

Running head: EXPLORING THERAPEUTIC ALLIANCE, AUTISM, AND CBT

Exploring the Therapeutic Alliance in Cognitive-Behavior Therapy with  
Children with Autism Spectrum Disorder: An Interpretative Phenomenological Approach

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**Abstract**

The therapeutic alliance (TA) is the most studied process of adult psychotherapeutic change (Zack et al., 2007) and has been found to have a moderate but robust relationship with therapeutic outcome regardless of treatment modality (Horvath, 2001). The TA is loosely described as the extent to which the therapist and the participant connect emotionally and work together towards goals. Conceptualizations of the TA with children have relied on adult models, even though it is widely acknowledged that the pediatric population will rarely willingly commit to therapy, nor readily admit to any challenges that they may be experiencing (Keeley, Geffken, McNamara & Storch, 2011). For children with Autism Spectrum Disorder (ASD) the therapeutic alliance may require an even greater retheorizing considering the communicative and social difficulties of this particular population. Despite this need, research on children with ASD and the therapeutic TA is almost non-existent. In this qualitative study, transcripts from semi-structured interviews with mothers of children with ASD were analyzed using Interpretative Phenomenological Analysis (IPA). IPA closely examines how individual people make sense of their life experiences using a theme-by-theme approach. The three interviewees were mothers whose children were participants in a nine-week Cognitive Behaviour Therapy (CBT) group for obsessive-compulsive behaviours (OCB). A total of four superordinate themes were identified: (i) Centralization and disremembering the TA, (ii) Qualities of the therapist, (iii) TA and the importance of time, and (iv) Signs of a healthy TA. The mothers' perspectives on the TA suggest that, for them and their children, a strong TA was a required component of the therapy. Implications for clinicians and researchers are discussed.

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Exploring the Therapeutic Alliance in Group Cognitive Behavior Therapy with  
Children with Autism: An Interpretative Phenomenological Approach

**Introduction**

In psychotherapy research, the therapeutic alliance (TA) is loosely defined as the extent to which the therapist and the participant connect emotionally and work together towards purposive goals. A sound TA is a basic principle in Cognitive-Behavior Therapy (CBT) (Beck, 1995), and it has been found to predict treatment outcomes across a variety of diagnoses and therapeutic approaches (Orlinsky, 2007). In keeping with this claim, Horvath (2010) combined the results of two meta-analyses and 10 independent clinical investigations on the TA and found a small weighted mean overall effect size (ES) of .21 (range-.06 to .89) with a median of .25 over a total of 90 independent studies. Considering the overall ES of psychotherapy is small (.39) the impact of the TA is considerable. Assuming that the active ingredients of a therapy, like CBT, are semi-independent, it is likely that a little over half of the beneficial effects of psychotherapy accounted for in previous meta-analyses are linked to the quality of the TA (Horvath, 2010).

The TA has not been significantly investigated with pediatric populations despite the widely held belief that it is especially important with children (Zack, Catonguay, & Boswell, 2007). Children receiving behavioural and psychological interventions are rarely self-referred, and they frequently do not acknowledge existing problems (Keeley, Geffken, McNamara & Storch, 2011), which may make developing a healthy TA more difficult. Research examining the TA with children with Autism Spectrum Disorder (ASD) is even more difficult to find. This large gap in the TA research could be due to the behavioural manifestations of ASD (which make it appear that the TA with this population is unimportant) or it could be that earlier misguided attempts to blame the disorder on uncaring mothers turned researchers away from the TA.

ASD is a neurodevelopmental disorder affecting relating and communicating where the skills required for these interactions are delayed or present as ongoing challenges (Robinson, 2011). A list of symptoms and behaviours identifying the core deficits are used to diagnosis the condition (DSM-V; APA, 2013), but the diagnosis does not provide a complete picture of the child with ASD. Patterns of stereotyped and repetitive behaviours, interests, and activities and the child's seemingly inability to understand other people's perspectives, social cues, and emotions (Davison, Blankstein, Flett, & Neale, 2008) may, at first glance, suggest that children with ASD are disconnected from life around them. However, the list of symptoms and behaviours used to diagnosis ASD may not correspond with how the child thinks or feels. For example, diagnostic criteria like "deficits in social-emotional reciprocity" and "deficits in developing, maintaining, and understanding relationships" (DSM-V; APA, 2013) does not mean they do not feel the need for connection or want it. Rather than being disconnected, the child's sensory and motor systems may impede their attempts at connection (Robinson, 2011). Moreover, ASD's social and communication difficulties do not preclude the child's need for interpersonal relationships (Bromfield, 2010).

Interpersonal relationships can be a source of confusion and anxiety for people with ASD and some have argued that this may have an effect on the development of a collaborative relationship (Donoghue, Stallard & Kucia, 2011). The nascent nature of the research may account for the abovementioned lack of research into the TA with the ASD population but a more problematic reason may lie in the belief that the social and communication deficits present in individuals with ASD make the TA with this population irrelevant to the outcome of treatment. Whatever the reason, investigating the importance of a therapeutic alliance with children with ASD has relevance not only for CBT but also for the many therapies traditionally involving children with ASD (e.g., speech, social pragmatics, and Intensive Behavioural Intervention [IBI]).



Using Interpretative Phenomenological Analysis (IPA), this qualitative research project is an exploration into the TA and its importance during the treatment of Obsessive Compulsive Behaviours (OCB) with CBT for children with ASD without an intellectual disability. OCB is a term used to describe both Obsessive Compulsive Disorder (OCD) (which individuals with ASD are at risk for) and repetitive behaviours. OCB will be described in greater detail in the Treatment section. IPA is a research methodological approach that examines how people make sense of their life experiences (Smith, Flowers, & Larkin, 2009). The method has its roots in psychology and recognizes the central role of the research analyst in understanding the perspectives of participants. IPA is an adaptable approach that privileges the individual and their perspectives by providing complete in-depth accounts of their experiences. The research participant's voice is always maintained by grounding the analysis in the text of the participant and allows researchers and clinicians to deeply hear and understand the participant's experiences (Smith et al., 2009). IPA research on the TA can also influence and contribute to TA theories, and to clinical practices like CBT by guiding the researcher and clinician in directions that are significant to the participants.

### **Theoretical Framework**

The theory this study used to interpret data is Bordin's (1979) conceptualization of the theoretical relationship. His approach was the first to explore the relationship between the therapist and client across all psychotherapeutic orientations and professional roles (including parenting) (Baylis, Collins, & Coleman, 2011). His theory was given the name "therapeutic alliance" and includes three broad categories: the bond, agreement on goals, and tasks. As will be discussed, the constructs of the TA require further clarification but Bordin's conceptualization is, nonetheless, the most widely accepted in the TA research and is the theoretical lens used in this study.

### **Purpose of Study and Research Questions**

The aim of the present study was to explore the perspectives of three mothers who had participated in a CBT group called *I Believe in Me, Not OCB* (Vause et al., 2010a) with their children, and using an interpretive phenomenological approach, closely examine their perceptions and observations of the TA between their children and a therapist. The four overarching questions I wanted to answer during this qualitative research were:

- (1) How do the mothers describe the relationship between their child and the therapist?
- (2) How did they know if a therapeutic relationship was present or absent (i.e., which behaviours or feelings did they observe in their child or in the therapist)?
- (3) How important did they think the TA was to the treatment outcome?
- (4) How does their perception of the TA compare with existing theories and data on TA with typically developing children?

As required by IPA, after the interviews I used the mothers' experiences and reflections to develop a theme-by-theme approach to describe and conceptualize the importance of the TA in this treatment. In preparation for this discussion of mothers' interview responses, the following literature review will examine the history and development of the TA, as well as the current research on the TA with typically developing and ASD pediatric populations.

### **History and Definition of the Therapeutic Alliance**

The TA is one of the oldest themes in psychotherapeutic research (Horvath & Symonds, 1991) and, with over 2000 studies, the most investigated process in adult therapeutic change (Zack et al., 2007). It has a long history; going back to 1913 when Freud first explored the negative and positive attachments the patient has towards the analyst. In psychoanalysis, this largely unconscious process is called transference and is viewed as a significant component of the therapy (Davison, Blankstein, Flett, & Neale, 2008). The analyst-patient relationship is seen to

reflect relationships from the patient's past rather than the actual interpersonal exchanges between therapist and patient. In a lecture given by Freud (1963), he describes transference as a window into the unknown corners of his patient's mind:

We overcome the transference by pointing out to the patient that his feelings do not arise from the present situation and do not apply to the person of the doctor, but that they are repeating something that happened to him earlier. In this way we oblige him to transform his repetition into a memory. By that means the transference, which, whether affectionate or hostile, seemed in every case to constitute the greatest threat to the treatment, becomes its best tool, by whose help the most secret compartments of mental life can be opened.

(p.496)

According to Freud's conceptualization, transference needed to be overcome in order to provide the patient insight into their hitherto, unconscious feelings. Since Freud, theories on the TA have evolved which now view the therapist-client relationship more as a curative ingredient of psychotherapy (Hawley & Weisz, 2005) than as a tool to unearth hidden and repressed emotions.

In the 1940's and 1950's, the humanistic psychologist, Carl Rogers, suggested the key component of therapy was the attitude and style of the therapist rather than any specific therapeutic technique (Davison et al., 2008). He conceptualized the positive therapeutic relationship as being built on the therapist's empathy, accordance, and unconditional positive regard toward the client. He calls this state of being with another "empathic" and explains it involves "laying aside the views and values you hold for yourself in order to enter another's world without prejudice [...] being empathic is a complex, demanding, strong yet subtle way of being" (p.4). The therapist values and accepts the client for who they are and whatever their behaviour (Davison et al., 2008). The shortcoming of Rogers' conceptualization of the empathic therapist, however, is that it examines only the therapist's ability to empathize and does not

address the role of the client in the reciprocal relationship. Ultimately, Rogers' empathic approach was replaced by a more dynamic view of the therapist-client relationship where both the client and therapist contribute to the development of the TA (Horvath & Symmonds, 1991).

Greenson (1965), a noted therapist to stars like Marilyn Monroe, coined the term "the working alliance". This term importantly moves away from Rogers' unilateral formulation of therapist empathy to a bilateral view. He saw the working alliance as a positive collaboration between the patient and the therapist where both are invested in the relationship (Greenson, 1965). Later, Greenson (1967) lists the skills and characteristics he considers essential in his clients: "able to listen to the analyst, comprehend, mull over, and introspect. To some degree he must also be able to remember, to observe himself..." (p.208). In addition, he believes the therapist must work in a manner that is "realistic and reasonable" (p.208) in order to develop a somewhat "realistic and reasonable working alliance" (p.208). Greenson's (1967) focus on the rational component of therapy was a decidedly sharp turn from the predominant focus on transference in the psychoanalytic community. He felt rationality was an important component of therapy, something that served to distinguish it from the sometimes strange, unique, and artificial nature of psychoanalysis (Parry & Birkett, 1996).

Bordin (1979) further elaborated on the theoretical framework of the working alliance and became associated with the term "therapeutic alliance". The three foundational components of the TA, as laid out by Bordin, include goals, tasks, and bond formation. In a well-developed therapeutic relationship the client and the therapist, working in collaboration, agree on therapeutic goals, as well as on the tasks that will help the client achieve the agreed on goals. The bond that forms between them is the positive emotional attachment, which includes trust, acceptance, and confidence (Campbell & Simmonds, 2011). Bordin's theory on the TA was pan-theoretical and, as such, opened up the concept of the TA to all helping relationships and not just

to therapies with psychodynamic leanings. In the following decades, several instruments were created that measured the TA. These psychometric tools allowed for novel empirical investigations (Horvath, 2001), several of which are explored below.

