CBT treatment for anxiety disorders. Observers were trained in coding videotaped sessions for adherence and child-therapist alliance, and anxiety levels were measured pre-, mid-, and posttreatment using self-reports. Initial findings indicated high levels of adherence and child-therapist alliance during treatment, but neither was correlated with outcome. However, using more precise measurements of true pre-post differences (reliable change scores), the researchers found a significant relationship between alliance and treatment outcome. The study suggests that more research is still needed to understand the role alliance may play in the treatment of youth.

More research has begun to support the importance of alliance in the youth population. The relationship between alliance and outcome has been found across a body of other studies. A meta-analysis by Shirk and Karver (2003) found that the working alliance was correlated with outcome across childhood treatment studies. In examining 23 different studies (with a median sample size of 47), treatment outcome was correlated with alliance across developmental levels, types of treatment (CBT, parent training, skills training), and reported problems (disruptive behavior, depression, anxiety). The study

found that the association between outcome and alliance was significant and stable across

the studies (underweighted effect size = 0.25).

Another meta-analysis, by Karver et al., (2006), supported a large to moderate

effect of alliance on treatment outcome. The study examined the degree to which alliance

caused variability in outcome across 49 different studies involving childhood

populations. Specifically, results indicated that therapeutic alliance accounted for the

greatest amount of variability in outcome, as compared to other factors in treatment

(autonomy, therapist self-disclosure).

A study by Kazdin, Marciano, and Whitley (2005) examined the impact that

alliance can have on children referred for oppositional, aggressive, and antisocial

behaviors. These types of behaviors are often associated with clients who can be difficult

to engage in treatment and may present as resistant. The participants included 185

children (ages 3 – 14 years) who were referred to a CBT clinic for family therapy. The

children and their parents completed self-reports about their perceptions of alliance pre-

and posttreatment. The study revealed that the more positively the child-therapist and

parent-therapist alliances were perceived during treatment, the greater the therapeutic

change in the children. Additionally, the study indicated that when alliance ratings were

stronger, perceived barriers to participation and treatment were fewer, and the

participants were more accepting of the treatment techniques.

Studies have shown both direct and indirect relationships between alliance and

outcome. Hawley and Weisz (2005) examined the link between alliance and symptom

improvement in 65 youth (ages 7 – 16 years) and their parents receiving community-based outpatient therapy. The findings indicated that youth alliance was significantly related to both youth and parent reports of symptom improvement. Additionally, parent rating of alliance were significantly related to higher levels of retention (more participation, less frequent cancellations). The study suggests an important relationship between alliance and treatment outcome in youth, both directly via the relationship formed with the youth and indirectly through the relationship formed with the parent.

Studies suggest that the alliance formed with parents can play a very important role in mediating treatment outcomes of children. For example, parents often facilitate treatment for their children by transporting them, making/keeping appointments, disclosing pertinent information about the child, and engaging in interventions at home to promote generalization of treatment (Fields, Handelsman, Karver, & Bickman, 2004; McLeod & Weisz, 2005; Karver & Carporino, 2010). The parent-therapist relationship is found to be moderately correlated with outcomes in youth across many different studies (Karver & Carporino, 2010; Karver et al., 2006; Kazdin, Whitley, & Marciano, 2006; Nock & Photos, 2006). In these instances, alliance plays an indirect or moderating role in treatment outcome.

Other studies have also examined both indirect and direct ways that alliance affects outcome. Shirk, Gudmundsen, Kaplinski, and McMakin (2008) examined 54 adolescents being treated for depressive symptoms in school-based clinics. Alliance was measured via self-reports and structured interviews. Results indicated a modest relationship between adolescent-reported alliance and changes in depressive symptoms (r

= .26). Furthermore, although therapist-reported alliance was minimally related to

outcome, it was predictive of the number of sessions the participants completed.

Therapeutic alliance, in turn, indirectly affected the adolescents' outcome. This finding

suggests that alliance may play both a direct and indirect or mediating role in treatment

outcome.

Studies have continued to demonstrate direct and indirect effects of alliance on

outcome. Research by Chiu, et al., (2008) examined more direct relationships between

child-therapist alliance and clinical outcomes for children specifically in the population

with childhood anxiety. The study utilized 123 CBT therapy sessions with 34 children

diagnosed with anxiety disorders that were videotaped and coded. The results of the study

indicated that higher ratings of the alliance by children early in treatment were associated

with greater anxiety-related symptom reduction at a midtreatment measurement.

Furthermore, the study also found that positive child-therapist alliance ratings were

associated with improvements in internalizing anxiety symptoms posttreatment. For

example, clients who reported a positive alliance reported less overall anxiety following

treatment than did those who perceived a negative alliance. The findings of the study

suggest that fostering a positive alliance early in treatment may be vital to a successful

outcome.

A literature review by Green (2006) focused on the indirect effects of alliance on

outcome. The study examined the impact that alliance has on other variables shown to

correlate with outcome. The findings of the review suggest that alliance may play a

critical role in moderating treatment outcome. For example, a positive therapeutic

alliance results in high levels of child involvement and motivation throughout the course

of treatment, which results in improved outcome (Green, 2006). Children with positive

perceptions of alliance are more motivated to engage in the tasks assigned by the

therapist, feel more in control of their own goals, and are more apt to trust the therapist

throughout treatment. A child who is not invested in therapy or feels that the therapy is

not efficacious is less likely to engage in treatment, resulting in a poorer treatment

response. A successful working alliance may help eliminate these barriers to treatment,

facilitating a successful outcome.

In summary, many studies have suggested that alliance may play an integral part

in treatment within the childhood population (e.g., Chiu et al., 2008; Shirk & Karver,

2003). Studies have suggested that alliance may play both a direct and indirect role in

affecting treatment outcome across a broad spectrum of populations. Some research has

begun to suggest that alliance may play an even more pivotal role in the population with

social anxiety.

