THERAPEUTIC ALLIANCE AND TREATMENT OUTCOME FROM THREE DIFFERENT

PERSPECTIVES IN CHILD TRAUMA THERAPY

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Abstract

The current study looked at the therapeutic alliance in child trauma therapy in a multi-site, controlled study with follow up. Parent, child, and therapist ratings were used to examine how therapeutic alliance changes over the course of Trauma Focused Cognitive Behavior Therapy (TF-CBT) that uses an exposure based method called a trauma narrative. Additionally, treatment response was examined in relation to therapeutic alliance. Participants were 65 children and their caregivers in a community based trauma therapy program in Canada. Children in treatment underwent TF-CBT, including the trauma narrative asking them to write out and process their trauma story in detail. Results for research question one indicated that despite how hard it was for children to participate in this intensive treatment method, children, therapists and parents reported positive ratings of the therapeutic alliance throughout treatment. Overall the children's ratings of alliance became significantly more positive from therapy start to finish. Results for research question two indicated that analyses did not find any relationship between ratings of therapeutic alliance and treatment response. Results were consistent across all three raters.

Keywords: Therapeutic Alliance, Maltreated Children, Outcome, Multi-Rater

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Therapy

Therapeutic alliance has been defined as agreement on therapy goals and tasks, and emotional bond between client and therapist (Bordin, 1979; Horvath & Luborsky, 1993; Martin, Garske, & Davies, 2000). It has been suggested that a strong therapeutic alliance is a prerequisite for effective implementation of therapeutic techniques and tasks, and is potentially, on its own, a curative factor (DiGiuseppe, Linscott, & Jilton, 1996; Garcia & Weisz, 2002). Research with youth who have not experienced trauma has also suggested that positive change in alliance over the course of treatment was associated with a higher rate of improvement in symptomatology (Bickman, Andrade, Athay, Chen, Nadai, Jordan-Arthur, & Karver, 2012; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Wei-Chin, 2000; Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006). A study conducted with maltreated adolescents demonstrated that those who showed more positive change in therapeutic alliance also displayed more positive treatment outcomes (Eltz & Shirk, 1995). The results of this body of research are in overwhelming agreement: A strong and healthy therapeutic alliance is essential in maintaining compliance with therapy tasks, maintaining session attendance, and for overall successful therapeutic outcome (Hawley & Weisz, 2005; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011).

Despite a large body of adult research on alliance, relatively few studies have extensively examined therapeutic alliance in child trauma therapy. Advances in the understanding of therapeutic alliance have remained largely focused on treatment with adults and relatively little is known about the importance of the treatment relationship in child therapy (Kazdin & Durbin, 2012). The few studies that have been done with youth have focused on non-maltreated children

and have found that therapeutic alliance affects areas such as motivation during treatment, engagement in the tasks assigned during therapy, and participant retention (Chiu, McLeod, Har, & Wood, 2009; Kazdin & Durbin, 2012; Kazdin, Marciano, & Whitley, 2005; Pereira, Lock, & Oggins, 2006).

Little previous work has been conducted on alliance with maltreated children undergoing trauma therapy, how that relationship changes over time, and how initial, midway, and final ratings of therapeutic alliance may be able to predict symptom outcome. Finally, relatively little work has taken a multi-rater perspective when considering therapeutic alliance with this population.

Therapeutic Alliance: History and Importance

The concept of therapeutic alliance has influenced psychotherapy for nearly a century. Sigmund Freud (1912) discussed the importance of transference within the psychoanalytic framework, Carl Rogers (1957) considered the therapist-client relationship necessary and central to change, and Greenson's (1967) model of therapeutic alliance divided the relationship into three components: transference, the working alliance, and the real relationship. Bordin (1979) was considered one of the first to consider contributions from both the therapist and the client in his conceptualization of working alliance. In Bordin's view, working alliance "substitutes the idea that the relationship is therapeutic in itself for the belief that working alliance makes it possible for the patient to accept and follow the treatment faithfully" (p.2). He used alliance to describe three elements of the therapist-client relationship: bond, task, and goals. Horvath (1995) summarized these three factors. He describes "Tasks" as referring to the behaviors in therapy and the thoughts that inform the basis of the therapeutic process that both parties consider relevant and efficacious. Horvath (1995) then describes the "Bond" as the attachment

between therapist and client that includes positive factors such as mutual confidence, trust, and acceptance. Finally, he states that a strong alliance is one that works towards mutually endorsed end goals.

It is now widely held that therapeutic alliance is a crucial element in most treatment modalities, and thought to be required for the effective implementation of most therapeutic tasks and techniques (Hawley & Weisz, 2005; Horvath & Luborsky 1993). Therapeutic alliance is currently conceptualized as a combination of: the emotional bond between client and therapist; the client's ability and motivation to adhere to the therapeutic tasks; the level of empathy and involvement demonstrated by the therapist during these tasks; and the mutual understanding and agreement of therapeutic goals (Abrishami, 2009; Thomas, Werner-Wilson, & Murphy, 2005).

Numerous studies hold that this relationship is, in fact, one of the best predictors of positive treatment outcomes (Orlinsky, Grawe, & Parks, 1994; Orlinsky, Ronnestad, & Willutzki, 2003; Wampold, 2001). In fact, it has been suggested by various studies that a strong therapeutic alliance is a pre-requisite for effective implementation of therapeutic techniques and tasks, and is potentially, on its own, a curative factor (DiGiuseppe, Linscott, & Jilton, 1996; Garcia & Weisz, 2002).

Therapeutic Alliance and Maltreated Children

The value and importance of therapeutic alliance with adults has been empirically supported by a number of studies. Considering the solid evidence that this relationship is central to therapy outcome in adult populations, it is important to extend this line of research to work involving children. The few studies that have been conducted on children focus on non-maltreated populations and on developmental factors that may contribute to how the alliance between adult therapist and child client forms (DiGiuseppe, Linscott, & Jilton, 1996; Green,

2006).

It has been argued that children in therapy face unique obstacles, relative to their adult counterparts, when engaging in these therapeutic relationships (DiGiuseppe, Linscott, & Jilton, 1996; Green, 2006). Developmental factors may interfere with the child's ability to connect with the therapist. For example, child clients rarely seek help on their own. They are not typically responsible for initiation of their own treatment and this might compromise engagement in the therapeutic relationship and motivation in completing therapy tasks (DiGiuseppe et al., 1996; Kendall et al., 2009; Piacentini & Bergman, 2001). Older youth are unsure of what to expect in therapy and can be resistant to complying with the treatment (Kingery, Roblek, Suveg, Grover, Sherrill, Bergman, 2006). Younger children may often simply not understand why they need to be in therapy (Green, 2006). Friedberg and McClure (2002) indicate that it is a unique challenge engaging the child and adolescent client, and that it is particularly difficult to find developmentally sensitive and appropriate ways to foster investment and trust in the relationship.

In addition to the obstacles that children in treatment face in general, maltreated children may face even greater obstacles in forming positive therapeutic alliances (Eltz, Shirk, & Sarlin, 1995). In comparison to non-maltreated children, children with histories of abuse show greater mistrust of others, as well as a greater unwillingness to take part in the therapeutic relationship during therapy (Eltz, Shirk, & Sarlin, 1995). If the trauma occurred within the context of a caregiving relationship, these children and adolescents may find it extremely difficult to establish feelings of safety or trust with any adult, including therapists (Eltz et al., 1995; Cloitre, Cohen, & Scarvalone, 2002).