Adam Horvath, a prominent Canadian researcher, emphasized the role of the therapist's attachment style and temperament on the quality of the TA (Campbell & Simmonds, 2011). He notably created the "Working Alliance Inventory" which is the most common psychometric tool used to measure the quality of the TA (Hanson, Curry, & Bandalos, 2002). Horvath's meta-analysis of two decades of empirical research showed a moderate but consistently reliable link between the quality of the TA and the therapeutic outcome (Horvath & Symonds, 1991). The magnitude of this relation appears to be independent of the type of therapy, and whether the outcome was assessed from the perspective of the therapist, client, or observer. Horvath (2001) found the following variables affected the quality of the TA: *client variables* (problem severity, type of impairments, and quality of attachments) and *therapist variables* (communication skills, empathy, openness and exploration, personality, experience, and training). He also made several important suggestions in regard to the therapists efforts to develop and maintain the TA: (a) in the beginning of therapy, the therapist should ensure that developing the TA takes precedence over technical interventions; (b) the therapist should actively solicit clients' opinions around the TA; (c) the therapist should have an open and flexible stance (d) the therapist should adopt client's ideas, and use client's expressions; and (e) the therapist in training should focus solely on the TA (rather than on a combination of the TA and adherence to the treatment protocol). These five concrete points are useful to any therapy regardless of theoretical leanings.

Despite the long history and abundance of research into the TA with adults, there is still no consensus on its components or constructs. This has led to a lack of cohesiveness in the research and measurement tools. Elvins and Green (2008) state there are serious shortcomings in the

conceptualization and measurement of the TA in research. According to Elvins and Green (2006), little is known about the specific components of the TA and there is discrepancy in the conceptualization of the alliance in the research. For example, there is a proliferation of measures for the TA, but without an agreement on TA theory, no measurement reflects all the components associated with the different constructs of the TA. Since there is no consensus the number of items varies greatly between measures, as do the subscales. Others have argued that past research is ultimately flawed because of inherent confounds in the measurement and analysis of the TA (e.g., the relationship between the strength of the TA and number of sessions attended) (Dunn & Bentall, 2007). Future research needs to examine the constructs of the TA to clarify the most pertinent components in the process. It is beyond the scope of this study to attempt to rectify these current concerns surrounding the lack of a consensus on a theory of the TA. Instead, the most widely accepted constructs of the TA in research (i.e., bond, agreement on therapeutic goals, and agreement on tasks) as described by Bordin (1979), will be used when discussing the TA.

### **The Therapeutic Alliance with Pediatric Populations**

The rise of behaviorism in the 1960's and 1970's meant that the focus of child psychotherapy shifted from the interpersonal relationship to a focus on observable tasks and on contingent reward and punishment (Zack, Castonguay, & Boswell, 2007). Still, a strong TA with a child is believed to be an important factor in behaviourally oriented child psychotherapy. A robust TA increases the child's participation in treatment components (e.g., skills building and exposure tasks) (Liber et al., 2010) and it is known that a weak alliance can predict premature termination of care (Zack et al., 2007).

Despite the TA's importance to treatment outcome, the key components of the TA with the youth population are unclear and there has been no agreement around a single definition (Zack et

al., 2007). In terms of existing frameworks, Bordin's (1979) model of the tripartite TA (i.e., one that entails a bond, an agreement on the tasks of therapy, and an agreement on the treatment goals) may be developmentally inappropriate for either children or adolescents. Several studies have found that "agreement of goals," for example, may not apply to younger populations. This component requires the client be able to conceptualize long-term goals, and link the goals to the session-by-session tasks of treatment (Zack et al., 2007). Children and youth may not have the cognitive or abstract abilities to be able to formulate, comprehend, or appreciate therapy goals. Setting long-term goals requires hypothetical and instrumental thinking along with delaying gratification (Zack et al., 2007). This developmental inability, combined with the fact that many child-patients come to therapy not interested in goals or treatment, makes the "agreement on therapeutic goals" an unlikely component of the child TA. Still, pediatric researchers continue to use adult alliance models that rely on this component (Zack et al., 2007).

Another recent study by Campbell and Simmonds (2011) examined therapists' perception of the TA with children and adolescents. Most notably, the therapists highlighted the collaborative nature of the TA, the parental alliance, therapist resources, and therapist self-awareness and well-being. They also stressed the importance of the therapist extending his understanding, reassurance, and support to the parents as well as to the children. This particular study emphasizes the importance of understanding whose perspective is being examined (e.g., the therapist, parent, or child) when investigating the TA.

In terms of treating specific disorders, Keeley et al. (2011) looked into factors that influence or reduce the treatment outcome of CBT for children with OCD. Using a multiple-informant (parent, child, and therapist) and a multiple-time point design, the researchers examined the predictive value of the TA on OCD symptom reduction, and determined whether changes in the TA over the course of the treatment predicted therapeutic outcome. Twenty-five youth, of age 7-

17years, participated in CBT for an average of 12 sessions. The tools used to measure the TA were the Therapeutic Alliance Scale for Children (TASC) and the Working Alliance Inventory (WAI). Results showed that the stronger child-rated, parent-rated, and therapist-rated therapeutic alliances were predictive of better treatment outcome. Importantly, using hierarchical regression analyses Keeley et al. (2011) found that larger and more positive TA shifts early in treatment were predictive of better treatment outcome. This follows the suggestion, mentioned above, from Horvath (2001) that the TA should take precedence over technical interventions in the beginning of therapy.

Baylis, Collins, and Coleman (2011) conceptualized The Child Alliance Process Theory. This theory was developed after the analysis of semi-structured interviews conducted with 7 children between the ages of 6 and 12 who had received counseling at the Calgary Health Region's Children's Mental Health Programs. As most models rely on adult populations to inform clinical work and research, the qualitative study aimed to explore the children's experience of the therapeutic relationship. The result is a progressive child-informed theory to guide the development of a strong alliance with children. It recommends that during therapy the therapist move back and forth between initiating and responsive behaviours with the child client. The Child Alliance Process Theory describes the therapeutic relationship and how it develops and encompasses both close and distant factors that influence the strength of the alliance. The theory lists Alliance Dependent Behaviours (ADB) (e.g., less talking, doing activities, being nice, expressing caring, active listening, focusing on the child) and Alliance Expectant Behaviours (AEB) (e.g., validating feelings, demonstrating patience, respecting confidentiality, doing activities, focusing on problem solving), which arose from the children's own experience and perception of the therapeutic alliance.

The Child Alliance Process Theory is helpful and relevant to this study. The themes of the



theory arose from qualitative research, which allows for a direct comparison of the themes that arise in this qualitative study on the TA. As well, the experiences in the Baylis et al. (2011) study were drawn from children's perspectives, in contrast to this study, which focuses on the parent's perspectives. This allows for an examination of how children and parent's experience of the TA may differ or converge. For these reasons the themes present in the Child Alliance Process Theory were compared for similarities and differences to the parents' experience of the TA when analyzing the data for this research.

### **Therapeutic Alliance and Autism**

Bromfield's (2010) *Doing Therapy with Children and Adolescents with Asperger Syndrome* is the only text found in the literature search that specifically addresses the therapeutic alliance with this population. Bromfield, a Harvard trained clinical psychologist, begins by speaking to the historically pervasive view, influenced, in part, by Bettelheim's (1967) perception of the role of the mother in causing autism, that any therapy with children and youth with ASD that involved talking and playing was seen as unhelpful and destructive. Yet, he says that every child with ASD has taught him; more than anything, that they have a powerful need for a connection to others and are capable of forming therapeutic relationships (Bromfield, 2011). He does not advocate replacing behavioural or language therapies, or social pragmatics instead his approach is a relationship-based therapy intended to inform, augment, and enrich all the other existing therapies for youth with autism. Bromfield's (2010) research (in the form of case studies) illuminates the importance of understanding and developing the TA with children with ASD and presents possible historical reasons for the lack of research in this area. The bias in the research is undeniable. From 1979 to the summer of 2011, the *Journal of Autism and Development* (which states that it is dedicated to all aspects of ASD) has published 2,262 articles; not one of these has focused on psychotherapy or counseling (Bromfield, 2011). Bettelheim's tragic error of claiming

mothers' emotional unavailability caused their child's autism resulted in psychiatry and psychology swinging the pendulum the other way, "where it got stuck" (Bromfield, 2011, p.7).

My modest hope is that the following study begins to help swing the pendulum towards the middle by seeking parent's perception of the TA. Often, as Solomon (2012) reminds us, parent observations can be as powerful as the observing eyes of a professional. As stated earlier, the aim of the present study was to explore the perspectives of three mothers who had participated in a CBT group for children with OCB and, using an interpretive phenomenological approach, closely examine their perceptions and observations of the TA between their children and a therapist.

### **Methodology**

The qualitative research approach used for this study is Interpretive Phenomenological Approach (IPA). Increasing in popularity, IPA research examines the ways people make sense of their major life experiences (interpretative) and explores the experience itself (phenomenological). IPA aims to examine individual cases for detailed and rich accounts that shed light on what the experience was like for *this* individual and what perceptions *this* individual has of *this* experience (Smith et al. 2009). IPA is based on the philosophy of phenomenology and hermeneutics. Phenomenology, a philosophical approach to the study of experience, was a movement founded by Edmund Husserl, who wanted to find a means for an individual to know their own experience in such a deep way that they could identify the essential qualities of their experience. Husserl believed that by knowing the essential features of an experience the individual would *transcend* the particular circumstances of their appearance and then this might illuminate a given experience for others too (Husserl, 1999). In this study, the mothers' experience of the TA between her child and the therapist will highlight the essential features of the alliance for them. In the knowing and sharing of their experience of the TA, others may begin

to better understand the paths to take to develop and maintain therapeutic relationships with children with ASD.

Martin Heidegger, another philosopher of phenomenology, coined the term “hermeneutic circle.” Given that Husserl formulated phenomenology as explicitly an interpretative approach, Heidegger’s circle describes the dynamic process that one must travel to understanding a text as a whole. Basically, this means that the understanding of the whole only comes from one’s understanding of the parts, as neither one can be understood without reference to the other (Smith et al., 2007). A hermeneutic circle is used for analyzing the text of the mothers’ experiences here. First, each parents’ individual experience is deeply analyzed and explored to gain an understanding the individual parts of the circle. Second, each individual experience is then compared and contrasted with the other so an understanding of all the texts is experienced as a whole.

IPA’s foundation in phenomenology and hermeneutics, then, requires that an analysis in IPA is iterative (repetitive) and idiographic (concerned with the particular). This is why the sample size in IPA research is small and contrasts with more dominant psychology research that is concerned with establishing laws of human behaviour and making claims at a population level (Smith et al., 2009). IPA is a suitable method for the research questions of this study since they are of an exploratory nature and their aim is not to explain or measure therapeutic alliance, but to discover how the parents experienced the relationship, how they describe the key features of the therapeutic alliance, and the meaning and importance they give to the therapeutic relationship in this particular therapy. IPA research uses “rich data” (Smith et al., 2009, p.56) collected from the descriptive and reflective stories of the participants who are able to speak freely and at length about their personal experiences. The in-depth, semi-structured interview is one of the best methods to acquire a descriptive first-person account (Smith et al., 2009).

The interview questions in IPA research purposively do not contain theoretical underpinnings and are instead constructed in such a way as to get at the answers to the original research questions. To do this, the researcher identifies the broad research area (in this case the TA) and then decides on a range of topic areas that the interview questions will touch on. For this study, general questions like “What brought you to therapy?” and “What was the experience like?” were asked first to begin the exploration of their experience on a general level. The next questions focus on the relationship between the child and the therapist but don’t introduce existing theories or terminology. “How would you describe the relationship between your child and the therapist?” “How did they interact?” and “How did you child feel about the therapist?” are asked to illuminate the original research questions. All interview questions are open-ended and the participants are encouraged to talk at length with minimal input from the interviewer (Smith et al., 2009). It can be argued that these questions are not completely devoid of theory as they direct the participants to speak about the relationship between the therapist and the child. The term “relationship” does mean an emotional association between two people (Oxford Dictionary, 2005), yet this is the exact phenomenon under exploration so it was necessary to name it during the interview.