Social Anxiety and Alliance

According to the *Diagnostic and Statistical Manual of Mental Disorders,* 4th

edition, text revision (*DSM-IV-TR*; 2000), social anxiety is characterized by a marked or

persistent fear of one or more social/performance situations in which the person is

exposed to unfamiliar people or the scrutiny of others, thus provoking anxiety.

Furthermore, the person often avoids social situations in order to alleviate the anxiety

associated with these interactions. The individual must also be aware of her or his

excessive fear. In children, all of the criteria must be met for at least 6 months (4th ed.,

text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Children with social

phobia often present as withdrawn or disengaged in unfamiliar situations, especially in

social settings.

Children struggling with social anxiety may face challenges that are unique to that

that disorder. Crawley, Beidas, Benjamin, Martin, and Kendall (2008) described social

phobia as a disorder characterized by the fear of one or more social and/or performance

situations. Clients with phobias often engage in exposure exercises to habituate the

anxiety associated with their fear. These exposure exercises can initially provoke high

levels of anxiety. In many ways, treatment sessions are exposure exercises for clients

struggling with social anxiety. In session, social exchanges take place between the

therapist and the client, which may provoke anxiety in clients struggling with a social

phobia (Alden & Taylor, 2004). For these reasons, treatment sessions, especially the

initial one, may be particularly difficult for clients with social anxiety. Initial anxiety at

the first session poses an immediate treatment concern for therapists when trying to treat

clients with social anxiety.

Additionally, research has examined behaviors associated with social anxiety in

children that pose additional barriers to treatment. Children who struggle with social

anxiety often present behaviors that include crying, tantrums, and withdrawing from

unfamiliar people in social situations. Furthermore, children with social anxiety often fear

negative evaluation (Spence, Donovan, & Brechman-Toussaint, 2000). Children entering

treatment are presented with a therapist whom they have never met and are expected to

interact with her or him. Therapists may struggle with engaging the child in treatment as a result of the child's level of anxiety.

Crawley et al. (2008) compared children diagnosed with Social Phobia to those diagnosed with Separation Anxiety Disorder and Generalized Anxiety Disorder. The participants included 166 children (ages 7 – 17 years) participating in individual or family CBT for anxiety symptoms. Results of the study demonstrated poorer outcomes in clients diagnosed with Social Phobia versus clients diagnosed with other anxiety disorders. The researchers discussed a few hypotheses for these differences based upon observations throughout the study.

One of these observations was that clients with social phobia appeared more withdrawn than other clients. The researchers hypothesized that more time was needed in order to establish a successful rapport with the client in order to facilitate effective treatment (Crawley et al., 2008). Another observation was that clients with social phobia appeared more worried about negative evaluation or judgment by the therapist. The researchers hypothesized that the clients were preoccupied with their anxiety about their performance and could not fully engage in treatment. The study suggested that future research continue to examine differences among anxiety disorders and consider methods of overcoming these treatment barriers when working with children who struggle with social anxiety.

Research is still very limited on the role that alliance may play in the treatment of children with social anxiety. However, several studies have examined the relationship

between alliance and social anxiety in the adult population. Research has begun to

suggest that many of the challenges therapists face when treating clients with social

anxiety may be avoided by actively developing an alliance during early sessions of

treatment. Hayes, Hope, VanDyke, and Heimberg (2007) examined 18 adult clients

undergoing CBT for the treatment of social phobia. The study examined the relationship

among alliance, session helpfulness, and ability to process emotions in 18 clients

involved in CBT treatment. The clients and an observer completed a revised 12-item

WAI. Results demonstrated that strong client-rated working alliances were related to

more improvement with overall symptom reduction, as well as increased reported levels

of session helpfulness and client engagement. The study indicated that many of the

typical barriers that therapists face when treating clients with social anxiety were

alleviated with the development of an early alliance.

Another important finding by Hayes et al. (2007) was that clients who perceived a

strong working alliance with their therapist often rated the sessions as helpful. Overall,

positive perceptions of the working alliance contributed to more positively perceived

treatment experiences. Clients struggling with social anxiety fear negative evaluation,

often contributing to their anxiety level during sessions. Clients who establish and

maintain a strong working alliance with their therapist are less likely to fear negative

evaluation during the course of treatment (Hayes et al., 2007). This implication is

important for the treatment of social anxiety, as it emphasizes the importance of building

a strong working alliance between the therapist and client.

Overholser (2002) further emphasized the importance of forming an early alliance when working with the population with social anxiety. His literature review examined the stages of treatment that led to a successful outcome with participants struggling with social anxiety: development of the therapeutic alliance, social skills training/relaxation training, exposure tasks, and relapse prevention. The literature consistently demonstrated that without first establishing a successful alliance, the client could not progress to the latter three components of treatment. Overholser identified common barriers to the treatment of client with social anxiety that can be alleviated with a positive alliance. These common barriers, consistent with a diagnosis of social phobia, included fearfulness of authority figures, apprehension about discussing social fears, and fear of evaluation of the therapist. By developing a strong alliance, the therapist can cultivate a safe and positive environment for the client, which is necessary for a successful outcome, especially in clients struggling with social anxiety. Furthermore, early alliance-building behaviors were found to be of particular importance cause of initial apprehensions about therapy (i.e., interactions with the therapist). The review concluded that the formation of an alliance prior to beginning treatment interventions resulted in more successful outcomes. As a result of the implications of this study, one may hypothesize that many of the alliance-building behaviors identified in the TABBS may be of particular importance in alleviating barriers with clients who struggle with social anxiety (i.e., general conversations, providing hope and encouragement, validation, finding common ground).