Despite the knowledge that alliance can be tricky to develop and maintain with children, very little work has been done to examine the therapeutic alliance in the context of child trauma

therapy. Research with non-maltreated children has shown that alliance predicts engagement in therapy tasks (Chiu, McLeod, Har, & Wood, 2009; Chu et al., 2004; Karver et al., 2008), positive therapy outcomes (Kazdin & Durbin, 2012; Liber et al., 2010; McLeod & Weisz, 2005; Shirk & Karver, 2003; Shirk et al., 2008), and may be key in maintaining treatment retention (Chu et al., 2004). Relatively little research, however, has been conducted on therapeutic alliance and therapy outcome with maltreated children in trauma-focused therapy (Eltz et al., 1995; Ormaugh et al., 2013). It is important that we extend our knowledge specifically to maltreated children in trauma therapy to inform best treatment practices and outcomes.

TF-CBT and the Trauma Narrative

Trauma Focused Cognitive Behavior Therapy (TF-CBT) has been shown to be an effective, empirically supported child trauma treatment that is component based and that incorporates an exposure based technique called The Trauma Narrative (Cohen, Deblinger, Mannarino, & Steer, 2004; Konanur, Muller, Cinamon, Thornback, & Zorzella, in Press; Lawson, 2009). TF-CBT was developed based upon a number of randomized controlled trials (e.g., Cohen et al., 2004; Cohen, Mannarino, & Knudsen, 2005; King et al., 2005). Evidence demonstrates the robustness of TF-CBT in decreasing symptoms when compared to other treatment approaches including non-directive supportive therapy (Cohen & Mannarino, 1996); supportive group therapy (Deblinger, Stauffer, & Steer, 2001); and child-centered therapy (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen & Mannarino, 1997). Six month and one year follow-up studies found that post-therapy PTSD symptom reductions were maintained (Deblinger, Mannarino, Cohen, & Steer, 2006; Konanur et al., in Press). Clinical and school therapists have successfully implemented the model with children ranging from preschool-aged to adolescence (Cohen & Mannarino, 1997; Cohen et al., 2006; Feather & Ronan, 2009; Little,

Akin-Little, & Gutierriez, 2009).

A central tool used in TF-CBT model is a method called the Trauma Narrative (TN). This technique helps children meaningfully organize and integrate their thoughts and emotions surrounding the trauma into autobiographic memory (Lawson, 2009). Usually taking the form of a story, picture album, or poem, the narrative involves the child remembering and recording a traumatic event over several therapy sessions. This technique uses gradual exposure to imagined stimuli related to the trauma, invoking conditioning mechanisms such as habituation and reciprocal inhibition to desensitize the child to memories about the traumatic event (Cohen, Mannarino, Berliner & Deblinger, 2000; Lawson 2009). It also allows the therapist to identify any problematic beliefs or attributions surrounding the trauma event (Cohen et al., 2006).

Therapeutic Alliance and the Trauma Narrative

Due to the nature of the tasks involved in creating a TN and the sensitive material inherent to traumatic memory, the process can be intense and emotionally evocative. Some therapists have expressed reluctance in using the method for fear the clients may become over aroused, feel unsafe, and blame the therapists for making them "relive" the trauma (Cohen et al., 2000, Cohen et al., 2006, Lawson 2009). Despite evidence that the TN is a useful exposure method in desensitizing the child to trauma memories (Cohen, Mannarino, Berliner & Deblinger, 2000), some therapists still express reservations (Lawson, 2009). They fear the therapeutic alliance, carefully fostered during the first phase of TF-CBT, may be damaged if they ask the child to relive these traumatic events in the form of a TN (Cohen et al., 2006, Lawson 2009). In order to address such concerns, it is important to examine how the therapeutic alliance changes during the course of TF-CBT. Changes in the relationship between the maltreated child and the therapist may be related to how engaged the child is in the treatment tasks, adherence, and willingness to

continue with trauma therapy (Hawley & Weisz, 2005; Horvath & Luborsky, 1993; Kazdin, Marciano, & Whitley, 2005; Horvath & Luborsky 1993). Considering the knowledge we already have surrounding therapeutic alliance research in determining outcome (Hawley & Weisz, 2005; Horvath & Luborsky 1993), and that change in alliance is also linked to therapy outcome (Bickman et al., 2012; Florsheim et al., 2000; Hogue et al., 2006), it is necessary to address concerns that therapists may have that intensive trauma exposure work such as the TN may cause a rift in the alliance (Lawson, 2009). Understandably, the nature of the alliance in the context of a psychologically challenging Phase Two[1] treatment in children will have implications for child trauma therapy more broadly. The current study is therefore specifically concerned with examining how alliance develops and changes over the course of TF- CBT.

Therapeutic Alliance: Predicting Treatment Response in Child Trauma Therapy

Research with adult populations has demonstrated that a strong early alliance is associated with significant improvements following therapy, due, in part, to clients' increased engagement in the therapeutic tasks (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Keller, Zoellner, & Feeny, 2010). Conversely, less positive treatment outcomes were associated with weaker alliance (Dalenberg, 2000; Eltz et al., 1995). In therapy with non-maltreated children, therapeutic alliance has been found to predict engagement in tasks (Chiu, McLeod, Har, & Wood, 2009; Chu et al., 2004; Karver et al., 2008) and positive outcomes (Kazdin & Durbin, 2012; Liber et al., 2010; McLeod & Weisz, 2005; Shirk & Karver, 2003; Shirk et al., 2008). Last, recent studies with adults have also suggested

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1 Phase Two or Stage Two: In trauma therapy this phase focusses on having clients process difficult trauma memories. Typically this work involves actively addressing traumatic experiences. Remembrance of such experiences, mourning trauma-related losses, exposure based methods and cognitive processing have all been viewed as part of Phase Two work. This is done to help the client integrate emotions and memories surrounding traumatic experiences into their personal autobiographies, desensitize them to triggering stimuli surrounding the memories, and identify problematic cognitions surrounding possible feelings of guilt, shame, and responsibility. This phase is only started once Phase One work is completed which helps ensure that safety has been established and that clients have the requisite emotion regulation and self-soothing skills.

that early alliance is the best predictor of therapeutic outcome, as opposed to midpoint or final ratings (Klein et al., 2003).

As previously noted, while therapeutic alliance has been heavily studied in adults, and less so with non-maltreated children, very little work has been done to examine how ratings of therapeutic alliance can predict treatment outcomes in trauma therapy with abused children. Also, studies with traumatized adults have been mostly concerned with examining only initial ratings of therapeutic alliance (Cloitre et al., 2002; Cloitre et al., 2004; Keller, Zoellner, & Feeny, 2010). Little to no research, however has been conducted to see if the same can be said with maltreated child populations. Because of this focus on adult populations, we do not know how different ratings of therapeutic alliance at different time points vary regarding outcome prediction with traumatized children. The current study is therefore specifically concerned with examining how initial, midway, and final ratings of therapeutic alliance during TF-CBT are able to predict treatment response regarding post-traumatic symptoms.

Therapeutic Alliance: Child Trauma Therapy and the Use of Multiple Raters

It is important to consider the reported therapeutic alliance in terms of who is rating the alliance (Hill, O'Grady, & Price 1988; Kazdin & Durbin, 2012). Using multiple raters allows researchers to gain a more in-depth look at how the different parties involved see a particular construct such as therapeutic alliance (Siminoff et al., 1995). In the study conducted by Siminoff et al. (1995) on disruptive child behavior in non-maltreated children, it was noted that parent ratings of a behavior or emotions can differ from the ratings of the child or teacher. Using multiple sources of information can give us a broader idea of each party's perception, giving a more in depth and multi-faceted view of a construct. In their study of non-maltreated children, Kazdin and Durbin (2012) point out that having multiple raters can control for errors in

correlations that occur because the rater is the same. A study examining multiple rater perspectives in disruptive child behavior points out that there is error associated with taking only one viewpoint of a construct (Siminoff et al., 1995). If similar ratings in therapeutic alliance can be demonstrated across raters, and across time periods, then the correlation in these ratings can be considered more robust (Kazdin & Durbin, 2012).