Theory on the TA was used after the interviews to “dialogue” with the data; however, the interview schedule avoided questions that deliberately used or suggested current TA theory as that could lead or manipulate the participants’ answers and/or limit the participants’ answers to a range provided by a TA theory (e.g., expressing caring, validating feelings).

An IPA approach allows for certain flexibility when analyzing data. There is no set method for dealing with the data but there is a definite commitment in IPA to understanding the participants’ perspective and their attempts to make sense of their experiences. During analysis, the following strategies suggested by Smith et al. (2009) were employed:

- Detailed, line-by-line analysis of transcription of the descriptions and understandings of each participant
- Identification of emergent patterns (themes) within this data, focusing on convergence and divergence, and commonality and nuance, first with the individual and then across the three participants
- The development of an interpretative account through “dialogue” between the data and previous research and psychological knowledge
- The development of a structure, frame, or gestalt, which demonstrates the relationships between the themes
- Organization of all the data into a format that allows the analytic process to be traced through the entire process (See Appendices C, D, & E)
- The use of supervision and collaboration to test, audit, and help develop the interpretation
- Development of a full narrative that takes a reader through the entire process which is typically theme-by-theme and includes a visual guide or diagram (p.79-80).

A more detailed description of the steps used during the analysis will be delineated in the Analysis section.

### **The Treatment: Function-Based CBT**

Current research has reported that 65% of young people with ASD have a comorbid affective disorder (Atwood, 2010), namely, social anxiety, obsessive-compulsive disorders (OCD), and specific phobias (Russell et al., 2013). OCD (the comorbid condition in this study’s treatment program) has occurs frequently in this population, with prevalence rates of 8% to as high as 30% reported (compared to 2% in the typically developing population) (Donoghue, Stallard, & Kucia, 2011; Russell et al., 2013). CBT is the dominant psychosocial therapy for typically developing

children with anxiety disorders (Ollendic, King & Chorpita, 2006) and there is a consensus that with certain modifications CBT can be used to address affective disorders in children with ASD without an intellectual disability (Moree & Davis, 2010). In a recent, randomized controlled trial, 47 children with ASD without an intellectual disability and anxiety participated in a 12-week manualized group-CBT program call Facing Your Fears (FYF) (Reaven, Blakely-Smith, Culhane-Shelburne, & Hepburn, 2012). The study demonstrated that 50% of the control group had clinically meaningful positive treatment outcomes compared to 8.7% of the treatment-as-usual group (TAU) who maintained their current intervention program.

Farrell, Waters, Milliner, and Ollendick (2012) evaluated the effectiveness of group CBT on treatment outcomes for children with OCD and complex comorbid conditions (including attention deficit disorder, ASD, and depression). Forty-three children and youth with OCD participated in the family-based CBT group. Eighty-six percent of the participants had a secondary psychiatric disorder and seventy-four percent had multiple co-morbid conditions. Farrell et al. (2012), found that comorbidity was not associated with poorer treatment outcomes ant the post-assessment but at six months treatment outcomes were poor for participants with multiple comorbidity and for those with attention deficit/hyperactivity disorder. Farrell et al. (2012) call for future research to examine ways to improve long-term outcome for children and youth with multiple comorbid conditions.

### **Procedure**

The interviews informing this project were conducted with three mothers of children who participated in a randomized controlled study using Group CBT using a specialized treatment protocol (Vause et al., 2010a) and manual, *I Believe In Me, Not OCB!* (Vause et al., 2010b). This group treatment involved two-hour group sessions, once per week for a total of 9 sessions and was led by Diane (a pseudonym), a MA student who had previous experience as a therapist in

this treatment. As part of the study, home visits by the research team were also conducted to get to know the child's home environment, and to collect assessment and treatment data. All the participants received an *I Believe in Me, Not OCB!* Workbook (Vause et al., 2010b). Among other things, the children's session-by-session workbook introduces the child to the session schedule, explains new concepts and therapeutic exercises, and describes group social skills building activities. The manual is specifically tailored to the cognitive-developmental learning style of children with ASD without an intellectual disability and addresses the challenges the child is experiencing with OCB. These repetitive behaviours can severely disrupt academic, social, and family functioning (March & Mulle, 1998). A general goal of CBT is to help the child internalize and use strategies to resist OCB so they, and their families, are able to live happier and more productive lives (March & Mulle, 1998).

In ASD research, repetitive behaviours are separated into two classes: (a) Autism-related obsessive-compulsive phenomena (AOCP), and (b) Obsessive-compulsive disorder (OCD) behaviours (Fischer-Terworth, & Probst, 2009). The first, AOCP, includes compulsive rituals and repetitive motor movements. AOCPs are not always associated with anxiety or guilt in the individual with ASD (Ruta, Mugno, D'Arrigo, Vitiello, & Mazzone, 2010) and for some; they may produce feelings of euphoria (Fisher-Terworth, & Probst, 2009). The second, OCD behaviours, involve compulsions like checking, ordering, washing, and rituals involving another person, and are performed in order to alleviate anxiety. Interruption of either of these repetitive behaviours can cause significant distress in the child with ASD and in individuals with OCD (Ruta et al., 2010). It is often challenging to make a distinction between AOCP and OCD behaviours in individuals with ASD, as they can strongly resemble each other. For instance, insistence on sameness behaviour, like sitting in the same seat, strongly resembles the "just-right" behaviours of OCD. As well, making the distinction even more challenging is the difficulty for

children with ASD to verbalize their obsessions (Gillott, Furniss, & Walter, 2001). In this treatment and research, the term OCB is used to represent both types of repetitive behaviours.

The key treatment components of this CBT program include: (a) a general introduction to OCB using a neurobehavioral framework; (b) psychoeducation; (c) mapping out OCB symptoms and gaining awareness of duration spent engaging in OCD behaviors; (d) creating a hierarchy of OCB; (e) use of exposure and response prevention (to which a large number of sessions are dedicated); and (f) relapse prevention and training for generalization. An additional treatment component of this therapy includes a function-based assessment and intervention, which will be discussed below. This is the reason this specialized CBT program is referred to as Function-Based CBT (FB-CBT).

### **Phase 1: Psychoeducation and mapping.**

The first two sessions of the group focus on building rapport, setting group expectations, and introducing and defining OCB. From a list of obsessions and compulsions, obtained during the assessment phase, the parent-child dyads work with the therapist to create a list of concrete obsessions and compulsions. A fear thermometer is used to rate the children's fear by quantifying how much distress they would feel when they are unable to engage in an OCB. After rating each OCB, the children map each one on a hierarchy with three concrete sections that represent the children's distress and resistance in performing OCBs. This mapping enables the therapist to individually determine what order the OCBs will be targeted during treatment. Throughout treatment the child tracks the progress of their behaviours using this map. They also learn externalizing statements that can be used during the exposure training. Parent training is also a component in each phase.

**Phase 2: Functional behaviour assessment + CBT skills training + exposure and response prevention.**



Throughout the course of the treatment, individualized function-based assessments are conducted for each obsessive-compulsive behavior the families are working on (e.g., bringing useless items home, excessive reassurance seeking, excessive hand washing). The therapist uses the Questions About Behavioural Function (QABF) questionnaire to gain further insight into the function of the child's OCB. The QABF includes five items to examine four acknowledged functions of behaviour including: (a) attention from others, (b) self-stimulation, (c) access to a tangible item, and (d) escape. Each of these items is rated on a 4-point scale from 0 (never) to 3 (often). The therapist then creates an intervention plan for the parents that target each perceived function of the OCB.

The cognitive training is an individualized psychoeducational component that helps the child become aware of the link between their OCB thoughts and behaviours (e.g., excessive tooth brushing is preceded by fearful thoughts of getting cavities). The therapist and the parent/child work together in directly disproving the OCB thought by demonstrating the irrationality of the thought and behaviour, as well as by examining the probability and personal responsibility (if applicable) of the feared thought. The therapist and parent/child dyads also challenge OCB thoughts indirectly in a number of ways: changing negative self-talk to positive self-talk, cultivating nonattachment, creating "bossing back" statements (e.g., "Leave me alone!"), teaching thought discrimination, making concrete rules (e.g., "I will brush my teeth for only 2 minutes"), and teaching replacement behaviours (e.g., "Instead of brushing my teeth for 30 minutes I will read a book").

OCBs are targeted one to two per week through Sessions 3 to 9. The exposure phase of the treatment has the child, with help from the therapist and parent; create a plan for a gradual exposure to a thought (and related stimuli) that may cause anxiety. The associated OCB is then either loosely or sometimes completely blocked (i.e., during a complete block the child would not

engage in the behaviour at all, and during a loose block the child would engage in the behaviour only partially and/or the duration of the behaviour would be reduced). During therapy, the child and parent choose items or activities that will be available to the child for reinforcement when they successfully perform the ERP exercise. The ERPs are practiced at home and reinforced daily so that over time the child is gradually exposed to the anxiety provoking thought more frequently and for greater lengths of time without being able to engage in their OCB.

For this study, the three participants chose to have the interviews completed in their homes after given the choice of having the interview completed in their home or at Brock University. Before the interviews began, the interviewer asked the participants to sign a hard copy of the consent. They were informed by e-mail communication and/or by telephone that the interview would be anywhere from 60 to 90 minutes long. The participants were reminded that they had the right at any time, before or during the interview, to withdraw from the study without consequence.

### **Instrumentation**

An audio recorder was set up in the interview space and recording began once a hard copy of the consent document was signed. Before beginning the interview, the interviewer reminded the participant about the protocol being followed to ensure their confidentiality, and the confidentiality of their child, as well as that of the therapists being discussed. The interviewer informed them that all identifying facts would be removed and their name would not be linked with any of the data provided.

An interview schedule (See Appendix A) was used in a flexible manner and was a guide for the interviewer. The schedule included possible prompts and probes to achieve more detailed accounts from the participant or to find out more about something interesting the participant had described. After the interview was completed, the interviewer thanked them for their time.

A verbatim record of the interview was transcribed and all words that were spoken by both the participant and the interviewer were recorded. Participants were sent electronic copies of the transcribed interview and were asked to check the transcriptions for accuracy and change or add any information they deemed necessary. This was a form of a member check. Member checks help ensure narrative and descriptive accuracy; however, none of the participants in this study chose to respond or make changes to the transcript.

### **Recruitment of Participants**

When first participating in the CBT treatment study, parents indicated their willingness to be contacted for future research pertaining to that study by checking a box. Only parents that indicated their willingness to be contacted again were approached (see Appendix B for Telephone and Email script). Choosing participants that stated they were willing to be contacted is a type of purposeful sampling. Purposeful sampling is a practice in qualitative studies. It means that the investigator chooses individuals because they can purposefully inform and help answer the research questions at hand (Creswell, 2007). More specifically, the type of purposeful sampling used in this study was a combination of homogenous and critical case sampling. The latter is useful in exploratory qualitative research where a small number of cases can significantly illuminate the phenomenon at hand and allows for logical (but not statistical) generalization to other cases (Creswell, 2007). A homogenous sample like this is often used when the phenomenon being explored is specific to the characteristics of a particular group. It also helps focus and simplify the study (Creswell, 2007). As well, most of the participants were mothers and to be able to compare their experiences of the TA (rather than differentiate) we contacted only mothers.