In review, therapists treating children with social anxiety face unique challenges that can negatively impact treatment. The symptoms and presentation of social anxiety in

children can make their treatment difficult, especially in early sessions. Research is

limited on the relationship between alliance and the treatment of social anxiety in

children. However, studies in the adult population suggest the possibility that the

formation of an early alliance in treatment can alleviate many of these challenges. Further

research is needed to study the impact that the development of an early alliance may play

in the treatment of children struggling with social anxiety.

Conclusion

Overall, previous research suggests an important relationship between alliance

and treatment. Additionally, specific alliance-building behaviors have been identified that

facilitate a positive working alliance. The therapeutic alliance has been found to be of

particular importance in the childhood population with social anxiety, who often struggle

with forming new relationships. The current study further examines behaviors that may

contribute to the development of a successful outcome. Furthermore, the relationship

between alliance and outcome is explored, specifically within the childhood population

with social anxiety.

Chapter 2: Hypotheses

Hypothesis 1: Early alliance building behaviors in the first session will predict perceived alliance in the last session of treatment.

Hypothesis 2: Early alliance building behaviors in the first session will be a greater predictor of perceived alliance in the last session of treatment in participants diagnosed with social anxiety as compared to those diagnosed with any other anxiety disorder.

Hypothesis 3: Early alliance building behaviors in the first session will predict the change in severity of anxiety-based symptoms over the course of treatment.

Hypothesis 4: Early alliance building behaviors in the first session will be a greater predictor of the change in severity of anxiety-based symptoms over the course of treatment in participants diagnosed with social anxiety as compared to those diagnosed with any other anxiety disorder.

Chapter 3: Methods

Design and Design Justification

This study utilized a correlational between- and within-groups design. An observational approach incorporated a trained third-party rating of the therapist alliance-building behaviors and overall rating of the therapeutic alliance. The observational design allowed coders to identify behaviors that may be difficult for subjective participants in the study to identify. Furthermore, it allowed for the coders to provide a nonbiased rating of the therapeutic alliance established between the client and therapist. A criticism of self-reports of perceived therapeutic alliance is that clients tend to rate therapists consistently high and may have limited insight regarding their alliance-building behaviors. This type of limitation can be avoided by utilizing objective coding of the videotaped sessions.

The design of the study allowed the researcher to identify possible correlations between early alliance-building behaviors in the first session and ratings of the overall therapeutic alliance in the last session. The study was a between-groups design, as it compared clients with a social anxiety disorder diagnosis to clients with other anxiety disorder diagnoses on alliance-building behaviors.

Participants

The participants consisted of 42 children (24 male; 18 female) ranging from ages 7 to 13 years ($M = 7.55$; $SD = 1.76$) in Grades 1 through 8. The participants were chosen from a larger study (Creed & Kendall, 2005) in which they received 16 sessions of

manualized cognitive-behavioral intervention (Coping Cat) at Temple University's Child

and Adolescent Anxiety Disorders Clinic (CAADC). The ethnic backgrounds of the

children were Caucasian ($n = 37$), African American ($n = 4$) and Hispanic ($n = 1$). The

participants carried a primary anxiety-related diagnosis. The breakdown of diagnoses was

Social Phobia ($n = 23$) and Other Anxiety Diagnosis ($n = 19$).

Inclusion and Exclusion Criteria (including screening procedures)

The participants chosen for the study (Creed & Kendall, 2005) from which the

current database originated, received a prescreening battery The Anxiety Disorder

Interview Schedule for DSM-IV-Children and Parent Versions (ADIS-IV-C/P) prior to

treatment. Each child had separate diagnosticians conduct parent and child interviews,

which were compiled into one report. The diagnosticians independently assigned

diagnoses to the children based upon these procedures. Children were required to have

an anxiety-related diagnosis to participate in the study. In the larger study, three treatment

modalities were administered: individual (child) cognitive-behavioral therapy (ICBT),

family cognitive-behavioral therapy (FCBT), and a family-based

education/support/attention (FESA) active control group. For the purpose of the current

study, only participants who received ICBT were examined in order to control for

differences resulting from treatment modality. Participants with a primary or secondary

diagnosis of social phobia were assigned to the "Social Phobia" group. Children without

a primary or secondary diagnosis of social phobia were placed in the "Other Anxiety"

group.

Recruitment

Participants in the study (Creed & Kendall, 2005) from which the database

originated were recruited via referrals by parents, school staff, and mental-health

professionals to the CAADC at Temple University. The participants were recruited for

the treatment of anxiety-based symptoms. The study was explained to the children and

their parents prior to beginning the study. The children signed an assent form, and their

parents signed consent to acknowledge participation in the study.

Measures

The Anxiety Disorder Interview Schedule for DSM-IV-Children and Parent Versions

(ADIS-IV-C/P; Silverman & Albano, 1996; Silverman & Nelles, 1988)

The ADIS-IV-C/P utilizes parent and child interviews to gather information about

current symptoms the child is exhibiting (Creed & Kendall, 2005; Silverman & Albano,

1996). The measure is a clinician-administered, semistructured diagnostic interview that

assesses major *DSM-IV* (1994) anxiety disorders and their associated pathology.

Composite diagnoses from the clinicians are determined from the information gathered

during the child and parent interview. The criteria for the diagnoses are based on the

presence of core symptom criteria and a clinical severity rating of ≥ 4 on a 0 - 8 scale (0

= *no impairment* and 8 = *severe impairment*). The measure allows the diagnostician to

screen for anxiety-related disorders. The measure was revised for the *DSM-IV-TR* (2000;

Silverman & Albano, 1996) and maintained strong reliability for both child interviews (*k*

= 0.63 - 0.80) and for parent interviews ($k = 0.65 - 0.88$; Silverman, Saavedra, & Pina, 2001).