TF-CBT is a unique form of trauma therapy in that both the child and the non-offending caregiver are active participants in the process (Lawson 2009). TF-CBT, includes both individual sessions for the child and primary caregiver as well as conjoint sessions with the two (Cohen et al., 2000). This unique aspect of TF-CBT allows the opportunity to gather multiple source ratings of the child-therapist alliance (Cohen et al., 2000). Ratings of therapeutic alliance can be captured for child, therapist and parent at different time points, providing a more complete look at how the alliance progresses in treatment. This allows for the reduction in error associated with having only one rating source (Kazdin & Durbin, 2012).

Hill et al. (1988) concluded, in his review of different methods used to measure the effectiveness of psychotherapy, that little work has been done using multiple raters and inter-rater reliability in treatment. This is also true for work examining trauma treatment with abused children. There are few studies on therapeutic alliance with maltreated children and fewer still that use multiple raters. The current study uses three different rater perspectives on the therapeutic alliance. These raters include child, therapist and non-offending caregiver.

Current Study

The current study aims to examine how therapeutic alliance changes and develops between child and therapist over the course of TF-CBT, an intensive child trauma therapy that teaches safety skills and provides exposure based treatment. The therapeutic relationship has been

shown to be integral in maintaining motivation and adherence to therapeutic process, and it is therefore important to examine more deeply, especially if there are concerns that the TN may challenge the therapeutic alliance (Chiu, McLeod, Har, & Wood, 2009; Kazdin & Durbin, 2012, Lawson, 2009). Second, the current study examines how initial, midway, and final ratings of therapeutic alliance predict treatment response in TF-CBT. Little work has been done with maltreated children surrounding therapeutic alliance and therapy outcome (Kazdin & Durbin, 2012). In addition, most studies have focused mainly on initial ratings of therapeutic alliance, ignoring midway and final ratings (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Keller, Zoellner, & Feeny, 2010). It is therefore important that we examine how therapeutic alliance relates to treatment response at different time points during therapy, and the current study aims to fill this gap in the literature.

Last, the current study is also unique in that it uses multiple raters to separately evaluate therapeutic alliance from the perspective of the child, caregiver, and therapist, thus reducing error associated with a single rating source, and allowing for a more in-depth examination of any changes in therapeutic alliance that take place over the course of therapy (Kazdin & Durbin, 2012).

Research Questions

Research Question 1. How does therapeutic alliance progress during the course of TF-CBT as rated by caregiver, therapists and the child? Specifically, does therapeutic alliance decrease, stay stable, or increase over the course of treatment?

Research Question 2. How do multiple ratings of therapeutic alliance, collected at several time points in TF-CBT, relate to treatment response? Specifically is therapeutic alliance, collected at session three, session eight and at final session, at all related to treatment response

collected at final session and at six month follow up, as rated separately by parent, therapist, and child? It is expected that therapeutic alliance will be related to treatment response.

Therapeutic alliance is measured by the Working Alliance Inventory (Caregiver) and the Therapeutic Alliance Scale for Children (Child and Therapist). Treatment response is defined as change in post-traumatic symptomatology as measured on the Trauma Symptom Checklist for Children : from pre-assessment data collection to data collection taken immediately after final therapy session; and from pre-assessment data collection to data collection taken at six month follow up. Three different raters reported separately on their views of Child-Therapist Alliance: child, therapist, and non-offending caregiver.

Method

Data for this thesis were collected through the larger Healthy Coping Program from March of 2006 to March of 2012 (Muller & DiPaolo, 2008). Ethics approval was granted by the Office of Research Ethics at York University. Additionally, ethics approval was granted by each of the following participating GTA (greater Toronto area) children's mental health agencies: Aisling Discoveries Child and Family Centre, Boost Child Abuse Prevention and Intervention, Child Development Institute, COSTI Family and Mental Health Services, The Etobicoke Children's Centre, The Hincks-Dellcrest Treatment Centre (Sheppard Site), The Hincks-Dellcrest Treatment Centre (Jarvis Site), Yorktown Child and Family Centre, and Peel Children's Centre. The study received funding from the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario (Muller & DiPaolo, 2008) as well as from the Hedge Funds Care Canada Foundation. Participant information is provided for children and caregivers who completed at least one data collection with the HCP.

Procedure

      Recruitment. Families were assessed for study inclusion when referred for clinical

services to Boost Child Abuse Prevention and Intervention (formerly Toronto Child Abuse

Centre) and Peel Children's Centre (PCC). Both agencies are non-profit organizations in the

Toronto area offering trauma assessment and therapy for children and their families. Referrals to

Boost and PCC were made by various sources. These included CAS, police services, other child

mental health centres, school staff, victim witness assistance program, family physicians, and

self-referral. Verification of the referral trauma was obtained through reports provided by the

local Children's Aid Society (CAS) or police services. Initially a meeting was conducted at the

agency that included an assessor/therapist from Boost or PCC, a researcher from York

University, and a non-offending caregiver. The purpose of this meeting was to inform the

caregiver about the treatment process, verify that the child and caregiver meet the eligibility

criteria of the research study, and to inform the caregiver about the research study and what

participation would entail.

      Eligibility. Families were invited to participate in the HCP only if the following

conditions were met: 1. The child was 7 to 12 years of age at the time of treatment; 2. The child

had experienced a verified traumatic event (e.g., abuse, community violence, home invasion); 3.

A non-offending caregiver(s) was willing and able to participate in assessment and treatment; 4.

The child and/or caregiver(s) did not have an active substance abuse problem or psychotic

disorder that interfered with functioning; 5. The child was not actively suicidal; 6. The child did

not have a documented developmental disorder (e.g., autism); 7. If the child and/or caregiver(s)

were taking any psychotropic medications, the regimen was stable; and, 8. The child had not

received prior treatment for the referral trauma. Caregivers provided written informed consent

and participating children provided written assent. As compensation for research participation, families were offered an opportunity to bypass the waitlist at the treatment agency; monetary compensation ($20 to $30 per data collection); and transportation tickets. Participation in clinical services and the research study was voluntary and families who declined participation (n = 31) were still offered clinical services.

      Assessment. The treatment phase using TF-CBT was preceded by an assessment of the child and caregiver at Boost or PCC to evaluate for specific treatment recommendations. During an assessment, individual meetings were held with both the child and caregiver. Assessments were completed in the larger study for 113 children. The mean length of the assessments was three to four sessions, and took place in the format of semi-structured clinical interviews. Detailed behavioral descriptive questions, activities, drawings, and questionnaires were used to collect information about the child's trauma experiences, and the effect of the trauma on the child's functioning and well-being. The information gathered was kept in the form of a scrapbook. The caregiver questionnaires queried family background information, developmental history, concerns about the child, relational dynamics in the family, other stressful experiences in the family, the strengths of the child and family, cultural considerations, information about the disclosure in the case of maltreatment, and how the child and family were coping following the traumatic event(s). After the assessments were completed, a feedback session was held with the assessor, TF-CBT therapist, and caregiver(s) to share the assessment report and explain the treatment rationale. There were several instances in which children attended the feedback. This was subjectively determined by the therapist and caregiver(s) depending on whether they believed it would be beneficial for the child to be present. Further information about this decision-making process was not obtained by the researchers.