### **Research Ethics**

This research received approval from Brock's Research Ethics Board (REB File #12-205-VAUSE) on March 27, 2013. During the conduct of this research, to ensure privacy and

confidentiality of the participants and the therapist, only the faculty supervisors, Dr. Tricia Vause and Dr. Danny Tarulli, and Kerry Houlding, this study's investigator, knew the names of the three participants recruited. After the recruitment phase, participants were given a number (e.g., Participant 1) and when discussing the project with faculty, their numbers were used instead of other identifiers like initials. Participant numbers were used, instead of initials because other student researchers are familiar with the participants in the group and could potentially identify the participant, the child, and the therapist involved if initials were used. The participants, the children, and therapist have been given unidentifiable pseudonyms. All other possible identifiers were altered or left out (e.g., names of schools, treatment centres, when the therapy took place or where, etc.).

### **Participants**

Most of the parents that participated in the FB-CBT treatment groups have been mothers, so for the sake of homogeneity only mothers were chosen for the interviews. An age range for the mothers was not a requirement. The children were between the ages of 7 and 13 when they took part in the therapy group. Each participant had Diane, a MA level graduate student who ran groups and researched the treatment, as his or her primary therapist. A description of the mother and child participants follows.

*Anita and Robert.* (All participants were given pseudonyms) Anita is mother to 12-year-old Robert. They took part in the FB-CBT group over a year ago. Robert had been experiencing obsessive-compulsive behaviours around water. Most importantly he refused to allow water to touch his body, which made maintaining general hygiene standards difficult. He was also displaying hoarding behaviours and he needed things to be "just right" (like having doors closed only a certain amount). Anita had been home schooling Robert for the past school year because of issues she was having with the school.

*Kelly and Megan.* Kelly is mother to 12-year-old Megan. Kelly attended the group a year ago. Megan had been bringing a large collection of stuffed animals with her whenever they went out in public and it was having an impact on the quality of their outings. Among other behaviours, she was unable to tolerate changes in her seating in different settings. Megan always had to sit in the exact same spot in the home, in the car, and at school.

*Christine and Jordyn.* Christine is the mother of 9-year-old Jordyn. They attended the group almost two years ago. Christine brought Jordyn to the group because of obsessive-compulsive behaviours, the need to receive toys, the need for her toys to be lined up around the house in a specific manner, the need to sit in specific spots, and refusing to touch water. The behaviours were interfering with the amount of time Jordyn could spend doing other activities. Jordyn had a history of difficult relationships with the school and Christine felt like she was in constant struggle with the school administration and teachers.

### **Data Analysis**

An IPA approach closely examines “how people make sense of their major life experiences” (Smith et al., 2009, p.1) without attempting to manipulate these experiences into predetermined categories or abstruse theories. This sense making is an interpretative undertaking, and, as an IPA researcher of TA, I am involved in a dual process: I try to make sense of the participant’s making sense of the relationship their child has with a therapist (Smith et al., 2009). This type of analysis reveals the convergences and divergences between individual cases and between these cases and existing TA theories.

In IPA, an in-depth analysis is achieved by utilizing the dynamic nature of the hermeneutic circle to understand and interpret text. The six-step analytic process (Smith et al., 2009) began with a reading and re-reading of the interview transcripts, while simultaneously listening to the audio recordings. This ensured the focus was on the participants’ experiences. The second step

was to make different coded notes on the transcript to indicate the type of analysis. These exploratory notes were either: descriptive (content driven), linguistic (language driven) or conceptual (meaning driven). During this step some of my own pre-existing knowledge of the TA directed the questions I asked and the comments I made. Still, all interpretations were stimulated and tied to the participants' accounts. The third step involved mapping the interrelationships, connections and patterns in the exploratory notes. The fourth step involved mapping and charting the themes that fit together. Once the first interview was complete, the same steps of analysis were taken to interpret the second and third interviews, treating each one as a stand-alone case. The final step was to look for patterns across the three cases, looking for connections between themes, possible superordinate and subordinate themes, as well as reconfiguring and relabeling themes. A paper trail of the six-step process is available upon request.

This in-depth analysis of the three conversations resulted in the discovery of four superordinate themes that capture the essence of the therapeutic alliance (TA) as observed and experienced by the mothers of the children participants. The pan-theoretical model of the TA as being composed of bond, task, and goal (Bordin, 1979) is not an accurate conceptualization of the TA experience of these parents. As this research found, the relationship between the therapist and the children is never described by the mothers in terms of "agreements on goals". Rather, they observe the bond between their child and the therapist as the main feature of the relationship without which their children would stop attending therapy. The four themes that emerged from the parents' accounts of the therapeutic relationship are:

1. "She wouldn't go"- Centrality and Disremembering the TA
2. Qualities of the Therapist;
3. "Diane took the time"- TA and the Importance of Time; and
4. No Resistance- Signs of a Healthy TA (See Appendices C, D, & E for emerging themes).

**Theme 1: “She wouldn’t go”- Centrality and Disremembering the TA**

This theme addresses the importance given to the therapeutic relationship by the mothers to the overall treatment outcome. It also encapsulates the paradoxical phenomenon whereby all three mothers describe the process of therapeutic success (i.e., a reduction in OCB behaviours) as occurring either suddenly or beyond the purview of therapy.

In the first excerpt, when asked about the importance of the relationship between Diane (the therapist) and Rob (the child), Anita (the mother) speaks adamantly:

Interviewer: And then how important to the overall treatment, like so the reduction of OCD? The therapeutic relationship, so that’s between him and Diane, how important would you think that was to all, the whole therapy?

Anita: Huge.

Interviewer: Huge. Okay.

Anita: For one, he wouldn’t have kept going.

Interviewer: Right.

Anita: I think I wouldn’t have made him go because I don’t want to go somewhere he doesn’t want to go

Interviewer: Yes, that’s true.

Anita: I would have let it end.

This excerpt succinctly and powerfully describes the importance of the therapeutic alliance. The relationship as Anita describes it takes on physical proportions (e.g., “Huge”) to punctuate the relationship’s importance. The statements “I wouldn’t have made him go” and “I would have let it end” indicate that Anita and Robert’s continued participation in the group hinged unequivocally on the relationship between Diane (the therapist) and Robert. The importance of a positive relationship between Robert and Diane for Anita is further emphasized during the

interview when she mentions Robert is being home-schooled because of recurring problems with teachers: “It’s just easier for me to give him grief than it was to deal with the school calling and throwing chairs or hitting somebody, I just couldn’t deal with that anymore”. For Anita, home schooling Robert takes less psychic and physical energy than handling fractious relationships between teachers and her son. Robert’s negative and unhappy experiences at school, along with her having to deal with the turmoil and fallout of these regular occurrences, means home-schooling is her only option. Again, this schooling decision, no less than the foregoing comments about the centrality of the bond between Robert and the therapist, reflects the importance this mother attaches to the relationship between her son and the authoritative adults in his life.

Robert is not the only participant in this study to have unhappy school relations; Christine, mother of Jordyn, reported witnessing teachers and teaching assistants physically and harshly restraining her daughter at school. Neither Robert nor Jordyn ever displayed aggression or emotional outbursts in any therapy sessions, which suggests their relationship with Diane and their experience in therapy was a less frustrating relationship for them. By implication, then, the children’s previous negative and aggressive experiences with adults in the school setting make a strong TA (with a therapist such as Diane) an imperative for their participation in the FB-CBT group.

Kelly also perceives the therapeutic relationship as being critically important in the improvement her daughter, Megan, experienced: “They have a bond for sure... Yes, you have to have a good relationship with Megan”. Here, Kelly, like Anita, states that to not have a “good” relationship with Megan means that the therapy wouldn’t happen; there is no alternative. When speaking about the relationship between Megan and Diane, Kelly more than any other parent uses emotion-based language. Three times she spontaneously uses the word “bond” to describe the relationship between Megan and the therapist Diane (“They have a bond for sure”, “There was a



bond”, and “The bond with Eva [student therapist] wasn’t the same as with Diane at all”). The first time I mention Diane (the therapist), Kelly is ebullient:

Interviewer: So, how would you describe the relationship between Diane and Megan?

Kelly: Oh, she loved Diane. Oh yes.

Kelly’s use of the word love in this extract is preceded and followed by the word “Oh”, which signifies Kelly’s sudden recall of the relationship. “Love” is the first word she uses, demonstrating the enjoyment Megan received from the relationship. Love is often referenced in romantic poetry or when describing the feelings parents have for their children and vice versa. In this context, I interpret it as an enthusiastic and strong connection between the therapist and child. Yet, as the interview progressed, I also learned that Megan is “outgoing” and “really attaches to people who show an interest in what she likes”. Kelly also couldn’t remember a teacher that Megan didn’t like which suggests that Megan often has positive relationships with professionals and adults outside her immediate family. Her ability to form attachments to others is a reminder that the TA is a reciprocal relationship: both the therapist and the client contribute to its formation.

Christine uses the less emotionally charged word “like” when describing her daughter, Jordyn’s, feelings towards Diane (the therapist), but the significance of the relationship to the outcome of therapy is just as strong:

Interviewer: How did you know if she liked (therapy)?

Christine: She would go...

Interviewer: And do you think it was because of that- [changes tack] what was it about therapy?

Christine: She liked Diane.

Interviewer: Has she ever had a therapist outside of even CBT, like that program,

other programs, where she hasn't liked the therapist or hasn't had ....

Christine: Oh, yes.

Interviewer: And would she tell you?

Christine: Yes. Yes, she tells me she doesn't—there's no point in her going if she doesn't like you.

Interviewer: Oh, and she wouldn't go?

Christine: She wouldn't. No, she wouldn't go, there would be no point in it.

Twice in the above excerpt, Christine states that if Jordyn didn't like a therapist there would be "no point". The "no point" suggests there would be futility in participating in therapy without a TA. Jordyn's response is not unique, as when asked about the relations between their children and the therapist each parent matter of factly stated that their children would not attend therapy if the relationship with Diane were not positive. Each interview excerpt demonstrates the high value parents put on harmonious relations for their children both within and outside the therapy setting. Indeed, they are willing to discontinue the treatment if their children are not happy with their relationship with the therapist. For these three participants, then, this disclosure centralizes the therapeutic alliance, for without it there would simply be no treatment (See Table 1).

The emotional bond is the only component of the TA mentioned by the parents. The mothers do not speak of the goals of therapy when asked about their overall experience of the therapy, nor during questions about the relationship between their child and Diane. The lack of reference to the tasks and goals of therapy raises questions about the suitability of Bordin's (1979) pan-theoretical model of the TA for this population. His theory lists three factors that make up the therapeutic alliance: bond, agreement on therapeutic tasks, and agreement on therapeutic goals;

Table 1

*Theme 1: Centrality of the TA*

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Anita:	“he didn’t respond to anyone but her” (p.15)  “Huge. I wouldn’t have made him go. I don’t want to go somewhere he doesn’t want to go. I would have let it end” (p.33)
Kelly:	“Oh Megan loved Diane. Oh yes. Yes, it was a good relationship” (p.8)  “They have a bond for sure. Yes, you have to have a good relationship with her” (p.23)
Christine:	“She wouldn’t go if she didn’t like Diane” (p.12)  “went because she liked Diane” (p.28)

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however, only one of the three of the components (i.e., the bond) was raised by the mothers. This may speak to the notion that clients experience the therapy very differently from the therapist. Irving Yalom (2002), psychiatrist and author, speaks of the idiosyncratic ways he and his patients remember and experience a therapy hour. During a case study, Yalom, the therapist, and a young female client both wrote summaries of their hour together. After several months of writing, he found that they each valued very different parts of the session. The patient never mentions her therapist's interpretations or advice in her summaries of the session but instead she writes of his small personal acts (like a compliment about her hair or a heart-felt apology for being late). Meanwhile, Yalom never mentions these acts in his summaries of their hour. It is possible that the discordance between Bordin's theory (1979) and the mothers' responses is an example of this claim that patients view therapy very differently from the therapist. The current TA theory may reflect the therapist's perception rather than the client's.