Therapist Alliance-Building Behavior Scale (TABBS; Creed & Kendall, 2005)

The TABBS measures therapist behaviors occurring in session that may impact the therapeutic alliance with the client (Creed & Kendall, 2005). Each of the 11 items on the TABBS is rated on a 4-point Likert scale ranging from 0 (*absent or present below a typical level*) to 3 (*strong, or present above a typical level*). The total TABBS score is the sum of the positive-valence items minus the sum of the negative-valence items.

The behaviors on the TABBS fall into two categories: negative-valence behaviors and positive-valence behaviors. The four negative-valence behaviors include (a) pushing the child to talk (therapist pressures the child to discuss her or his anxiety symptoms beyond the comfort level of the child); (b) being too formal (the therapist makes the relationship between her or himself and the client too formal rather than facilitating a relaxed and comfortable environment); (c) not following through on promises (the therapist does not follow through on promises she or he makes to the client, such as not following through with promised rewards, resulting in disappointment); (d) talking at an inappropriate level (the therapist talks in a way that alienates the client, such as talking as if the client were not in the room or using language above the client's cognitive ability).

The seven positive-valence behaviors include (a) customizing the session (the therapist tailors the session for the specific client by engaging in behaviors like asking for

information about the client's likes and dislikes and incorporating this information into

the session in the form of rewards and activities); (b) being playful (the therapist presents

activities and therapy as a whole in a playful manner, such as utilizing fun activities and

games as rewards or therapeutic tasks); (c) providing hope and encouragement (the

therapist expresses encouragement about therapy and states hope for the client to make

progress); (d) collaboration (the therapist presents therapy as a team effort with the client

and involves the client in setting goals, by asking for feedback, and by making the client

feel empowered in the session); (e) validating (the therapist demonstrates respect for the

client's feelings and responds to the client's fears and hesitations about therapy); (f)

having general conversations (conversations occur between the client and therapist that

do not focus on therapy, but rather on a topic of interest to the child); and (g) finding

common ground (therapist engages in behaviors that emphasize common ground between

the client and therapist so that the client may feel connected to the therapist in a special

way; however, overly personal comments were rated no higher than 1 on a 0 - 3 scale).

The Therapeutic Alliance Scale for Children Revised (TASC-R; Shirk & Saiz, 1992)

The TASC-R is a self-report measure completed by the therapist and client at the

end of each session. The TASC-R is a 12 item, 4-point Likert scale completed by both the

child (i.e., "I liked spending time with my therapist"; I felt like my therapist was on my

side and tried to help me") and by the therapist ("The child liked spending time with you,

the therapist"; "The child considered you an ally"; Creed & Kendall, 2005). The total

scores reported by the child and therapist are used as an "overall score." Good internal

consistency and test-retest reliability among youths (alpha = .93. r = .79) and parents

(alpha = .81, r = .82) have been reported (Hawley & Weisz, 2005).

Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings,

& Conners, 1997)

The MASC-R is a self-report measure consisting of 39 items rated on a 4-point

Likert scale that can be used to assess outcome. The inventory is comprised of four

factors: physical symptoms (tense, restless, somatic symptoms), social anxiety

(humiliation, rejection, public performance fears), harm avoidance (perfectionism,

anxious coping), and separation anxiety. The structure holds for male and female, as well

as both younger and older, youth. Good test-retest reliability has been reported across

studies (Crawley et al., 2008; March et al., 1997).

Procedure

In the larger study from which the database originated (Creed & Kendall, 2005),

the referrals for children to the CAADC were made by parents, school staff, and mental-

health professionals. Parents signed an informed consent form and children signed an

assent form, which indicated that all sessions would be audio- and videotaped. Parents

and children were administered the ADIS-IV-C/P, which was part of the prescreening

battery. Separate diagnosticians conducted the parent and child interviews to avoid bias,

and each diagnostician conducted approximately an equal number of interviews.

Following each interview, the diagnosticians individually assigned diagnoses based upon

the child and parent interviews and then reached composite diagnoses using the "or" rule

method (Silverman & Albano, 1996). The ADIS-IV-C/P was also administered

posttreatment. Additionally, the MASC-R was administered pre- and posttreatment to

measure anxiety levels.

Children who met the prescreening criteria were randomized to one of three 16-

week manualized treatments (average 1 per week) that lasted 60 minutes a session. Staff

members of the CAADC had the child complete the TASC-R at the end of each session

and submit it in a sealed box. A total rating from the end of the first and last sessions was

used in the analyses.

Coders were trained on the TABBS measure prior to coding. The coders consisted

of three master's-level students recruited from an anxiety research group at Philadelphia

College of Osteopathic Medicine. A doctoral-level student at Philadelphia College of

Osteopathic Medicine trained the coders during a 2-hour seminar. The training session

familiarized the students with the measures and operational definitions of the factors

being coded in accordance with the TABBS guidelines. Following the training, the coders

used "practice" videotaped sessions to code using the TABBS (first session only) until

their interrater reliability reached a level of reliability intraclass correlation coeffecient

(pICC) $\geq$ 0.7 (Cicchetti, 1994). The doctoral-level student supervised the practice

sessions and initial coding of the videos.

The coders independently viewed the first session of 42 videotaped treatment

sessions, coding the first session using the TABBS. The coders remained blind to all

coding of the videotaped sessions and administered self-report measures. A 10% overlap

check was conducted halfway through the coding to check for maintained internal

consistency.

Chapter 4: Results

Reliability of Coders

A single-measure reliability ICC (rICC) determined that adequate reliability had been obtained at the end of training, prior to coding (rICC = .91, $p < .0001$). During the datacoding process, an unannounced reliability check demonstrated that reliability had been maintained (rICC = .94, $p < .0001$).

Statistical Analyses

For the purpose of a comprehensive analysis, alliance-building behaviors were examined individually as well as grouped into overall "Positive" and "Negative" alliance-building behavior composites. Note that Pearson's product-moment correlation coefficients were run as a primary analysis to determine if a significant relationship existed between the variables. A regression was performed only when the initial correlation was found to be significant.