TF-CBT. A total of 65 children completed at least one collection of therapeutic alliance data during the completion of TF-CBT. Mean treatment length was between 17 to 18 sessions. During treatment, individual therapy sessions with the child and caregiver occurred in parallel. The child was taught various skills like emotion regulation and psycho-education regarding safety, etc. The parent was then taught the same material in a separate session. This was to allow caregivers to help the child practice skills they had learned in therapy that week.

The treatment followed a model outlined by the acronym PRACTICE. Parenting Skills are taught throughout treatment to improve child/caregiver interactions. These include the use of praise, selective attention, and time-outs. Psycho-education involves educating the family about trauma, normalizing the child and caregiver's response to the trauma, and dispelling commonly held myths about trauma (e.g., the family is alone in their experience). Relaxation educates the child to learn how to reduce distressing physiological symptoms linked to the trauma (e.g., increased heart rate, muscle tension, shallow breathing). Affective Expression and Modulation teaches the child emotion regulation techniques including feeling identification, and positive imagery and self-talk. Cognitive Coping and Processing helps the child to identify problematic automatic thoughts (e.g., "The abuse was my fault") and then replace them with alternative adaptive thoughts. Part of this process involves having the child provide a detailed account (e.g., written story, cartoon, play) of his/her traumatic experience in the form of a Trauma Narrative. Cognitive distortions the child may have about his/her responsibility for the trauma can be addressed during this activity. As the child remembers painful trauma-related thoughts, the therapist supports the child by having them use the relaxation and coping skills learned earlier. Concurrently, the therapist prepares the caregiver during their session so they are able to respond appropriately to potentially shocking and/or difficult information contained in the child's trauma

narrative. In Vivo Mastery of Trauma Reminders involves reducing fears of innocuous trauma cues. This occurs through gradual exposure of the child to the trauma reminders in a safe setting while they use the relaxation techniques they were taught in earlier sessions. Conjoint Parent-Child Sessions allow the child to share the trauma narrative with his/her caregiver and discuss the knowledge and skills they have learned in therapy. Enhancing Future Safety and Development is used to teach the child personal safety skills (e.g. saying "no" for appropriate limit-setting, confiding in a trustworthy adult).

Model Fidelity. An educational model was used to train therapists in the use of TF-CBT, and to insure ongoing model fidelity. Skill acquisition occurred through mandatory reading of the TF-CBT training manual (Cohen et al., 2006), completion of the TF-CBT web-based training program, and participation in a series of TF-CBT training workshops over the course of the research study. Ongoing supervision was provided at monthly clinical meetings by psychologists with extensive expertise in the TF-CBT model, Dr. Amy Hoch and Dr. Melissa Runyon (CARES Institute in New Jersey). The psychologists provided case consultation, focusing on the delivery of TF-CBT with children and caregivers in the program. In addition, these consultative meetings were supplemented by monthly, intra-agency, small-group, supervision meetings presided over by local therapists with expertise in TF-CBT. All TF-CBT training requirements were considered essential, and clinician attendance was monitored. During treatment, therapists were required to specify the length of time they spent on a given TF-CBT component following each session. This information was captured in an adherence checklist which was reviewed for deviations from the treatment model to determine ultimate eligibility for inclusion in the research sample.

Data Collection. The measures used in the larger study, of which the current study is a part, were administered as part of a larger battery of psychometric measures which queried participants' thoughts and feelings related to the traumatic experience. The battery of questionnaires typically required approximately two hours to complete all measures at each time point. Following recruitment, participants were randomly assigned to either a non-waitlist group or waitlist control group. Non-waitlist participants completed measures pre-assessment, post-assessment/pre-therapy, post-therapy (which occurred soon after the final therapy session), and six months after therapy had ended. Participants in the waitlist control group completed a pre-waitlist data collection, waited for three months without receiving any clinical services, and then followed the same data collection procedure as the non-waitlist participants.

The current study is concerned only with the non-waitlist participants who completed trauma symptom measures after the final session, and at six month follow up data collection. These participants also completed therapeutic alliance measures at sessions three, eight, after the final therapy session data collection described above.

Measures

Therapeutic Alliance Scale for Children (TASC; Shirk & Saitz, 1992). The TASC was used to assess the child`s alliance with the therapist. The measure has a strong conceptual connection with Bordin`s (1979) definition of alliance. Two versions of TASC, parallel in content and format, were completed by child and therapist. The scale comprises 12 items, rated on a 4-point scale ranging from 1 (*not like me*) to 4 (*very much like me*). The items ask about the extent to which children perceive their therapist as an ally, like to spend time with their therapist, and feel that they can talk about their problems with their therapist. It has been found to be a reliable instrument, with Cronbach`s alphas ranging from 0.88 to 0.93 for the child version, and

from 0.94 to 0.96 for the therapist version (Creed & Kendall, 2005; De Vet et al., 2003; Hawley & Waisz, 2005). Reliability analyses with the current sample showed that the measure has good internal consistency, with alpha coefficients ranging from 0.75 to 0.93.

Working Alliance Inventory (Horvath, 1992). This is a 12-item checklist that uses a 5-point Likert scale (1-*seldom* to 5-*always*). This scale was completed by the parents to assess how they felt about their relationship with the therapist as TF-CBT involves active participation of the non-offending caregiver or parent and includes parallel sessions with the parent and therapist as well as joint sessions with parent, child, and therapist. The self-report measure aims to capture the three key aspects of the therapeutic alliance as conceptualized by Bordin (1980): (a) agreement on the tasks of therapy; (b) agreement on the goals of therapy; and, (c) development of an effective bond. The items ask questions such as "My therapist and I respected each other" (Horvath, 1992). A study done by Guedeney and colleagues (2005) in a French primary care setting found that initial ratings of therapeutic alliance as found by the WAI were positively predictive of the quality of alliance ratings taken four months later. Hanson and colleagues (2002) conducted an analysis on the reliability generalizability of the WAI and found the reliability estimates to be robust. The scale mean reliance estimates ranged from 0.79 to 0.97 with a modal estimate of 0.92 (Hanson, Curry & Bandalos, 2002).

Trauma Symptom Checklist for Children (TSCC) (Briere, 1996). The TSCC (Briere, 1996) is a 54-item self-report measure designed to assess trauma-related symptoms among children (ages 8-16) who have been exposed to traumatic life events. The TSCC was standardized on large clinical and nonclinical groups (Briere, 1996). Children rated how often they experienced symptoms on a 4-point Likert scale (1 = never and 4 = almost all of the time). The TSCC yields scores for the following six main clinical scales: Anger (ANG), Anxiety

(ANX), Depression (DEP), Dissociation (DIS), Posttraumatic Stress (PTS), and Sexual Concerns (SC). T scores are used to interpret the child's level of symptomatology and are standardized transformations of the raw scores (M = 50, SD = 10). For all clinical scales except SC, T scores at or above 65 are considered clinically significant. T scores in the range of 60 through 65 are suggestive of difficulty and may represent subclinical (but significant) symptomatology. Two response-distortion scales indicate whether a child is under or over-responding to an invalid degree. The clinical scales have been found to have high internal consistency reliability and good validity. Internal consistency reliability coefficients are strong for five of the clinical scales, ranging from 0.80 to 0.89. In the current study, we examined the relationship between therapeutic alliance and the PTS scales in this measure.