It is important to note that while mothers spoke of the bond component of the three-part theory, often providing laudable descriptions of the therapeutic relationships throughout the transcripts, they did not mention the importance of these relationships spontaneously during their response to the first two questions (i.e., "Tell me about how you came to participate in the CBT group with your child?" and "What was the experience like in the group?"). I interpret this as an unintentional disremembering of the relationship. Disremembering is to forget, to be unable to remember (Webster's, 1968). We spend a lot of time trying to unconsciously control the contents of our minds. One way we do this is by "up-front" selectively attending to certain aspects of our world (Jacoby, Kelley, & McElree, 1999). This may be one of the most successful ways to regulate memory content because how we direct our attention strongly affects what we remember later (Broadbent, 1957). Arguably, what the parents' first remember of the therapy may be an

artifact of where their attention was directed during the process. For the three parents in this study, the focus of attention was on seeing a reduction in OCB at home. When first asked about her overall therapy experience Kelly replied: “She [Megan] liked going... I think that she did very well, like just for the results that happened at home.” When Anita was asked the same question she responded: “It was really great for what we worked on then. We picked up all new ones...but they don’t really get in the way of life”. Upon reflection of their overall therapy experience, these parents consider improvements in the home. They only consider the therapeutic relationship and its contribution to the success of therapy through a dialogical process with the interviewer.

During the interviews with the mothers, as stated, no mother ever spontaneously mentions the therapist. The opening questions ask what brought them to therapy and their overall experience in the FB-CBT group. While I expected an unsolicited mention of Diane (the therapist), it was not until the third question of the interview (i.e., “How would you describe the relationship between your child and the therapist?”) that Diane’s name was mentioned. There are many possibilities besides the notion that the therapist was not important as to why this was the case. The time since the therapy (approximately one to two years) may have also obscured the mother’s particular memories of the therapeutic experience and not until a specific question about Diane triggers their memories did the relationship between the therapist and child become more predominant in their minds. Further, it is possible that the mothers never considered the components of the treatment and that it was not until the interview, when asked specific questions about it, that, they started to analyse the factors that made the FB-CBT treatment helpful to them. Most likely, each point contributes to the lack of immediate reference to Diane. However, while neither point negates the centrality of the TA in these three cases, it does question the conscious, predominance of the TA for these parents. Eatough and Smith (2006) explain that meaning

making is a process that involves re-experiencing and re-interpreting, so it is possible the participants were interpreting their experience of treatment in one way, and then, once a specific question about Diane was asked, they engaged in the process of re-experiencing and re-interpreting. Only once a re-interpretation occurs, that is, only once Diane is mentioned, does the TA become a central component of the treatment for these parents.

Meaning-making can be “ambiguous, ambivalent, and confused” (Eatough & Smith, 2006, p.115) and this description could certainly apply to the mothers’ interpretation of the TA: instead of a spontaneous recognition of the importance of TA, the mention of the TA’s centrality only came after being asked questions, remembering, and considering the overall therapeutic experience. With these parents, meaning making around the TA came dialogically during the interview itself. The meaning of the TA to their overall experience was not waiting to be discovered by me, the researcher. Instead, the meaning emerged through a joint process between the participant and the interviewer (the importance of dialogical meaning making for the TA and for IPA will be returned to in the Implications section). A closer examination of the disremembering of the TA during the interviews provides insights into the ways in which parents interpret their overall experience of therapy and to where their “up-front” attention is directed during the therapy and how meaning emerges through the interview process.

Interestingly, while discussing the improvements the parents observed in their child, the participants did not attribute the changes to a specific therapeutic component (e.g., “Bossing Back OCB”, exposure training [which occurs when children, with parents coaching, gradually expose themselves to the feared object, thought, or action]), or to the therapeutic relationship. In the following excerpt, for example, Anita describes Robert’s refusal to wash his hands and how after performing behavioural exposures for two days, she stopped having to track (i.e., keeping a

daily record of the number of times the unwanted behaviour occurs) and reward (a part of the treatment plan is for the parent to reward desirable behaviours) when he did wash his hands:

Anita: How many times have we asked him to wash his hands? Like a million times. No, he just started doing it one day, like we were tracking it and he just like after—I think it was—that’s what it was, he got the reward thing was gummies.

Interviewer: Oh, right, yes. Yes.

Anita: And I think after—like on day two, I didn’t even have to reward him anymore, like it was like that, I think I even texted or something, and it was like okay day two, we’re done, you know, it would have been like I had to continue for the whole week and keep rewarding him, I stopped with the rewards because he didn’t even ask for them.

During treatment, children often practice exposures to long-standing obsessive-compulsive behaviours for the duration of the therapy. Yet Anita describes exposures as occurring for only a couple of days before going into remission (this is not typical during treatment).

It is tempting to explain the phenomenon away by claiming poor memory, but each of the three mothers had similar experiences of their children’s reduction in obsessive-compulsive behaviours as occurring outside of therapy and without mention of the therapeutic process. This is another example of disremembering. Kelly describes Megan’s new ability to leave her numerous stuffed animals at home (instead of having to take all of them every time they went out in public, a behaviour that had caused family friction before therapy) as a result of action they took at home: “So, we did little steps here and there, you know we would get her to where it was good that she could leave (her stuffed animals) at home.” The improvement came from Kelly acting in the home and having her daughter to leave the animals at home, placing Kelly as the agent around which therapeutic improvements occur. In a similar interpretation of the therapy,

Christine credits Jordyn's quick intellect as a factor in her success with FB-CBT: "So, it really worked well for her, the therapy, she picks it up." For Christine, then, successful therapy is described as something that her child can "pick up" and does on her own. Similarities exist, then, among each parent's explanations for their child's success.

These three excerpts, taken from the mothers' explanations for their children's successes do not specifically refer to therapeutic processes. Perhaps it is because each parent was so close to the event, that is, that their participation meant they were intimately engaged in the process of therapy, that they cannot immediately recall the therapeutic relationship with the child or the process of the therapy. The parents' interpretations speak to the integral way people experience and orient their world around particular ends and not isolated factors such as therapeutic relationship. For the parents, the TA is present and imperative, but, while recalling therapeutic successes, it is not the first factor that they consider. Christine's point on where the real work of FB-CBT therapy occur may explain this disconnect:

Interviewer: How was it at home? [asking about exposures]

Christine: Oh, it's never as easy at home.

Interviewer: No, just at the therapy.

Christine: You know it took us—you know we leave a McDonald's without the prize and she got – but you just picked her up and you – you know instead of giving her the prize just to shut her up, you know, keep the peace, you know, we just started not giving her—we were doing what I was told to do, I mean at the therapy, they're not doing that, right.

Interviewer: That's right.

Christine: You're doing it—you're doing the work at home really, you're not doing the work.



Christine makes an important point: the difficult work of therapeutic change occurs in the home, away from the therapy environment and the therapist. This framing helps explain why parents may not immediately speak of the TA. During the therapeutic process her attention was not on the relationship between her daughter and the therapist; rather, her focus was on the challenges she was facing. Home is where the majority of the child's time is spent and is where change, setbacks and gains are taking place. This point has clinical implications and will be examined further in the discussion section.

### **Theme 2: Qualities of the Therapist**

While conducting the interviews I did notice that many of the therapist characteristics and skills of which the parents spoke were similar to those identified in current theories of the TA with pediatric populations. Despite these similarities, however, with further exploration, it became clear that compared to the more common TA literature based on typically developing children, the parents' transcripts reflected differences and dissimilar emphasis on certain therapist qualities. Accordingly, this theme—qualities of the therapist—focuses on the parents' perceptions of the important traits of the therapist (See Table 2).

**Quality 1: Collaborative.** When considering the pertinent qualities of a therapist that lead to the development of a positive therapeutic relationship, I examined both the traits and skills the mothers spontaneously mention when describing Diane and compared it to lists based on current TA theory. The mothers' lists of the important traits and qualities of the therapist differ from those provided, for example, in the Child Alliance Process Theory. For instance, Anita, mother of Robert, describes an important quality she observed in Diane that is not mentioned in the Child Alliance Process Theory:

Anita: There was never a power struggle.

Interviewer: No. Okay.

Anita: No.

Interviewer: Never a power struggle, so she didn't...

Anita: No. She would get what she wanted, but it wasn't by saying you're going to do what I say and that sort of thing, it was all balls in the air I mean and that's the only thing that worked so far.

From her interview, it is clear that Anita views forced interactions with her son as power struggles. His history in school shows that he has not experienced many collaborative relationships with adult authority figures, yet Anita is aware that this is the only way to be in a relationship with him. Indeed, Anita suggests that one reason the FB-CBT therapy was successful with Robert was because of the collaborative nature of the relationship with the therapist. Collaboration needed to be present and demonstrated by the therapist in order for a bond to form. Anita's experience suggests that, even more so than with typically developing children, minimizing power struggles and increasing collaboration with children with ASD is imperative to bond formation.

Returning to the above quoted excerpt, the metaphor given by Anita of Diane with the "balls in the air" is that of an adept and flexible juggler. To have many balls in the air takes skill, and requires the ability to reach beyond normal boundaries when a ball is about to fall. In contrast to this depiction of Diane, Anita describes another therapist (from a social-skills group that Robert ultimately dropped out of) as "having her hands full". Being able to adeptly keep "balls in the air" suggests that one should not have too many; unfortunately, the therapist leading the unsuccessful social-skills group was not able to successfully juggle (i.e., be an effective therapist) because of the large number of participants. Given this interpretation and from my own experience as a therapist, I consider the number of group members to be an important quality of

Table 2

*Theme 2: Qualities of the Therapist*


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Anita:	“amazing” (p.15) “clear” (p.18) “don’t challenge him” (p.28) “lighten up” (p.29) “good at knowing how to reach kids” (p.17) “rewording” (p.17,31) “reduce frustration” (p.20) “We need to get through this then we’ll have a snack” (p.21), “balls in the air” (p.23)
Kelly:	“comfortable” (p.24) “fun” (p.10, 22,24) “do lots” (p.22) “gives ego-boost, praise” (p.23, 24), “easy conversations” (p.9), “adaptable” “giving personalized awards” (p.9)
Christine:	“nice” (p.21), “fun” (p.21), “give child prize” (p.20) “patience” (p.29, 40) “attentiveness” (p.6), “know how to work daughter” (p.10), “ignore bad behaviour, reminders” (p.10) “lots of praise” (p.13), “distraction” (p.27), “removal of attention” (p.16)

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the environment (and will examine important environmental contributions, such as participant numbers, to development of the TA further on).

**Qualities 2 and 3: Being fun and giving praise.** While the main factor for developing a successful therapeutic relationship with Robert appears to be collaboration, for Megan and Jordyn it was the therapist quality of “being fun”. Being fun and giving praise could be included under the category of “being nice” in the Child Alliance Process Theory, but I feel it is important to list and examine these qualities individually as they are each given considerable time in both interviews. Kelly and Christine use the word “fun” a number of times to describe what their children liked about Diane and the therapy. Kelly explained that, “Yes, she [Megan] would always talk about Diane and tell the teacher... Megan would say ‘Yes, Diane was really fun and she would do lots of stuff with me and give me stickers and you know encouraged me to try harder’.” The fun aspect of the therapist and therapy drew Megan out of her shell. Jordyn was also drawn to Diane and her fun factor:

Interviewer: So she was very outgoing, very...

Christine: Yes she was, yes she was very fun and visual, you know. And she had lots of expression and it was like I like her.