The first hypothesis was analyzed using Pearson's product-moment correlation coefficient to determine if alliance-building behaviors in the first session of treatment were related to perceived alliance in the last session. As outlined in Table 1, neither the positive behaviors ($r = 0.44$, $n = 42$, $p = 0.78$) nor the negative behaviors ($r = -0.15$, $n = 42$, $p = 0.33$) were significantly related to perceived alliance. Additionally, the individual behaviors were not significantly related to perceived alliance, (See Table 1 and Table 2 for means, standard deviations, and correlations). No further analyses were needed, as the correlations were not significant.

The second hypothesis was analyzed using Pearson's product-moment correlation coefficient to determine if the alliance-building behaviors were associated with perceived alliance when separating the children into two groups: Social Phobia and Other Anxiety Diagnosis. In the Social Phobia group, the composite of neither the positive behaviors (r = 0.06, n = 23, p = 0.78) nor the negative behaviors (r = 0.20, n = 23, p = 0.35) was associated with perceived alliance in the last session, as outlined in Table 3. The individual alliance-building behaviors in this group were not associated with perceived alliance. No further analyses were needed since the correlations were not significant.

In the Other Anxiety Diagnosis group, the positive alliance-building behaviors composite was not significantly related to perceived alliance in the last session (r = -0.02, n = 19, p = 0. 93). No further analyses were run, as this correlation was not significant. However, interestingly, the negative alliance-building behaviors composite was significantly negatively correlated with perceived alliance in the last session of treatment (r = -0.63, n = 19, p = 0.004) in the Other Anxiety Diagnosis group (see Table 3). When the alliance-building behaviors were examined individually, they were found to be unrelated to outcome when separated from the composites (see Table 3).

A linear regression analysis revealed that engaging in negative alliance building behaviors in the first session of treatment was a significant predictor of perceived alliance in the last session (β = -2.63, p = 0.004), accounting for 39.3% of the variance in the perceived alliance for the Other Anxiety Diagnosis group (see Table 4).

Table 1

Means and Standard Deviations for Alliance-Building Behaviors and Perceived Alliance

Measure	*M*	*SD*
Perceived alliance (last session)	43.43	5.57
Positive behaviors	15.19	4.53
Negative behaviors	.57	.86
Customizing the session	2.21	.75
Being playful	2.21	.84
Providing hope	1.88	.77
Collaboration	2.26	.79
Validating	2.17	.79
Having general conversations	2.38	.73
Finding common ground	2.07	.84
Pushing the child to talk	.14	.52
Being too formal	.21	.42
Not following through on promises	.10	.48
Talking at an inappropriate level	.12	.33

Table 2

Correlations Between Alliance-Building Behaviors and Perceived Alliance

Measure	2	3	4	5	6	7	8	9	10	11	12	13	14
1. PA	.04	-.15	.14	-.02	-.02	.06	.072	.07	-.04	-.11	-.10	-.03	-.07
2. PB		-.14	.86**	.83**	.75	.80**	.91**	.78**	.80**	.06	-.22	.18	-.44**
3. NB			-.12	-.14	.03	.097	-.18	-.24	-.23	.47**	.54**	.45**	.53**
4. CS				.62**	.68**	.64**	.80**	.60**	.64**	.17	-.31*	.21	-.50**
5. BP					.60**	.57**	.71**	.62**	.64**	-.02	-.20	.19	-.36*
6. PH						.53**	.71**	.39*	.39*	.23	-.22	.23	-.33*
7. C							.70**	.54**	.59**	.08	-.03	.19	-.12
8. V								.69**	.64**	.12	-.33*	.21	-.55**
9. GC									.67**	-.08	-.03	-.04	-.40**
10. CG										-.14	-.12	.04	-.30
11. PC											-.15	-.06	-.10
12. BF												-.10	.53**
13. NF													-.07
14. TI													

Note. PA = perceived alliance (last session); PB = positive behaviors; NB = negative behaviors; CS = customizing session; BP = being playful; PH = providing hope; C = collaboration; V = validating; GC = general conversation; CG = common ground; PC = pushing child to talk; BF = being too formal; NF = not following through; TI = talking at an inappropriate level

p < .05. **p* < .01.

Table 3

Correlations, Means, and Standard Deviations Between Alliance Building Behaviors and

Perceived Alliance (Social Anxiety and Other Diagnosis Groups)

Measure	Social anxiety group			Other diagnosis group		
	r	*M*	*SD*	*r*	*M*	*SD*
PA		43.09	6.46		43.84	4.39
PB	.06	14.65	4.92	-.020	15.84	4.03
NB	.20	.44	.66	-.627**	.74	1.05
CS	.10	2.09	.79	.206	2.37	.68
BP	.08	2.22	.80	-.157	2.21	.92
PH	.10	1.87	.82	-.263	1.90	.74
C	.12	1.87	.82	-.075	2.47	.77
V	.04	2.00	.80	.085	2.37	.76
GC	.05	2.26	.81	.095	2.53	.61
CG	-.08	2.13	.87	.062	2.00	.82
PC	.14	.09	.29	-.344	.21	.71
BF	.10	.17	.39	-.454	.26	.45
NF	.07	.04	.21	-.102	.16	.69
TI	.12	.13	.34	-.429	.11	.32

Note. PA = perceived alliance (last session); PB = positive behaviors; NB = negative behaviors; CS = customizing session; BP = being playful; PH = providing hope; C = collaboration; V = validating; GC = general conversation; CG = common ground; PC = pushing child to talk; BF = being too formal; NF = not following through; TI = talking at an inappropriate level

*p < .05. **p < .01.