Sample

Children. In the larger study, of the 113 children who completed at least one data collection in the HCP, 80 were female and 33 were male. The children's ages ranged from 6 years, 10 months to 12 years, 10 months (M = 10 years, 0 months, SD = 1 year, 8 months). Children's ethnic background consisted of European-Canadian (39.3%), African/Caribbean-Canadian (17.9%), Asian Canadian (11.6%), Latin American-Canadian (10.7%), South Asian Canadian (6.3%), Aboriginal (1.8%), and Other (e.g., Middle Eastern; 12.5%). The predominant type of trauma for which children were referred was sexual abuse (75.2%). Children were also referred for physical abuse, witnessing domestic violence, traumatic grief, home invasion, and bullying/assault by peers. A significant proportion of the children (74.3%) had experienced multiple types of trauma including exposure to other types of maltreatment (e.g., neglect), war and/or conflict, and divorces/separations. In the current study, of the 113 total participants, we are concerned with the 65 who completed at least one therapeutic alliance measure as well as one

trauma symptom measure. The demographic makeup of this smaller sample is similar to the larger sample. Table 1 provides demographic comparisons between those that completed the pre-assessment data collection and those that completed the follow-up data collection.

Table 1

A Comparison of the Demographic Characteristics of Child Samples at Pre-assessment and Six Month Follow-up

Demographic Variable	Pre-assessment	Follow-up
Gender		
Female	68.9%	74.5%
Male	31.1%	25.5%
Age	M = 9.6 years	M = 9.3 years
Ethnic Background		
European-Canadian	39.6%	40.4%
African/Caribbean-Canadian	17.0%	17.0%
Latin American-Canadian	10.4%	8.5%
Asian Canadian	12.3%	6.4%
South Asian Canadian	5.7%	10.6%
Aboriginal	1.9%	0.0%
Other	13.2%	17.0%
Referral Trauma		
Sexual abuse	74.5%	74.5%
Physical abuse	11.3%	10.6%
Witnessed domestic violence	7.5%	2.1%
Traumatic grief	2.8%	4.3%
Home invasion	2.8%	6.4%
Bullying/assault by peers	0.9%	2.1%

Note. This table is based upon first Therapeutic Alliance data collection sample size (n=65) and follow-up sample size (n=43).

Caregivers. In the larger study, non-offending caregivers totaled 98 and consisted of 87 females and 11 males. Caregivers ranged in age from 25 years to 72 years ($M = 37.30$, $SD = 8.21$). There were eight caregivers who had multiple children involved in the HCP. In these sibling cases, the caregiver participated in all components of treatment for each child but did not always opt to complete psychometrics for all of his/her children due to time constraints. The relationship of the caregiver to the child was primarily identified as biological mother (82.6%), however a foster parent, biological father, adoptive father, stepfather, or guardian also participated in research and treatment. Marital status of the caregivers consisted of single (33.0%), married (29.1%), divorced (12.6%), common-law relationship (11.7%), widowed (1.9%), or other (11.7%; e.g., separated). The highest level of education reported by caregivers included: "completed/some high school or less" (19.6%), "trades certificate/diploma" (7.8%), "completed/some university/college" (51.0%), and "graduate school or professional training" (3.9%). Annual household income in Canadian dollars before taxes ranged from "Below $10,000" (10.1%), "$10,000 to $14,999" (14.1%), "$15,000 to $19,999" (13.1%), "$20,000 to $29,999" (14.1%), "$30,000 to $39,999" (1.0%), "$40,000 to $49,999" (13.1%), "$50,000 to $59,999" (11.1%), and "$60,000 or more" (23.2%). The Poverty Line for a single adult working full-time (35 hrs/wk) in Ontario where the study took place is $19,719 (Poverty Free Ontario, 2013). Table 2 Provides a comparison of the demographic characteristics of caregiver samples at post-waitlist/pre-assessment and six month follow-up.

Table 2

A Comparison of the Demographic Characteristics of Caregiver Samples at Post-waitlist/Pre-assessment and Six

Month Follow-up

Demographic Variable	Post-waitlist/Pre-assessment	Follow-up
Gender		
Female	89.6%	89.4%
Male	10.4%	10.6%
Age	37.0 years	36.2 years
Marital Status		
Single	29.5%	23.5%
Married	29.5%	40.4%
Divorced	13.2%	4.3%
Common law relationship	12.3%	12.8%
Widowed	1.9%	4.3%
Other	13.2%	14.9%
Highest Level of Education		
Graduate school/professional training	3.8%	2.1%
Completed/some university/college	49.0%	48.9%
Trades certificate/diploma	8.7%	6.4%
Completed/some high school or less	38.4%	42.5%
Annual Household Income		
Below $10,000	8.9%	4.3%
$10,000 to $14,999	16.8%	21.7%
$15,000 to $19,999	13.9%	21.7%
$20,000 to $29,999	13.9%	4.3%
$30,000 to $39,999	1.0%	2.2%
$40,000 to $49,999	11.9%	10.9%
$50,000 to $59,999	10.9%	6.5%
$60,000 or more	22.8%	28.3%

Note. This table is based upon post-waitlist/pre-assessment sample size (n = 95) and follow-up sample size (n = 40).

Perpetrators. Limited demographic information about the perpetrator(s) in each research case was obtained from measures completed by the clinician who completed the assessment with the child and caregiver. Generally, the perpetrators were: known to the child victim (92.0%), male (96.5%), and adults (80.5%). They were identified as family friend (31.0%), biological father (24.8%), relative (15.9%), stranger (5.3%), sibling (4.4%), peer (3.5%), biological mother (2.7%), stepfather (2.7%), school staff (2.7%), or multiple perpetrators (7.0%). The length of time between the children's traumatic experiences and their referral to clinical services ranged from: 0-3 months (18.6%), 4-6 months (24.8%), 7-9 months (8.0%), 10-12 months (9.7%), more than 12 months (29.2%), and an unknown length of time (9.7%).

Therapists. Of the 34 therapists who participated in the HCP, 33 were female and 1 was male. Therapists ranged in age from 24 to 57 years (M = 34.18 years, SD = 7.32). The highest level of education completed by therapists included Master's Degree (75.8%), partial Doctoral Degree (12.1%), partial Master's Degree (6.1%), Undergraduate University Degree (3%), and College Diploma (3%). Education and training backgrounds consisted of social work (60.6%), psychology (24.3%), art therapy (6.1%), psychodynamic child therapy (3%), marriage and family therapy (3%), and child and youth care (3%). Therapists had varying levels of clinical experience with trauma-exposed children, from less than 1 year to 27 years.

Exclusions, Missing Data, and Withdrawals

Families referred for clinical services were excluded prior to research participation if they did not meet the study eligibility criteria. Subsequent exclusion from the HCP occurred for several reasons. Participants were excluded prior to therapy if the assessor determined that an alternative intervention approach was needed (e.g., the child was to be re-located to a treatment residence). Participants were excluded following therapy if there were concerns around model

fidelity in a particular case. Finally, participants were excluded during the six-month period following TF-CBT if the child and/or caregiver continued to receive clinical services outside the purview of the HCP during that time. Table 3 provides sample sizes, exclusions, and withdrawals at each time point in the HCP.

Table 3

Sample Size, Exclusions and Withdrawals of Children by Time Point

Time point	N	Exclusions	Withdrawals
Pre-Assessment	113	3	25
Pre-Therapy	76	9	13
Post-Therapy	56	2	6
6 Month Follow up	43	0	0

Missing data occurred for several reasons. First, the child did not complete the outcome measure (e.g., he/she became distressed and the data collection was terminated). Second, the caregiver did not complete the outcome measure (e.g., the caregiver completed measures for only one of the siblings participating in the HCP). Third, the family withdrew from the HCP.

Withdrawal from the HCP was typically a consequence of a family opting out of clinical services (n = 36) rather than exclusively from the research study (n = 11). Withdrawal from clinical services typically occurred because the caregiver and/or child were uninterested in pursuing treatment or the family moved from the agency catchment area. Withdrawal from the HCP was most often because the family was too busy to complete the research measures in addition to completing TF-CBT.