In addition to “being fun,” Diane’s skill of providing praise to the two girls was also a quality that increased their enjoyment of therapy. As Kelly stated, “It gave her that ego-boost.” Christine echoed this sentiment: “She didn’t mind it, she liked doing the homework but she also liked going there and hearing everybody say what a great job she did.” Praise has been a cornerstone of behavioural analysis since the beginning of the field (Stevens et al., 2011) and adult attention “is one of the most powerful and generally effective forms of reinforcement for children” (Cooper, Heron, & Heward, 2007, p. 273). Diane’s ability to provide genuine praise and positive “fun” attention to the two girls helped to create a positive TA.

The above therapist qualities of “being fun” and praising may present a potential conflict within professional realms as there has been a move away from describing the tasks of educators and therapists in a language that is emotive and expressive (Smith, 2004). Even as I write about these themes, I also have concern that the tone appears unprofessional. It is important to recognize, however, that fun is a theme that emerges in other accounts as well. Baylis et al. (2011), for example, also understand the need for fun when interacting with children as one of their basic research assumptions about the therapeutic alliance with children is that: “Having fun in sessions and being playful is important to children and helps them talk about difficult subjects” (p.85). For the two female children in this study therapy was about doing activities and receiving lots of praise and prizes during sessions. For the boy participant it was about being able to, at times, take breaks, and play on his DS. The narratives of the three mothers demonstrate that they are aware of the importance of fun for their children just as the children in the Baylis et al. (2011) study spoke of the need for their therapist to be fun.

**Quality 4: Reducing frustration.** Despite the importance of fun and collaboration I know that the cognitive training component of FB-CBT requires the therapist to help the child become aware of the thoughts and beliefs behind their OCB so they can (a) develop constructive self-talk, (b) experience cognitive restructuring and (c) learn to cultivate detachment from their thoughts and beliefs (March & Mulle, 1998). It can be difficult for children with ASD to verbalize and to identify cognitions and emotions because of impaired Theory of Mind skills (Baron-Cohen, 1997); as a result, cognitive training is an element of the treatment that can be frustrating for some children even with modifications.

Instead of parental reports of child complaints or moments of frustration with the therapy, I heard of the ways Diane was able to seamlessly get the children to be involved in the cognitive

training. In the following excerpt, after describing how much Robert hates any kind of work in school, the subject of cognitive restructuring in therapy is raised:

Interviewer: So, how would you say the therapist handled the work component of therapy? Because I know there is the work component where you have to write—sit down and-

Anita: I did all the writing, so he described for me.

Interviewer: And was he okay—like talking about it, he was okay, did he consider that work, did he fight that?

Anita: Yes. Yes, he considers having to talk about things work, for sure.

Interviewer: And so Diane was able to—

Anita: “We need to get through this, and then we’ll have snack”, or “then you can play with your LEGO”, or “then we can”—because she always had a list up of what was going to go on that night.

Reducing possible frustration levels (by having the mother transcribe the child’s responses) and using a behavioural technique called the Premack principle (also known as “Grandma’s Law”) are two strategies used by Diane. The Premack principle states that making the opportunity to engage in a behaviour that occurs at a relatively high rate (e.g., playing LEGO or having a snack) contingent on the occurrence of low frequency behaviour (e.g., discussing obsessions with the therapist) will function as a reinforcement for the lower frequency behaviour (Cooper et al., 2007). The absence of conflict between Diane and Robert is significant, considering his typical high levels of frustration with adult relationships, and also reflects a strong therapeutic alliance. Christine also describes times when Diane uses considerable therapeutic skill with Jordyn:

Interviewer: So, do you remember a time ever when Diane or the other therapist was asking for something from Jordyn that maybe she wasn’t getting or maybe like a higher

frustration level, did she ever have those moments, when it didn't go well?

Christine: I can't remember. She probably—I would think she would have, because you know nobody is perfect, nobody gets it all, but I think a lot of the time whenever she got frustrated Diane would—like if we were doing the homework with her, like the work of the thing, and Diane could see we weren't getting anywhere with her, she would just say oh let me sit and – you know and she would sit down, and then she would get the work done with her in two minutes, you know, so and like I said if she gave her any grief she would just start doodling, and what are you doing, well I'm waiting for you, you know when you're ready let me know, you know, and she just kept doodling. And she taught her a few lessons that way, because sometimes she doodled a little longer than she should have doodled, you know, but I'm behaving, I'm listening, well I don't know, are you, you know, and she got the idea that she's not going to mess around with her, you know, I'm not going to put up with your crap, you know, you're going to do the work and we're going to do it the fun way or I'm just not going to do it with you, you know.

Diane ignored any off-task behaviours to increase the amount of Jordyn's on-task work and she waited for Jordyn to notice that her attention was not available. While Christine's description of Diane hypothetically speaking to Jordyn with sentences like “not going to mess around” or “not going to put up with your crap” sound harsh when used to describe an interaction with a child it is Christine's interpretation of the how Diane got Jordyn to participate in the cognitive training portions of treatment. The surprising element in this description is that Diane appears quite forceful and demanding; yet she still elicited Jordyn's full participation. Interestingly, not one of the three interviewees mentions their children having conflict during the treatment, even during the challenging therapeutic process of cognitive training. The lack of conflict and frustration

indicates to me a healthy TA between Diane and the children (especially when considering two of the children's past difficult relationships with school teachers). Her abilities to complete the cognitive training while maintaining cooperation from the children contribute to her ability to maintain the therapeutic relationship.

All four of these therapist qualities are intertwined. When a therapist is “fun” or “collaborative” they are also concurrently reducing frustration. As well, receiving praise could also be considered a component of being fun. Although interconnected, these qualities are best left separated as the parents repeatedly mentioned these qualities individually and are most helpful for the practicing therapists when explicitly expressed.

### **Theme 3: “Diane took the time”- TA and the Importance of Time**

One important factor that was frequently raised by the parents in this study was the concept of “taking time” (see Table 3). Time's relation to the development of a strong therapeutic relationship is not discussed in existing TA theories, but I would argue its relevance to the development of a relationship with Robert, Megan, and Jordyn is significant. Without attending to the concept of time, the TA that existed between the children and Diane may never have happened. The idea of “having time” was used by parents to describe both positive experiences (e.g. “He took the time”) as well as negative ones (e.g., “They just never took the time”). I see managing time (“having time” and the ability to “take time”) as not only a therapist trait but also as a quality of the environment. As such, I have made “time” a separate theme in this analysis. A therapist with too many participants (as in the example of the social skills group therapist described by Anita) typically does not choose to have an overly large number of participants; rather, it is the clinic or centre that sets group numbers. Even a highly skilled and caring therapist would have trouble developing a healthy TA with ten participants. Therapists with such large groups or caseloads may not have the required time to develop a healthy TA. Fortunately, the



Table 3

*Theme 3: TA and the Importance of Time*

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- Anita: “we’ve seen I don’t know how many psychiatrists and psychologists but they all spend like a minute with him” (p.3),  
“always had a list up” (p.21),  
“improvement comes with time” (p.10),  
“he needs down time” (p.22, 23, 24)
- Kelly: “took the time to find out what each of their interest were” (p.26),  
“do lots of stuff” (p.22)
- Christine: “took time to get to know each child and what they liked” (p.11, 13)  
“hair dresser able to take the time to cut hair” (p.25)
-

nature of this particular research project and therapy meant that the therapeutic environment had “enough time” in it for each child.

Anita raises the concept of time when describing the difficulties she had with getting an autism diagnosis for Robert:

And they spent like six months doing all the assessments, whereas really nobody took that kind of time and did the full on—even the school did a psychological assessment... We’ve seen I don’t know how many psychiatrists and psychologists, but they all spent like a minute with him.

Not spending time, in her experience, means you can’t really get to know Robert. A significant amount of time, and not “a minute”, is required for a relationship to develop. This excerpt shows that time can be spent, like money, and is a valuable commodity to Anita in getting help for her son. In her description of a positive experience with a hairdresser for Jordyn, Christine also indicates that she views time as a commodity:

...and this girl who cuts her hair, two of her children have autism, so she knew how to act with her, you know, like they would just chit chat for a while and she would spend an hour with her for you know a five-minute haircut, you know, and she would—just oh well let’s look at the books, and they would look through the magazines and then they would kind of figure out what they wanted to do.

Christine uses the language of commerce when describing how the hairdresser “spends” an hour (like a person “spends” a dollar). The frustration described by Anita and the gratitude expressed by Christine speaks to the value of professionals slowing down and taking time with their children.

The parents also spoke of the time Diane took in getting to know what snacks and awards the children in the group preferred. The following excerpt from my interview with Christine is exemplary of her attention to such personal details:

Yes, well they would have just adjusted it, like the boy got different things than the other girl did, and different things than Jordyn got. So, they just kind of asked them what kind of things do you like, what are you interested in, and those prizes would turn up, you know like the other girl loved books or something like that, so they brought her those kinds of things, and he liked like dinosaurs and comic strips, or I don't know, I can't remember, and you know he got marbles one time—oh, he got marbles. You're giving me princess stuff, I want marbles. I don't want princess stuff, I want marbles.

The type of attention Christine is describing here, knowing exactly what each child's likes and dislikes are takes time inside and outside therapy. The children appreciate the items they receive but Christine understands that the real value lies in the positive perceptions and feelings the children develop toward therapy and the therapist. Taking time is a necessity for this type of effective TA.

Another example of the importance of time in the therapeutic environment comes from events that occurred each session. Robert's mother speaks of the importance of "down time" for him during therapy:

Anita: Yes, and they had a lot of their own time too, because she worked with the parents.

Interviewer: Right. Yes. Yes.

Anita: Parents would go off and work, so he could bring his DS, they brought LEGO, they have time on their own. So, that was an incentive too, because there's nothing he likes more of.

Robert's enjoyment of therapy also came from being able to take time away on his own. The

FB-CBT therapy schedules in short breaks for the children to have snacks, play, or in Robert's case, take some time to be alone. For Robert, "down time" is necessary for his successful participation (as another reason for his negative experience in the social skills group was the absence of breaks). Having scheduled breaks reduced possible conflicts between Diane and Robert and thereby increased opportunities to form a healthy TA.

Not all participants required the same "down time" during their therapy sessions with Diane. Both Megan and Jordyn appreciated the time available to partake in activities. Kelly's description of the joy Megan received because Diane was able to take time to discover her interests is similar to Jordyn's joy in receiving a personalized reward:

But, there were times—you know Diane took the time to find out what each of their interests were... They both liked their DS', playing with their DS so, she said okay well bring in your game and we shall see you guys play for 20 minutes, right. So, they were so stoked and oh, it's awesome, we get to go to therapy and we get to play on our not iPods, DS', right. So, they were all excited about that, and then they did some baking and (...) but, every time we went, she was always looking forward to the activity, well what are we doing today, you know, so she if she forgot or something like that so she always looked forward to the arts and craft time.

There was scheduled time in each session to allow for these extra activities, which allowed the therapist and the children to get to know and enjoy being with one another. Without taking this extra time, it is likely the therapy space would feel sterile and rushed and limit the development of the TA.

#### **Theme 4: No Resistance- Signs of a Healthy Therapeutic Alliance**

One of my original research questions was: "How does the parent know if a therapeutic relationship was present or absent? (Which behaviours or feelings did they observe in their child

or in the therapist?).” Increasing our understanding of the behaviours present in the child when the TA is sound will help therapists monitor the relationship throughout therapy and attend to any potential fractures. I assumed the parent’s would be as or more capable of determining this than the therapist or a TA questionnaire score. Parents are the people most familiar with their child and have a history of past behaviours to draw on. The parents in this study did report having strong indicators that their child had positive relations with the therapist, and the patterns that emerged from the interviews were much clearer than I expected (See Table 4).