Table 4

Regression Predicting Perceived Alliance in the Other Diagnosis Group

Predictor	B	SE	β	Sig
Neg. Behaviors	-2.63	.79	-.63	.004

The third hypothesis was analyzed using Pearson's product-moment correlation coefficient to determine if the alliance-building behaviors were associated with a change in severity of the anxiety-based sessions during the course of treatment. Change scores were used to measure differences in anxiety symptoms between the first and last session of treatment. Results indicated that neither the positive composite behaviors ($r = -.05$, $n = 38$, $p = 0.76$) nor the negative composite behaviors ($r = 0.09$, $n = 38$, $p = 0.58$) were associated with a change in anxiety symptoms in the overall sample. Additionally, the individual behaviors were not associated with a change in outcome (see Table 5). No further analyses were needed, as the correlations were not significant.

The fourth hypothesis was analyzed using Pearson's product-moment correlation coefficient to see if the alliance-building behaviors were associated with a change in anxiety symptoms when separating the children into two groups: Social Phobia and Other Anxiety Diagnosis. For the Social Phobia group, neither the positive composite behaviors ($r = -0.25$, $n = 22$, $p = 0.26$) nor the negative composite behaviors ($r = 0.02$, $n = 22$, $p = 0.92$) were associated with a change in anxiety symptoms. The individual behaviors were also not associated with a change in anxiety (Table 5). Similarly, for the Other Anxiety

Table 5

Correlations, Means, and Standard Deviations Between Alliance Building Behaviors,

Perceived Outcome, and Change in Anxiety Symptoms

	All diagnoses			Social anxiety group			Other diagnosis group		
Measure	*r*	*M*	*SD*	*r*	*M*	*SD*	*r*	*M*	*SD*
CA		-12.11	21.67		-9.46	14.99		-15.75	28.64
PA	-.06	43.43	5.57	.02	43.09	6.46	-.15	43.84	4.39
PB	-.05	15.19	4.53	-.250	14.65	4.92	.14	15.84	4.03
NB	.09	.57	.86	.022	.44	.66	.18	.74	1.05
CS	-.14	2.21	.75	-.149	2.09	.79	-.13	2.37	.68
BP	.12	2.21	.84	-.305	2.22	.80	.38	2.21	.92
PH	-.16	1.88	.77	-.322	1.87	.82	-.05	1.90	.74
C	.02	2.26	.80	-.118	2.09	.79	.17	2.47	.77
V	-.08	2.17	.79	-.327	2.00	.80	.15	2.37	.76
GC	-.19	2.38	.73	-.234	2.26	.81	-.14	2.53	.61
CG	.09	2.07	.84	-.088	2.13	.87	.21	2.00	.82
PC	.17	.14	.52	.021	.09	.29	.25	.21	.71
BF	-.18	.21	.42	-.114	.17	.39	-.20	.26	.45
NF	.09	.10	.48	.051	.04	.21	.13	.16	.69
TI	.06	.12	.33	.121	.13	.34	.02	.11	.32

Note. CA = change in anxiety; PA = perceived alliance (last session); PB = positive
behaviors; NB = negative behaviors; CS = customizing session; BP = being playful; PH =
providing hope; C = collaboration; V = validating; GC = general conversation; CG =
common ground; PC = pushing child to talk; BF = being too formal; NF = not following
through; TI = talking at an inappropriate level
*p < .05. **p < .01.

Diagnosis group, neither the positive composite behaviors ($r = 0.14$, $n = 16$, $p = 0.60$) nor the negative composite behaviors ($r = 0.18$, $n = 16$, $p = 0.60$) were associated with a change in anxiety symptoms. The individual alliance-building behaviors were also not associated with changes in anxiety symptoms (see Table 5). No further analyses were needed, as the correlations were not significant.

As no correlations were found between the alliance-building behaviors and outcome, a Pearson's product-moment correlation coefficient was used to determine if a relationship between perceived alliance and outcome existed in the sample. No correlations were found between perceived alliance and changes in anxiety symptoms overall ($r = -0.06$, $n = 38$, $p = 0.71$), in the Social Phobia group ($r = 0.02$, $n = 22$, $p = 0.93$), or in the Other Anxiety Diagnosis group ($r = -0.15$, $n = 16$, $p = 0.59$; (see Table 5).

Chapter 5: Discussion

The importance of the working alliance in treatment is well documented, and research has begun to identify specific therapist behaviors that may contribute to its development (Creed & Kendall, 2005). The purpose of the current study was to explore a possible relationship between alliance-building behaviors in the first session of treatment and perceived alliance/changes in anxiety symptoms at the conclusion of therapy. Furthermore, the study sought to explore possible differences between two conditions: social phobia and other diagnoses.

Alliance-building behaviors were examined individually as well as grouped into two composites for the purpose of analyses: positive and negative behaviors. The results revealed that alliance-building behaviors were related only to perceived alliance in the nonanxiety (other diagnosis) group. Specifically, negative behaviors were predictive of perceived alliance with this sample. In other words, if a therapist engages in negative alliance-building behaviors in the first session, a child with an anxiety disorder (other than social phobia) is more likely to report a lower rating of alliance later in therapy.

One implication that may be drawn from these findings is that engaging in negative alliance-building behaviors may outweigh or counter the engaging in positive alliance-building behaviors when developing a working alliance. One might hypothesize that children are more sensitive to negative therapist behaviors and that simply avoiding these behaviors (regardless of engaging in positive behaviors) may yield more positive perceptions of alliance. The idea of avoiding negative behaviors is consistent with recent

research that examined specific negative behaviors and characteristics of a therapist that

contribute to alliance ruptures. Ackerman and Hilsenroth (2001) identified several

behaviors that contribute to ruptures in alliance, including being rigid, uncertain,

exploitive, critical, distant, tense, aloof, and distracted. The results of the Ackerman and

Hilsenroth (2001) study showed that these behaviors caused ruptures in alliance across

various theoretical orientations, suggesting that these behaviors have an effect regardless

of other factors. It may be beneficial to begin shifting the focus of research to therapist

behaviors that hinder or rupture alliance, rather than focusing solely on what contributes

to a positive working alliance, as much of the research has done thus far.