The retention rate for clinical services (68.1%) was lower than the retention rate for the

research study (88.5%). The pattern for family withdrawal was dependent on withdrawal type (i.e., clinical services vs. research study). A comparison of these groups revealed that families who withdrew from clinical services were most likely to do so following the pre-assessment data collection, either before they began the assessment or at some point during the assessment. In contrast, withdrawals from the research study peaked following the post-therapy data collection i.e., during the six months following TF-CBT.

Alliance data were available for 65 children at session three, 62 children at session eight, and 59 children at post-therapy data collection. In order to assess the relationships among multiple independent and dependent variables simultaneously, the data were analyzed using a mixed level model. To analyze the change in TA from time point to time point, a pairwise comparison was then used to assess any significant change from time point to time point for all three raters. Data were examined for normality and univariate and multivariate outliers. Univariate outliers were identified in the data for child alliance at session three and post-therapy. Results were not altered upon removal of the outliers and therefore they were kept in the analyses.

A mixed level model was also used to analyze for correlation between the three therapeutic alliance data collections and treatment response. This was to allow for inclusion of participants with missing or incomplete data. Data were examined for normality and univariate and multivariate outliers. Again, univariate outliers were identified in the data for child alliance at session three and post-therapy. Results were not altered upon removal of the outliers and therefore they were kept in the analyses.

Results

Research Question 1

How does therapeutic alliance progress during the course of TF-CBT as rated by caregiver, therapists and the child? Specifically, does therapeutic alliance decrease, stay stable, or increase over the course of treatment?

Children's Self-Reported Ratings of Alliance. A mixed model pair-wise comparison was conducted on ratings of therapeutic alliance taken at therapy sessions three, eight and post-therapy data collection. A significant positive increase in ratings of therapeutic alliance was observed from therapy session three (*M*= 42.51, *SD*= 4.86) to the final therapy session (*M*= 44.30, *SD*= 3.78), *t*(52)= -3.12 *p*= .003. Alliance ratings at the eighth session did not differ from alliance ratings at either the third session or post-therapy collection. Table 4 presents mean differences, and 95% confidence intervals for the mean differences for child self-ratings of alliance at therapy sessions three, eight, and post-therapy collection.

Table 4

Pairwise Comparisons of Child Self-Report of Alliance by Time Point

					95% CI for *M*D	
		MD	*df*	*p*	*Lower Bound*	*Upper Bound*
Session 3	Session 8	.09	57	.890	-1.32	1.15
	Final Session	1.64*	52	.003	-2.69	-.58
Session 8	Session 3	.09	57	.890	-1.32	1.15
	Final Session	1.61*	52	.010	-2.80	-.40
Final Session	Session 3	1.64*	52	.003	-2.69	-.58
	Session 8	1.61*	52	.010	-2.80	-.40

*Note: * p < .05.*

Therapists' Self-reported Ratings of Alliance. A mixed model pair-wise comparison was conducted for ratings of therapeutic alliance taken at therapy session three, session eight and at the post-therapy data collection. Overall there was a significant increase in ratings of therapeutic alliance from time one (*M*= 38.83, *SD*= 5.97) to time three (*M*= 41.12, *SD*= 5.59), *t*(49)= -3.02 *p*= .004; and from time two (*M*= 39.61, *SD*= 5.65) to time three (*M*= 41.12, *SD*= 5.59), *t*(47)= -3.03 *p*= .004. Alliance ratings at the eighth session did not differ from alliance ratings at the third session, but were significantly different from the post-therapy session. The therapist's ratings of therapeutic alliance were initially reported as positive (*M*= 38.83, *SD*= 5.97) and remained positive to time two (*M*= 39.61, *SD*= 5.65) and to time three (*M*= 41.12, *SD*= 5.59). Table 5 presents mean differences, and 95% confidence intervals for the mean differences

for therapist ratings of alliance at therapy session three, session eight and post-therapy data collection.

Table 5

Pairwise Comparisons of Therapist Self-Report of Alliance by Time Point

					95% CI for MD	
		MD	df	p	Lower Bound	Upper Bound
Session 3	Session 8	0.78	54	.195	-1.97	.41
	Final Session	1.96*	49	.004	-3.26	-.66
Session 8	Session 3	0.78	54	.195	-1.97	.41
	Final Session	1.84*	47	.004	-3.06	-.61
Final Session	Session 3	1.96*	49	.004	-3.26	-.66
	Session 8	1.84*	47	.004	-3.06	-.61

*Note: * p < .05.*

Parent's Self-reported Ratings of Alliance. A mixed model pair-wise comparison was conducted for therapeutic alliance ratings taken at therapy session three, session eight and post-therapy data collection. Overall there was no significant change in ratings of therapeutic alliance across any of the time points. The parent ratings of therapeutic alliance were initially reported as positive (*M*= 50.36, *SD*=4.68) and remained positive to time two (*M*= 48.88, *SD* = 6.39) and time three (*M*=49.31, *SD*= 6.32). Table 6 presents mean differences and 95% confidence intervals for the mean differences for parent ratings of alliance at data collection session three, session eight, and at post-therapy data collection.

Table 6

Pairwise Comparisons of Caregiver Self-Report of Alliance by Time Point

		MD	df	p	95% CI for MD	
					Lower Bound	Upper Bound
Session 3	Session 8	-1.40	24	.371	-1.86	4.82
	Final Session	-1.52	20	.288	-2.29	7.34
Session 8	Session 3	-1.40	24	.371	-1.86	4.82
	Final Session	-0.68	46	.133	-.53	3.89
Final Session	Session 3	-1.52	24	.288	-2.29	7.34
	Session 8	-0.68	46	.133	-.53	3.89

*Note: * p < .05.*

Research Question 2

How do multiple ratings of therapeutic alliance, collected at several time points in TF-CBT, predict treatment response? Specifically, is therapeutic alliance collected at session three, session eight and at final session at all predictive of treatment response collected at final session and at six month follow up, as rated separately by parent, therapist, and child?

A mixed level model was used to analyze the data collected. Treatment response was defined as change in post-traumatic symptomatology as measured on the TASC: from pre-assessment to post-therapy, and from pre-assessment to six-month follow-up. Three different raters reported on their views of child-therapist alliance: child, therapist, and caregiver.

Overall, no significant relationship was found to exist between therapeutic alliance and treatment response for any of the raters and at any of the time points. Additionally, effect sizes

for all relationships between therapeutic alliance and treatment response by all three raters were found to be small. Table 7, 8 and 9 presents the means, standard deviations, and samples sizes of child, therapist, and caregiver ratings of data collection, respectively, at pre-assessment, pre-therapy, post-therapy, and six months following therapy.

Table 7

Therapist Self-Report of Alliance by Time Point and Post Traumatic Symptom (PTS) Outcome as rated by TSCC by Time Point

		t	*df*	*p*	95% CI	
					Lower Bound	*Upper Bound*
Session 3 Alliance	Post Therapy PTS	-..67	3	.547	-1.54	1.10
	6 month Follow up PTS	-.17	3	.873	-2.02	1.71
Session 8 Alliance	Post Therapy PTS	.78	3	.490	1.60	1.52
	6 month Follow up PTS	.51	3	.641	-1.62	2.65
Final SessionAlliance	Post Therapy PTS	-2.05	3	..131	-2.59	1.65
	6 month Follow up PTS	-.78	3	.491	-3.63	1.69

Note: * p < .05.