When asked how she knew whether Robert’s experience was positive in the FB-CBT therapy, Anita gave an example of her recent experience in a social-skills group:

Anita: So, he will go if I tell him to go, but even that the therapist this time says—or the person running it, says that he’s like stressed out the whole time, and I know because I can tell when I pick him up.

Interviewer: How can you tell when he’s stressed?

Anita: He’s probably verbally like talking under his breath and saying comments. He won’t participate, say “I’m not doing that,” won’t answer, say “I don’t know”. He just shuts down.

Robert may not be able to verbalise his stress but his nonverbal communication is still highly effective in expressing his feelings. It is apparent that Anita is able to determine when Robert is not having beneficial experiences in a group. When asked how she knows when he is enjoying or having a positive experience in therapy, Anita identifies a simple and straightforward behaviour: “Well, the fact that he wanted to go back”. Anita used her son’s lack of resistance and cooperation as her behavioural sign that Robert was doing well. Christine had a similar response way when asked if Jordyn liked going to therapy: “She would go...(if she had not wanted to go)

Table 4

*Theme 4: No Resistance- Sign of a Healthy TA*

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Anita: “Well, the fact that he wanted to go back” (p.20)

Kelly: “She enjoyed it, she always looked forward to going” (p.27)

Christine: “She would go...(if she didn’t want to go) she would say I have a headache or I don’t feel good, and she would do the homework” (p.14)

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she would say I have a headache or I don't feel good, and she would not do the homework".

Kelly, on the other hand, reads Megan's enthusiasm as her positive sign: "She enjoyed it, she always looked forward to going". Kelly noted that Megan did not feel like this on her first day of therapy, before meeting Diane, when she said, "I don't want to go. I don't want to go; I don't want to do this". Her turn around from not wanting to go the first session to looking forward to going by the second session is another positive signal for the mother. All three of the children in this study are able to verbally and non-verbally communicate their stress and/or enthusiasm for their experiences and their parents listen.

All three of the mothers speak of the children exhibiting little or no resistance to the therapeutic experience and two talk explicitly of their children's enjoyment. This theme is important as it presents a clear and strong indicator for parents and therapists to watch for in the earliest stages of therapy. The other themes relate to the importance of the TA, and processes and qualities the therapist can attend to in herself and in the therapy. This final theme demonstrates what the parents and therapists can look for in their child; namely a lack of resistance to therapy and the therapist. During therapy, whenever a therapist encounters resistance they can use this as a possible sign of a fracture in the TA. Lack of resistance and its importance in therapy with all populations will be explored further in the discussion section.

### **Discussion**

All four of the themes in this study are highly related to one another and all contributed to the positive therapeutic relationships with the children and to their positive therapeutic outcomes. For example, a lack of resistance in the child to therapy is connected to the therapist qualities, which is connected to the therapist having enough time in and outside of therapy to develop and display these important qualities and traits. This in turn all points to the centrality of the TA for the parents when directly asked about the relationship. The four themes, and their relation to

existing research and theories will be discussed here. As well, the importance of IPA methodology in exploring this phenomenon will also be addressed.

### **“She wouldn’t go”**

The finding of this study on the centrality of the TA in the mothers’ experience of their child’s therapy is consonant with the empirical literature on TA in typically developing children (Baylis et al., 2011, Zack et al., 2007) and also clearly answers my third research question: How important did mothers think the TA was to treatment outcome? Mothers’ interpretations of the TA most frequently mentioned the component of the bond. There were also some descriptions by the mothers that included a second component of Bordin’s (1979) model that, as noted earlier, includes bond, agreement on tasks, and agreement on therapy goals. Agreement on tasks (e.g., Diane and participants agreeing to do cognitive training before having a snack) was certainly secondary to language that referred to the affective connection of the TA. However, the parents never mentioned agreement on goals as a factor in the TA and this is in line with other child-TA research, which has also found that Bordin’s model (specifically the third component of the TA: agreement on therapeutic goals) is not in accord with the pediatric data (Zack et al., 2007). Two possible reasons provided for the absence of the goal component are: (a) children have less developed cognitive skills which are needed to formulate long term goals; and (b) children are most often referred to therapy by adults and may have no interest in setting therapeutic goals (Zack et al., 2007). The communicative and social difficulties of children with ASD do not change the importance of an affective connection in the therapeutic relationship. In fact, the significance these mothers give to the relationship (they would not go if there wasn’t a positive TA) made the TA an imperative for the continuation of treatment.

Research on pediatric TA by Digiussepe et al. (1996) suggests that therapists’ focus on the bond and neglect of agreement on goals and tasks threatens the development of the TA. They



state that one way for child and psychotherapy to move forward is to use therapy strategies that “focus on developing the insight and attitudes toward change that already have been achieved by self-referred clients” (p. 87). The experience of the three parents in this study, however, suggests otherwise. Interpretations of the TA by these mothers focused largely on the bond aspect of the TA, with only some secondary comments directed to agreement on tasks. This may be an artifact of the way the interview questions were framed, referring as they did to “the relationship” between Diane and the child, and may hence reflect the ways parents define the word relationship. This would not affect the analysis of the results, however, since the TA is, at its core, a relationship. The parents’ responses demonstrate the importance they give the TA and the ways in which they define it.

Going from these mothers’ experience, it appears that the first task of therapy needs to be the formation of an affective bond if children are to continue attending therapy. Horvath (2001) makes a similar suggestion in his research, noting that, in the beginning of therapy, developing the TA needs to take precedence over technical interventions. This may pertain especially to children with ASD considering the likelihood of past negative experiences with typically developing peers (Frankel, Gorospe, Chang, & Sugar, 2011) and teachers (Ashburner, Ziviani, & Roger, 2010).

Unfortunately, difficult experiences at school, like the ones described by Anita and Robert’s mothers, aren’t unusual for parents with children with ASD. It has been reported that 70% of parents of children with ASD are concerned with their child’s education (Hurlbert, 2011). Smith (2004) states that the shortage of teachers with appropriate training and qualifications is “the most significant challenge facing the field” (p. 140). A lack of qualified teachers increases the chances of negative experiences in the classroom for children with ASD. Like two of the three participants in this study, children with ASD may be entering a therapeutic environment with a

history of relationships with unskilled adult authority figures. This possibly makes establishing a healthy TA even more important in the therapeutic environment. However, a positive TA with the child is not the only consideration for the therapist when parents are also involved in the therapeutic process.

Christine's forthright comments about the challenges experienced in the home during exposures points to another consideration for successful pediatric therapeutic outcomes: the level of support and empathy the parents receive during the treatment. Acknowledging and, if possible, alleviating some of the parental burden (e.g., through therapist-supported exposures) may help decrease the stress and fatigue associated with implementing therapy that some parents may experience.

### **Qualities of the therapist**

The Baylis et al. (2011) Child Alliance Process Theory was based on the perceptions of children who had been in a therapeutic relationship. Interestingly, the therapist qualities that the children in that work viewed as important in the TA were quite similar to the parents' perceptions in this present study, suggesting that, regardless of the age, the qualities deemed as important in the TA are the same. Even though I did not mention existing theories to the parents, the praise for the therapist echoes many of the Alliance Dependent Behaviours (ADB) foregrounded in the Child Alliance Theory (Baylis et al., 2011). Descriptions of Diane being "friendly," "nice," "patient," "attentive," and "doing activities" are similar to four of the six ADBs in Baylis et al.'s (2011) theory. As well, the children in the former study were from a developmentally typical population, which also suggests that the therapist qualities are the same for both populations. The numerous qualities provided by the mothers describing the therapist provide insight to the first research question: How do the mothers describe the relationship between their child and the therapist? The qualities shown by the therapist could be extended to describe the whole

therapeutic relationship. The relationship was “fun”, “nice” “collaborative”, and “not frustrating”.

### **“Diane took the time”**

The importance of time for the TA was a recurring theme in these mothers’ recollections of their child’s therapy; it is a theme that isn’t often discussed in other studies and also answers the first research question: How do the mothers describe the therapeutic relationship? The Campbell and Simmonds (2011) study does mention the importance of taking time but describes it in terms of “therapist resources”. Similarly to the theme of “therapist resources”, mothers in this study viewed time as a commodity, where time “spent” helped develop a beneficial relationship with their children. Without the availability of time, other important factors from the Child Alliance Process Theory, like being nice, doing activities, and active listening, could not occur. The parents raised the theme of time in the interviews in reference to the TA and to the FB-CBT group.

Unprompted, parents also talked about other professionals and other community members, and the amount of time that is taken with their child in different social contexts. Nespor, Hicks, and Falls (2008) state that parents feel that when professionals like therapists, teachers, and doctors interact with their child in short temporal units, without regard to the child’s life and experience outside of that short moment, the child’s biographical and contextual identity becomes erased and the child with a disability become a case or diagnosis, comparable only to other children with similar diagnoses. The feeling of professionals neglecting to truly understand a child is emoted when Anita describes the short amount of time the doctor’s took with her son (“but they all spent like a minute with him”). It is impossible to understand a child’s identity in “a minute” and thus all other parts of their life are erased. An understanding of the complete child then requires time, time that is not always available in professional settings.

In addition, research on young people with ASD suggest they have a different sense of temporality (e.g., seem not to have a sense of time passing, lose track of time, etc.) (Zukauskas et al., 2009) and this disposition may make time an even more important factor to consider in the therapeutic environment and for the formation of the TA. Therapists may benefit from expecting these differences in temporality when scheduling breaks or building the TA while doing fun activities (e.g. participants may need more time than a typical person). What may appear to be enough time from the therapist's perception may not be enough from the child's. Time, in short, is an integral component of the TA.

### **No Resistance**

This theme succinctly answers the second research question: How did the mothers know if a therapeutic relationship was present or absent? In short, the child offered no resistance to attending the therapy sessions. In the future, when soliciting feedback from parents after the first session, therapists can simply ask the parent "Did Johnny want to come today?" The child's unwillingness to attend treatment can be used as a signal that the TA may be suffering. In Motivational Interviewing (MI) (an evidence-based approach for facilitating positive behavioural change), resistance is viewed as an interpersonal phenomenon (i.e., it exists between the client and the therapist and is not merely something the client is doing) and it is a signal to the therapist that they need to take a different approach (Miller & Rollnick, 2002). When encountering resistance from a client, the principle is to roll with resistance and not directly oppose it. When dissonance is encountered in a therapeutic relationship MI's belief it is the therapist's "responsibility to perceive the dissonance, understand its source and find ways to restore consonance in the working relationship" (Miller & Rollnick, 2002, p.46). When working with children, the parents' or therapist's observations of strong resistance to attending therapy can be viewed by the therapist in the same way that MI views resistance: a sign that a different response

is required by the therapist, and a signal to specifically focus on developing the TA. When resistance is viewed in this manner, instead of directly opposing it, the therapist has an opportunity to then demonstrate the qualities and traits that will help develop and maintain a healthy therapeutic relationship.

### **Limitations**

It is important to address a number of possible limitations of this study. For homogeneity, only parents who indicated their willingness to be contacted for future research were chosen possibly suggesting that only those who had positive experiences in therapy were participating. While this homogenous sample was chosen for principled reasons (to focus and simplify the research) it would be beneficial in future studies to seek the experiences of parents whose therapeutic outcome was not as positive. By exploring the experiences of families who had negative outcomes comparison could be made as to the quality of the TA, the traits of the therapist, and/or other factors that contributed to an unsuccessful experience, with the qualities mentioned in this study.

Further, the present study was retrospective in nature and the time since the therapy groups was between approximately one to two years. It is possible that the time between the interviews and the end of treatment influenced the ways in which the parents made sense of the TA. The length of time between the interviews and the end of therapy may have obscured the memories and details of the parents' experiences. If the interviews took place immediately after the treatment group ended the parents may have had a fresher and possibly different experience to relate to the interviewer.