Results further indicated that alliance-building behaviors were not related either to

perceived alliance in the overall sample or to the social phobia group (contrary to the

hypothesis). Furthermore, alliance-building behaviors were not correlated with outcome

across groups. Further analyses were not needed, as the relationships between these

variables were not significant. As these relationships were not found to be significant, the

rationale for the hypotheses will be revisited, as will the exploration of several premises

that might help explain these findings.

The first purpose of the study was to examine possible therapist behaviors that

might predict perceived alliance. The importance of establishing a therapeutic alliance as

early as possible in order to render a positively perceived alliance is well documented

(e.g., Horvath et al., 2011; Horvath & Greenberg, 1994; Russell et al., 2008; Shirk &

Karver, 2003). For example, Horvath et al. (2011) examined how alliance building in

very early sessions with adults facilitated lower dropout rates and led to higher levels of

perceived alliance in later sessions. The study showed that alliance formation in early sessions was essential to alliance development (vs. attempting to develop an alliance later in treatment). This study, among others, rendered support for a hypothesis that alliance-building behaviors in the first session may predict perceived alliance later in treatment. In particular, the alliance-building behaviors examined in the current study were the same as those identified in Creed and Kendall (2005), who found significant relationships with perceived alliance. Both the current study and Creed and Kendall (2005) drew samples from the same data set. Since both studies derived from the same data set, examining the methodological differences between the two is important in order to gain a better understanding of what may have accounted for incongruencies in the findings.

A fundamental difference between the two was that the current study identified alliance-building behaviors only in the first session of treatment and measured perceived alliance only in the last session of treatment; Creed and Kendall (2005) utilized concurrent and cumulative ratings of both alliance-building behaviors and perceived alliance from Sessions 1-3 and Session 7. In other words, their study looked at how alliance-building behaviors predict alliance within the same session, rather than later in treatment. Furthermore, Creed and Kendall (2005) grouped Sessions 1-3 together and used cumulative ratings, rather than focusing on the sessions individually. Based upon these important differences, several hypotheses might be drawn to explain the differences in findings.

The current study examined alliance-building behaviors as a predictor of perceived alliance later in treatment, rather than concurrently examining the relationship

between behaviors and alliance within sessions. While Creed and Kendall (2005)

demonstrated that therapist behaviors could predict alliance at the end of the current

session, the current study was interested in whether identifying alliance-building

behaviors could be used as a predictor of perceived alliance later in treatment. Based

upon the discrepancies between the findings of the two studies, one might hypothesize

that, overall, the identification of alliance-building behaviors is more useful as a

concurrent predictor of perceived alliance rather than as a longer-term predictor.

Also, Creed and Kendall (2005) utilized cumulative ratings of behaviors and

alliance from the first three sessions while the current study focused solely on the first

session. One hypothesis that could be drawn from the difference in findings is that

alliance is formed across the first few sessions of treatment, not just the initial session.

Perhaps if alliance-building behaviors had been identified across the first three sessions,

they would have been more predictive of perceived alliance later in treatment. The

rationale for identifying alliance-building behaviors only in the first session was that the

study sought to explore the possible long-term implications across treatment of engaging

in alliance-building behaviors immediately in treatment. For example, by using this

methodology, the current study was able to show that engaging in negative-alliance

behaviors early in the first session can set a precedence for perceived alliance by the end

of treatment. One should also note that the only other session Creed and Kendall (2005)

examined was the seventh session, halfway through treatment. Some research suggests

that as treatment approaches desired outcome, ratings of alliance may be skewed by

improvement (Creed & Kendall, 2005; Feeley, DeRubeis, & Gelfand, 1999). Because of

this difference, one could hypothesize that the ratings in the current study were skewed by the introduction of exposure exercises to treatment. Another possibility is that alliance-building behaviors in the first session of treatment may have been more predictive of alliance halfway through treatment rather than at the end. This temporal difference could have impacted findings.

Aside from methodological considerations, another point to consider is that research on the identification of alliance-building behaviors is very new. Since research is still very new, this begs the question of whether other important therapist behaviors other than those identified in the TABBS are vital to alliance development. Previous studies have identified several therapist factors (other than those in the TABBS) that were found to be important to the development of a working alliance. These additional factors include, but are not limited to, exuding confidence, enthusiasm, and warmth, and making accurate interpretations (Ackerman & Hilsenroth, 2003). The Ackerman and Hilsenroth (2003) study showed that when these therapist characteristics were identified, they were often predictive of perceived alliance. Perhaps the inclusion of these additional behaviors (and others) would allow for a better prediction of perceived alliance later in treatment.

Based upon prior research, the current study had hypothesized that the identification of alliance-building behaviors would be particularly predictive in the social phobia group. For example, Overholser (2002) found that establishing an early alliance was vital to treatment but was often more difficult for clients with social phobia because of symptoms related to their diagnosis (e.g., fear of judgment, apprehension discussing their symptoms). This study among others supported the idea that alliance may be more

difficult to form with the population with social phobia; therefore, engaging in alliance-building behaviors should have an even greater effect in the social phobia group than in any other diagnostic group examined.

A possible interpretation of these findings is that youth with social anxiety were more resilient to the negative alliance-building behaviors in their perception of alliance. Research suggests that children with social anxiety may have a harder time identifying and distinguishing positive and negative alliance-building behaviors. This concept is consistent with research by Alden and Taylor (2004) that suggests many children with social anxiety have difficulty processing social information and may engage in self-protective behaviors to avoid being hurt or rejected. Youth with social anxiety may be engaging in self-protective behaviors even prior to their initial interactions with the therapist in anticipation of the session. Therefore, they may be less affected by the therapist's behaviors in session. If this theory holds true, therapists should shift their focus to addressing these self-protective behaviors or thoughts prior to engaging the client in treatment (i.e., relaxation training).