Table 8

Child Self-Report of Alliance by Time Point and Post Traumatic Symptom (PTS) Outcome as rated by TSCC by Time Point

					95% CI	
		t	*df*	*p*	*Lower Bound*	*Upper Bound*
Session 3 Alliance	Post Therapy PTS	.204	5	.846	-1.10	1.48
	6 month Follow up PTS	-.069	5	.947	-1.96	1.83
Session 8 Alliance	Post Therapy PTS	1.07	5	.330	-1.16	2.02
	6 month Follow up PTS	-1.12	5	.310	-3.28	0.99
Final Session Alliance	Post Therapy PTS	-.76	5	.481	-2.67	0.28
	6 month Follow up PTS	1.02	5	.352	-1.01	2.91

*Note: * p < .05.*

Table 9

Parent Self-Report of Alliance by Time Point and Post Traumatic Symptom (PTS) Outcome as rated by TSCC by Time Point

					95% CI	
		t	*df*	*p*	*Lower Bound*	*Upper Bound*
Session 3 Alliance	Post Therapy PTS	1.19	5	.258	-.23	2.09
	6 month Follow up PTS	1.70	5	.115	-2.92	2.79
Session 8 Alliance	Post Therapy PTS	1.18	5	.290	-1.16	3.01
	6 month Follow up PTS	.89	5	.581	-1.65	2.40
Final Session Alliance	Post Therapy PTS	-.69	5	.263	-1.89	.28
	6 month Follow up PTS	-1.77	5	.627	-2.92	.50

*Note: * p < .05.*

Discussion

The current study looked at how therapeutic alliance changes, as reported by three different raters, over the course of TF-CBT with maltreated children. This study also examined whether therapeutic alliance, as reported by three different raters at different time points, was predictive of treatment response. Although much work has already been done in examining the role of therapeutic alliance in adult therapy and with non-maltreated children, (Bordin, 1979; Horvath & Luborsky, 1993; Martin, Garske, & Davies, 2000), this study is unique in that it specifically examines therapeutic alliance with maltreated children undergoing TF-CBT, and also uses a multi-rater perspective.

Results of this study indicated that children, caregivers, and therapists all provided high ratings of therapeutic alliance throughout TF-CBT. This is encouraging because therapeutic alliance is considered integral to positive treatment outcomes in both adult and child literature (Bordin, 1979; Horvath & Luborsky, 1993; Martin, Garske, & Davies, 2000). In fact, it was found that both child and therapist ratings of therapeutic alliance not only remained positive throughout the course of TF-CBT, but both child and therapist ratings became significantly more positive from session three to post-therapy. This significant positive increase in perceptions of the relationship occurred despite the fact that children faced challenging traumatic memories in the form of a trauma narrative, a kind of progressive exposure, during therapy.

Concerns exist in the therapeutic community that asking a child to discuss their trauma experiences in detail could significantly affect the therapeutic relationship between child and therapist (Cohen et al., 2000; Cohen et al., 2006; Lawson, 2009). Some therapists are concerned that if they invite children to discuss these difficult and evocative trauma memories, the children could become re-traumatized and blame the therapist, thereby damaging the alliance (Lawson,

2009). The findings of the current study contradict this idea, and in fact reports by both children and therapists showed a significant positive change in alliance from beginning to end of therapy, despite the use of a trauma narrative. Moreover, Konanur et al. (in press) found that the same sample of children also experienced positive improvement in PTSD symptomatology despite the use of the same exposure based methods during the course of TF-CBT. Therefore a uniform positive improvement in both therapeutic alliance ratings and PTSD symptomatology occurred even though the children were asked to engage directly with their traumatic memories during TF-CBT.

The current study also evaluated whether ratings of therapeutic alliance were predictive of treatment response. Inconsistent with the proposed hypothesis, there was no significant relationship between any of the alliance ratings and ratings of treatment response at any of the time points. One likely reason for the lack of relationship between therapeutic alliance and treatment response in the current study is a statistical one: The alliance ratings collected were such that there was not enough variability for a relationship between therapeutic alliance and treatment response to be detected.

Therapeutic alliance was overwhelmingly positive across raters and across time points in this study. Participants responded very positively to questions about alliance, which reduced variability within the sample, and therefore reduced the ability to detect any possible relationship between alliance and treatment response. Simply put, the sample did not contain negative ratings of therapeutic alliance to compare to the positive ratings and therefore had limited variability. Cramer and colleagues (2010) state clearly that low variance in a sample can reduce the experiment's ability to detect effect and it is likely that this occurred with the current sample.

Looking at these particular findings through a clinical lens is also instructive. When one does, the results may imply a certain threshold level of positive alliance. In the current sample, ratings ranged from good to very good. As mentioned, this likely represents low variability in the sample. However, beyond the statistical matter, this suggests that once a high rating is reached in relation to the therapeutic alliance, good or very good simply does not make very much difference, at least as far as prediction of treatment response is concerned. Of course, this idea is limited to the current study, an investigation of children undergoing TF-CBT.

Still, theoretically the concept of a "good enough" alliance may be advanced here, and may be applicable to other psychotherapies as well. Following from the "good-enough mother" concept, psychoanalyst D.W. Winnicott in 1953 proposed that the mother-child "micro interactions" are small representations of how the child will eventually need to act autonomously in the larger world. The mother slowly moves away from the child in small increments, and her increasing failure to adapt to the child's every need prepares the child for the realities of the external world (Winnicott, 1953). These "failures to adapt" on the mother's part teach the child about independence and self-efficacy. The theory also makes the broader statement that the mother or caregiver does not need to be perfect in parenting for the child to mature effectively and successfully. The "good-enough mother" will instead provide the necessary lessons to the general satisfaction of the child, and the relative "failings" of the mother will, in fact, serve as lessons about the adult world (Winnicott, 1967). As long as the caregiver is "good enough," then the child will learn the necessary lessons to grow into an effective adult. So too, theoretically it may follow that once the therapeutic relationship reaches a certain level of quality (the "good-enough alliance"), minor failings on the part of the therapist may not end up to be problematic to the overall treatment.

Clinical Implications

There are several clinical implications of the findings of the current study. First, this study emphasized that therapeutic alliance is not negatively affected during the use of exposure based methods in trauma therapy. Past analyses done with the same study sample have already shown that TF-CBT, along with its trauma narrative, successfully reduced PTSD symptoms in the maltreated child sample (Konanur & Muller, 2013; Konanur et al., in press). The current study goes further to show that exposure based methods like the trauma narrative are not only *not* harmful to the therapeutic relationship but in fact children and therapists both reported significantly positive growth in alliance during the use of therapy that incorporates these methods.

An implication of this finding is that therapists need to monitor themselves for countertransference reactions when deciding whether or not to move into exposure based trauma work. The current study suggests that therapeutic alliance is not negatively affected by using this exposure based method in trauma therapy with children. Therapist feelings of anxiety and reluctance to advance into this more difficult part of therapy may be strong, especially with new or inexperienced clinicians. However, therapists should ask themselves whether their reluctance is a response to the client's needs, or their own. Specifically, is their reluctance due to difficulties the client is genuinely facing in successfully doing the requisite Phase One work (establishing safety, self-regulation skills), work that is necessary prior to moving on to challenging Phase Two exposure-based tasks; or, is the therapist reluctance a response to personal feelings of anxiety or guilt, which arise when clinicians invite such children to re-live painful memories of sexual abuse. Certainly, either scenario is understandable, but from a clinical standpoint, it is important that therapists carefully consider why they are resisting

carrying out challenging exposure-based trauma work, especially in light of findings suggesting that such work is both helpful to the treatment relationship and to treatment outcome.