Another possible limitation of the study is the language used in the semi-structured interview. The word 'relationship' and 'therapeutic relationship' were used to ask the parents about the association between the therapist and the child. It could be argued that the use of the

term ‘relationship’ resulted in the parents speaking mostly to the emotional connection and not to other aspects of therapy or the TA. IPA interview questions need to be directed towards “meaning” so questions about peoples’ understanding, experiences, and sense-making activities are situated within specific contexts” (Smith et al., 2009). In this IPA study the parents first made sense of their overall therapeutic experience and then of the relationship between the therapist and their child. The questions produced data on the perceptions of the parents on the therapeutic relationship. Their rich perceptions could not have been recounted without using the word “relationship” in the interview questions.

IPA research acknowledges the influence of the researchers perspective on interpreting the data as well as their influence on the construction of meaning (Smith et al., 2009). I have been involved in the FB-CBT study both as a researcher and a therapist (but I was not involved with the therapy of the participants in this study). This dual role may have influenced the interpretation and meaning I have given to the words of the parents and the importance I perceive in their narratives on the TA. As a therapist, I may look for evidence in the words of the parents that, to me, point to the significance of the TA, but those same words may not carry importance to a researcher who is not a therapist.

### **Implications for Theory and Practice**

IPA is a methodology grounded in psychology and is a useful method for exploring parents’ perceptions of the TA. Interpretation in IPA is always grounded firmly in the words of the participants. Understanding participants’ sense-making of the TA has allowed for a unique view of this highly studied phenomenon. The parents’ interpretations also demonstrate that their experience of the TA is not far from the experiences of the therapist or child.

As mentioned in the analysis, the notion of meaning-making being a dual process in the interview also has implications for the dialogical nature of IPA. It is stated that the perceptions of the interviewer cannot be avoided during the analysis of the participants' words. My questions and asking for clarifications were a part of the re-interpreting and re-experiencing that is the heart of IPA. Just as the researcher cannot be separated from the analysis, neither can she be separated from the meaning-making activity of the participant. While analyzing the mothers' interpretations of the TA it became clear that the importance of the TA was not fully formed and waiting to be unearthed; instead, the meaning emerged during the interview and in this act the interviewer cannot help but be involved in the meaning-making process.

The parents' experience reported in this paper may present benefits to the research and clinical communities by helping to create concrete and key behaviours on the part of the therapist, as well as identify behaviours displayed by the children that promote and indicate a robust TA. These findings may help therapists learn new ways to emotionally connect with the children and better appreciate the signals that indicate a successful connection has been made. This is important as the need for human connection and emotional empathy is often overlooked in children with autism (Bromfield, 2009). It will be illuminating if future research investigates participants that did not have successful therapeutic outcomes to discover features of those relationships and discover how, from the parents' perspectives, the relationship could have been improved.

The knowledge gained from this study in conjunction with the findings of other child-oriented TA research (Baylis et al., 2011; Bromfield, 2010; Campbell & Simmonds, 2011; DiGiuseppe, Linscott, & Jilton, 1996), alerts therapists that parents perceive the existence of an emotional connection between their child and therapist as essential to the therapy outcome. The results of this analysis are a starting point for revising the training for future therapists. As noted

earlier, Horvath (2001) suggested that the TA take precedence over the technical aspects of therapy. Perhaps in the future, therapist training will focus less on the theoretical and technical aspects of the treatment, and more on developing the novice therapist's ability and skill to form deep and healthy bonds. I imagine this type of training would involve a more introspective type of learning that would explore the therapists' own attachment and communication styles.

I hope that the experiences of these three mothers and their children lead to the development of theories on the formation and maintenance of therapeutic relationships between therapists and children with ASD. The importance of the TA with children with ASD should not be overlooked. Given the many different types of therapies children with ASD are typically involved in, future research could investigate the importance of the TA for specific therapies. As well, research into tools that measure the TA, specifically with the ASD population, could benefit those in clinical environments, as well as the research community. However, the construction of such tools requires a consensus on the definition and key components of the TA. This is the largest hurdle for researchers to overcome. Without a consensus, the theories and tools will continue to measure disparate elements, and the TA with diverse populations, like autism, will remain underserved.

In the existing body of research, little attention has been given to exploring and understanding the emotional lives of children with autism. Due to misconceptions of autistic children (largely perpetuated by the work of Bettelheim), researchers have been hesitant to venture into the world of the autistic child's emotional development. Science has instead focused on quantifiable aspects of care, such as behavioural analysis, skill acquisition, and social pragmatics. Gratefully, significant advances have been made in the field, improving the educational and social trajectories of children with autism. This research project, along with other similar studies into the TA, are ideally signs of a larger shift that is happening in the ASD



research community, a shift towards an understanding of the emotional world and need for human connection of children with ASD.

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*Appendix A*Interview Schedule

Reminders to participants: There are no right or wrong answers! Please take your time in answering. Sometimes I might ask shorter questions to make sure I understand what you told me (i.e., So are you saying...?) or if I need more information (i.e., Can you tell me more about that?) I also might return to a question if I feel the need.

1. Please could you tell me about how you came to participate in the FB-CBT group with your child?

(Prompt: What was happening with your child? What made you decide to participate in the therapy group?)

2. Overall, what was the experience like in the group?

3. How would you describe the relationship between your child and the therapist?

(Prompt: Did your child like coming to therapy? What was your child like before a therapy session? After a therapy session?)

4. During a therapy session, how did your child and the therapist interact?

(Prompt: What kinds of things did they do together? Did they play? Did they work together? How?)

5. How did you know how your child felt about the therapist?

(Prompt: If your child spoke of the therapist outside of treatment what would your child say? What behaviours did your child do that let you know this?)

6. How did the relationship between your child and the therapist change as therapy progressed?

(Prompt: Do you think it got worse or better? Did it change when your child started doing exposure work?)

7. How important was the relationship between your child and the therapist to the overall outcome of the treatment?

(Prompt: Would you say it was kind of important, really important, not very? What would you say was important in the overall outcome?)

*Appendix B***Email and Telephone Scripts**Email Script:

Dear (Name of Possible Participant)

Hello. My name is Kerry Houlding and I am a graduate student at Brock University. I'm a researcher and therapist with Dr. Tricia Vause's research into Cognitive Behaviour Therapy.

I'm contacting you to inquire if you would be interested in participating in a 60 to 90 minute, informal, and relaxed interview exploring your experience of the therapeutic relationship between (First name of child) and your child's primary therapist during the group. The interview could take place either in your home or at the university, at a time convenient for you. I'm looking for three participants to take part in this qualitative research.

I believe the knowledge gained from hearing of your and (Child's name) experience can help therapists learn new ways to make emotional connections with children with autism. Often this need for human connection and emotional empathy is overlooked in children with autism.

All identifying information (including your name, your child's name, and the therapist's name) will remain confidential. Only my faculty supervisors (Dr. Vause and Dr. Tarulli) and I will have this knowledge. As well, you are able to withdraw from the study at anytime, up to the interview, and until June 1, 2013 (after this date the research will be submitted to the university for academic purposes). This research has received approval from Brock's Research Ethics Board (REB File #12-205-VAUSE)

If you have any questions or are interested in participating, please contact me via email or telephone (416-524-3990).

Kind Regards,  
Kerry Houlding

Telephone Script:

Hello. Good evening.

My name is Kerry Houlding and I am a graduate student at Brock University.

I'm a researcher and therapist with Dr. Tricia Vause's research into Cognitive Behaviour Therapy.

I'm calling to ask if you'd be interested in taking part in a 60 to 90 minute, informal interview exploring your experience of the therapeutic relationship between (First name of child) and your child's primary therapist during the group.

The interview could take place either in your home or at the university.  
At any time that is convenient for you.

*Appendix C*Interview 1: Anita and Rob- Emergent Themes

- Pronoun changes
- Parental fatigue
- Importance of time: “always had a list up”(p.21), “comes with time”p.10, “no one taking time” (p.3), “improvement comes with time” (p.10), “down time” (p.22, 23,24)
- Strong expression of negative emotions
- Overstated language
- Acknowledgement of progress
- Denial of progress
- Paradox as a coping mechanism
- Therapeutic progress as automatic: “he just started doing it one day” (p.25)
- Child as typical
- Child as unique
- Therapy as work
- Parental confidence
- Importance of TA: “didn’t respond to anyone but her” (p.15)
- Failures of institutions and professionals
- Acceptance
- Strategies to avoid power and struggles
- Positive therapist traits and strategies: “clear” (p.18), “good at knowing how to reach kids” (p.17), “rewording” (p.30), “empathy” (p.30), “don’t challenge him” (p.28), “demonstrative, friendly” (p.15), “amazing” (p.15)
- Positive characteristics of therapeutic environment: “because only three she could...” (p.17), “responsible for more people, hands are full” (p.17), “smaller group, quieter, this group quite rowdy” (p.16)
- Exposure work and therapeutic techniques
- Absence of power struggle; this is a positive therapist trait

*Appendix D*Interview 2: Kelly and Megan- Emergent Themes

- Concerns with others judgments about OCB
- Pronoun changes
- Overstated language
- Parental fatigue
- Child's emotional responses experienced as difficult
- Therapy as small steps: "we did little steps" (p.3)
- Contrasting statement
- Positive strategies: "school gave her own private space" (p.4)
- Negatives of the therapy environment: "small group" (p.5)
- Importance of TA to parents: no mention (until p.5)
- Positive results
- Positive therapist traits: "personal" (p.30), "took time" (p.26), "gave ego-boost" (p.23, 24), "fun" (p.22, 24), "do lots of stuff" (p.22), "patience" (p.21), "comfortable" (p.24), "non-judgmental" (p.24), "involvement and time" (p.8), "easy conversation, outgoing, goofed around" (p.9)
- Traits of child
- Quick development of TA: "I don't want to go" (p.11), "by second session" (p.9)
- Positives of therapeutic environment: "therapy happy place, no trouble" (p.10), "fun" (p.22)
- Therapy as not real world
- Parental fatigue
- Therapy as sudden: "just figured it out, I get it" (p.13)
- Dismissal of therapeutic strategies: "if you're going to cater to her she'll love it and be your BF" (p.8)
- Exposure and fracture of TA
- TA-Bond: "development with therapist but not peers" p.20, "had a bond" (p.22), "bond made her comfortable" (p.24)
- Parental Involvement
- Negative Therapist Traits: "not comfortable, inexperience" (p.29)

*Appendix E*Interview 3: Christine and Jordyn- Emergent Themes

- Severity of OCB
- Therapy as sudden: “she picks it up” (p.1)
- Behavioural Solutions
- Pronoun changes
- Importance of TA: “you can get books on CBT and do it yourself but doesn’t work” (p.28), no immediate mention of therapist till (p.4), “She went to treatment because she liked Diane” (p.12), “wouldn’t go if she didn’t like Diane” (p.20)
- Use of therapeutic strategies
- Positives of therapeutic environment: “time to know each child, what they liked” (p.11, 13), “group members all have same problem” (p.5)
- Positive therapist traits: “nice” (p.21), “fun”(p.21), “give child prize” (p.20), “patience” (p.29, 40), “attentiveness” (p.6), “know how to work daughter” (p.10), “ignore bad behaviour, reminders” (p.10) “young” (p.21)
- Positive therapeutic strategies: “lots of praise” (p.13), “distraction” (p.27), “removal of attention” (p.16) “visuals” (p.15)
- Parental frustration
- Parental involvement
- Therapy as fun: (p.14)
- Successful cognitive strategies: (p.14)
- Exposure and fracture of TA: “didn’t associate therapist with exposures but Mom” (p.17)
- Importance of time: “she would spend an hour with her” (p.25)
- Absence of power struggle: “struggles as school occurred same time at treatment” (p.39)
- Abilities of children with autism- “these kids are sharp” (p.41)