The other purpose of this study was to see if alliance-building behaviors were associated with outcome. Overall, neither the alliance-building behaviors nor the perceived alliance was related to outcome in this study. Despite the existing literature in support of a relationship between alliance and outcome (Green, 2006; Martin et al., 2000; Norcross 2002), especially within the youth population (Karver et al., 2006; Shirk & Karver, 2003), there is also literature that suggests that perhaps alliance is not effective at directly predicting outcome. DeRubeis, Brotman, and Gibbons (2005) concluded that

more research needs to be done on alliance and outcome before utilizing alliance as a predictor. They also suggested that research should continue to focus on "specific" therapeutic factors rather than on "nonspecific" factors. Although the findings and implications of current research are still mixed regarding alliance as a predictor of outcome, further research clearly should be done in this area.

Additionally, research that does find correlations between outcome and alliance have mixed findings as to whether alliance should be considered a mediating or moderating variable. If alliance were indeed a moderating predictor of alliance, alliance-building behaviors should also be moderators. Research by Sexton (2007) described nonspecific therapist factors as moderating predictors of therapeutic change. By aligning with those findings, one could hypothesize that alliance-building behaviors could have been affecting another factor that directly relates to outcome. Further research with this data set is needed in order to rule out therapist behaviors as a possible moderating variable.

Limitations

There are several potential limitations to this study. First, the identified therapist behaviors were limited to those delineated in the TABBS. As previously mentioned, perhaps incorporating other therapist behaviors into the measure would help identify further information about how an alliance is formed. Furthermore, developing an objective measure of alliance-building behaviors that the youth, parent, and therapist could complete in order to obtain convergent reports may be useful.

Similarly, only the perceived alliance self-reports of the children were examined. Only utilizing children's self-reports could potentially leave out important information about how the therapist perceived the alliance. Research by Sexton, Hembre, and Kvarme (1996) suggested that the interplay of the perceived alliance by both the child and therapist in the first session might set the precedence for alliance in later sessions of treatment. In the future, this limitation could be by minimized including the alliance ratings of the parents and therapist, as well as possibly including an observer rating of alliance.

There were also a few limitations with regard to the sample itself. The sample consisted of youth diagnosed with anxiety disorders in a CBT clinic. Only examining youth diagnosed with anxiety disorders at a CBT clinic may limit the generalizability of the findings to other populations, as the role alliance-building behaviors plays may differ for children diagnosed with other disorders and who receive other treatment modalities. Also, the size of the sample was limited to 42 children, and this number decreased further when the sample was split into two groups. Utilizing children only in the individual CBT treatment group also reduced the size. Although utilizing only the ICBT group controlled for treatment differences, it also reduced the sample size. Perhaps utilizing children and also their families in other treatment groups from this sample would result in further findings.

All of the therapists in this study received similar training in CBT prior to this study and were trained to work with this specific population. Research by Black, Hardy, Turpin, and Parry (2010) found differences in alliance ratings among various theoretical

orientations. This may suggest that alliance looks different or is formed in distinct ways according to treatment modalities employed. Further, whether or not clinicians from this study had any prior training directly in alliance building is unclear. To further this point, in the overall sample, the positive alliance-building behaviors occurred much more frequently than the negative alliance-building behaviors. Several hypothesizes may explain this (e.g., prior therapist experience/training, subjective coding), as discussed earlier. However, the frequency of positive behaviors as compared to negative behaviors potentially could have resulted in ceiling (positive behavior ratings) or floor (negative behavior ratings) effects.

A potential limitation within the analyses is that change (gain) scores were used to assess outcome. Research is mixed and continues to fluctuate on whether gain score analysis (GSA) or analysis of covariance (ANCOVA) is the best measure of outcome. For the purpose of this study, GSA was chosen, as recent research suggests that gain scores may portray the most accurate representation of outcome when the groups are not randomized (Knapp & Schafer, 2009). Although the overall data set was randomized, the specific groups in this study were not, as participants were divided based upon social phobia or nonsocial phobia diagnoses. However, utilizing ANCOVA may be possible if another study were completed that utilized the randomized samples prior to dividing them, as then the participants would be in truly randomized groups.

Future Research

Future research should continue to examine alliance-building behaviors that contribute to the development of a successful therapeutic relationship across different populations. Continuing to identify and examine potential behaviors other than those used in this study that may contribute to the development of a successful working alliance would be beneficial. Seeing how alliance-building behaviors affect perceived alliance in other populations and with treatment modalities other than CBT would also be interesting. Studying other alliance in other theoretical orientations would promote generalizability and would allow for further exploration into the importance of alliance in treatment.

Future research should also continue to examine the effect of positive versus negative therapist behaviors on alliance. Several studies have emphasized the importance of examining positive to negative ratios with regard to social exchanges and human emotions (Fredrickson & Losada, 2011). In other words, sometimes a certain number of positive exchanges/attributes can outweigh the negative exchanges/attributes, and vice versa. Perhaps the same is true when examining alliance-building behaviors. Future research should take this perspective into consideration with regard to alliance-building behaviors.

Research should also continue to explore the effect that the alliance has on clients with social phobia, examining possible implications for the treatment of this population. Although behaviors identified in this study did not appear to be largely related to alliance

in the social phobia group, other behaviors may be specifically important to engage in when working with these clients. Future research should also continue to examine the relationship between alliance and outcome, specifically in the youth population, as current research is limited in this area. Of particular interest would be an examination of alliance-building behaviors as moderating variables to outcome in the child population.

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