Concerning the finding that alliance did not predict trauma symptom outcomes, the proposed idea of the "good-enough alliance" may be useful, especially when considering therapist-client interactions, and the expectations that therapists have of themselves. If it is true that, clinically, a "good" therapeutic alliance is just as effective as a "great" therapeutic alliance, then this leaves more room for therapists to explore conflict within the relationship, and allows for slightly more flexibility when dealing with ruptures in alliance. If we can extend the notion of the "good-enough mother" to the "good-enough alliance" then small failures on the part of the therapist may help the client to constructively manage different types of conflicts within the safety of the therapy room (Winnicott, 1953).

Furthermore, the idea of "good-enough alliance" allows for ruptures in alliance to become opportunities to practice conflict resolution, an interpersonal task that is typically stressful for trauma survivors. As long as the therapist can react to these ruptures in a way that thoughtfully uses the conflict to help the client grow, they can then do so without too much fear that the client's therapeutic progress will somehow negatively suffer from this temporary break in relationship. The therapist can focus less on trying to maintain a perfect relationship with the client out of fear that any conflict will disrupt the therapy, and can work instead with the knowledge that as long as they provide the necessary support and containment, the relative "failings" of the therapist will in fact serve as lessons about the real world outside the therapy room (Winnicott, 1967).

Limitations and Future Directions in Research

There are several limitations of note in the current study. As detailed previously, variability in alliance ratings was quite low. Overall, children, therapists, and parents all rated the alliance as steadily positive throughout the entire study. These positive ratings either remained stable, in the case of the parents, or became more positive, as was the case with both children and therapists. As there were no cases where the alliance was rated as very negative, we have no way of comparing any cases of poor alliance to the cases of positive alliance to gauge accurately if a relationship existed between ratings of alliance and treatment outcome.

Secondly, if we assume that the therapeutic alliance ratings were accurate, it may then be necessary that clinicians and researchers work towards developing more sensitive tools for measuring the therapeutic relationship. These more sensitive measures would ideally be able to distinguish better between similar alliance ratings such as "good" and "excellent". This increased sensitivity would then make it easier to obtain variability with even widely similar responses and therefore better gauge whether a relationship existed between alliance and treatment outcome.

Alternatively, one could also take the position that the reason alliance ratings were so uniformly high in the current study is because the reporting of these ratings were incorrect or biased in some way. It is possible that the self-report measures we used did not accurately access how the responders actually felt about the therapeutic relationship. The children may have not understood some of the questions or were careless with their responses. It is also possible that they answered consistently positively about their therapists because of response demands; that is the children, as well as parents, may have been hesitant to respond negatively to questions about

the therapist, therefore affecting how they respond to questions about the therapeutic relationship.

Considering these potential issues with alliance ratings, it is possible that there exists better ways to access a child's true views about their relationship with their therapists. Replacing the self-report measures with an interview or with observation and scoring method may more accurately capture how child clients view alliance. It may be beneficial for future work to be done around developing a child therapeutic alliance measure that both accurately accesses the child's true views of the therapeutic relationship and is sensitive enough to distinguish between more subtle differences in alliance ratings.

A third limitation to the study involved the fact that only minimal information about the reasons for participant withdrawal was collected. In the future, studies could place heavier emphasis on evaluating what families and therapists did not find helpful during the treatment process. This may also include factors that participants believed affected therapeutic alliance, and potentially the relationship between the therapist and family as well. This information could be informative when examining any existing concerns about therapeutic alliance during the course of TF-CBT, and clinically it could inform therapists about how to address any of these concerns within session.

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Appendix A

<u>Working Alliance Inventory – Client Short-Revised</u>

Instructions: Below is a series of statements about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space – as you read the sentences, mentally insert the name of your therapist in place of _____ in the text.

For each statement, please take your time to consider your own experience and then circle the appropriate response. The rating scale is not the same for all statements. **PLEASE READ CAREFULLY!**

As a result of these sessions I am clearer as to how I might be able to change.

| Seldom | Sometimes | Fairly Often | Very Often | Always |

What I am doing in therapy gives me new ways of looking at my family's situation.

| Seldom | Sometimes | Fairly Often | Very Often | Always |

I believe _____ likes me.

| Always | Very Often | Fairly Often | Sometimes | Seldom |

_____ and I collaborate on setting goals for my therapy.

| Seldom | Sometimes | Fairly Often | Very Often | Always |

_____ and I respect each other.

| Always | Very Often | Fairly Often | Sometimes | Seldom |

_____ and I are working towards mutually agreed upon goals.

| Always | Very Often | Fairly Often | Sometimes | Seldom |

I feel that _____ appreciates me.

| Always | Very Often | Fairly Often | Sometimes | Seldom |

_____ and I agree on what is important for me to work on.

| Seldom | Sometimes | Fairly Often | Very Often | Always |

I feel _____ cares about me even when I do things that he/she does not approve of.

| Always | Very Often | Fairly Often | Sometimes | Seldom |

I feel that the things I do in therapy will help me to accomplish the changes that I want.

| Seldom | Sometimes | Fairly Often | Very Often | Always |

_____ and I have established a good understanding of the kind of changes that would be good for me and/or my family.

| Seldom | Sometimes | Fairly Often | Very Often | Always |

I believe the way we are working with my family's problem is correct

| Alway | Very Often | Fairly Often | Sometimes | Seldom |

Therapeutic Alliance Scale for Children

We are going to read some sentences about meeting with your therapist. After reading the sentence, you decide how much the sentence is like you. Is it: (read each of the four possible answers and point to the appropriate statement/figure on the cue card). Let's try this example:

I play games with my therapist when we meet together.

Would you say that is:

   Not Like You   A Little Like You   Mostly Like You   Very Much Like You

(Check the child's response, e.g., What makes you think that?)

Here are the rest; remember there are no right or wrong answers, just how you feel.

1)   **I like spending time with my therapist.**

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

2)   I find it hard to work with my therapist on solving problems in my life.

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

3)   I feel like my therapist is on my side and tries to help me.

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

4)   I work with my therapist on solving my problems.

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

5.   When I'm with my therapist, I want the sessions to end quickly.

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

6.   I look forward to meeting with my therapist.

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

7.   I feel like my therapist spends too much time working on my problems.

1	2	3	4
Not Like You	A Little Like You	Mostly Like You	Very Much Like You

8)   I'd rather do other things than meet with my therapist.

1   2   3   4
Not Like You   A Little Like You   Mostly Like You   Very Much Like You

9)   I use my time with my therapist to make changes in my life.

1   2   3   4
Not Like You   A Little Like You   Mostly Like You   Very Much Like You

10)   I like my therapist.

1   2   3   4
Not Like You   A Little Like You   Mostly Like You   Very Much Like You

11)   I would rather not work on my problems with my therapist.

1   2   3   4
Not Like You   A Little Like You   Mostly Like You   Very Much Like You

12)   I think my therapist and I work well together on dealing with my problems.

1   2   3   4
Not Like You   A Little Like You   Mostly Like You   Very Much Like You

<u>Therapeutic Alliance Scale for Children</u>
(Therapist Form)

Please rate your patient's current presentation in therapy on the following scales. Circle the number corresponding to your rating for each item.

1)   The child likes spending time with you, the therapist.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

2)   The child finds it hard to work with you on solving problems in his/her life.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

3)   The child considers you to be an ally.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

4)   The child works with you on solving his/her problems.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

5)   The child appears eager to have sessions end.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

6.   The child looks forward to therapy sessions.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

7)   The child feels that you spend too much time focusing on his/her problems/issues.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

8)   The child is resistant to coming to therapy.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

9) **The child uses his/her time with you to make changes in his/her life.**

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

10) **The child expresses positive emotion toward you, the therapist.**

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

11) **The child would rather not work on problems/issues in therapy.**

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

12. **The child is able to work well with you on dealing with his/her problems/issues.**

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient