ALLIANCE AFTER EVIDENCE: THE IMPACT OF YOUTH-THERAPIST
ALLIANCE ON TREATMENT OUTCOME FOR INTERNALIZING YOUTH, OVER
AND ABOVE PROTOCOL EFFECTS

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Abstract

Empirically supported treatment (EST) protocols have been identified for the most common emotional and behavioral problems in youth (e.g., Chorpita et al., 2011; Lonigan, Elbert, & Johnson, 1998; Weisz, Doss, & Hawley, 2005). The role of the therapeutic alliance has received relatively less empirical examination, although when examined, it consistently accounts for at least a modest amount of variance in treatment outcome (Shirk & Karver, 2003; Karver et al., 2006). Furthermore, the impact of the alliance on youth treatment outcome typically is examined in lieu of, rather than in concert with, the impact of treatment procedures or content. The purpose of the current study, therefore, was to examine the impact of the youth-therapist alliance on treatment outcome, over and above the impact of treatment protocol. The study was conducted in a sample of youth with internalizing behavior problems ($N = 75$), randomly assigned to either empirically supported or usual care treatment conditions. Results indicated that whereas internalizing youth improved by the end of treatment under all conditions, the impact of treatment protocol was negligible, as was the impact of the youth-therapist alliance as measured at the end of treatment, over and above treatment protocol and when considered independently. Both methodological and conceptual factors may be indicated in these results, including choice of alliance measure, restriction of range encountered when applied to an internalizing population, and issues of temporal precedence.
Introduction

The last decade has seen significant progress in the identification of empirically supported treatments\(^1\) (ESTs) for emotional and behavioral disorders. Starting with the 1993 report of the American Psychological Association’s (APA) Division 12 Task Force on Promotion and Dissemination of Psychological Procedures, and continuing in a series of successive reports and publications, ESTs have been identified for adult emotional and behavioral disorders ranging from panic disorder to major depressive disorder to bulimia nervosa (e.g., Chambless, 1996; Chambless & Hollon, 1998). Since 1998, similarly exhaustive efforts have been conducted to identify ESTs for youth emotional and behavioral disorders (Burns, Hoagwood, & Mzaarek, 1999; Chorpita et al., 2011; Hoagwood, Burns, Kiser, Ringelsen, & Schoenwald, 2001; Kazdin & Weisz, 2003; Lonigan, Elbert, & Johnson, 1998; Weisz, Doss, & Hawley, 2005). With efficacious treatments established for the most common disorders in adults and youth, recent years have seen increasing efforts to disseminate, adapt, and implement these interventions for use in community settings.

Whereas the EST movement has directed its efforts toward determining the utility of specific interventions or treatment protocols in psychotherapy, a separate line of inquiry has focused on evaluating the attributes of empirically supported relationships (ESRs). The APA’s Division 29 Task Force on Empirically Supported Therapy Relationships was founded, at least in part, in response to the EST movement (Norcross, 2001). The ESR movement first emerged in the literature with the release of a special

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\(^1\) The terms *empirically supported treatment* and *evidence-based treatment* will be used interchangeably herein, defined as treatment supported by empirical evidence.
issue of the journal *Psychotherapy* in 2001 (e.g., Norcross, 2001; Lambert & Barley, 2001). According to the Chair of the Division 29 Task Force, the central purpose of the ESR movement was “to identify, operationalize, and disseminate information on empirically supported therapy relationships” (pp. 347-348), or the key features of therapy relationships linked to positive psychotherapy outcomes (Norcross, 2001).

The EST and ESR movements share several common features, not the least of which is the goal of maximizing treatment outcome via the judicious application of research evidence. Both movements currently recognize the validity of both therapeutic techniques and the therapeutic relationship or alliance as bases for therapeutic change. The Division 29 Task Force describes their work as, in some respect, an expansion of that done by the Division 12 Task Force (Norcross, 2004, ¶ 1). And indeed, both advocates of ESTs and advocates of ESRs note that the only argument for studying treatment protocols/techniques to the exclusion of relationship factors, or vice versa, is if all variability in treatment outcome is accounted for either by one or the other.

In spite of their shared features and their shared importance, the literatures on these two topics are generally distinct. This is to say that researchers tend to examine either treatment protocol or therapeutic relationship factors as agents of therapeutic change, but not both. Alliance typically is not addressed in studies that primarily focus on the relation between treatment techniques or protocols and treatment outcome, or is considered only as a moderator of the protocol-outcome relation. As for studies that primarily examine the alliance-outcome relation, technique or protocol content is often ignored or considered only as a moderator of the alliance-outcome relation. For instance, in the most recent meta-analysis of the literature on the relation between therapeutic
relationship variables and treatment outcome in youth, the number of the 49 studies that contained information about treatment protocol was so small that they had inadequate power even to examine protocol as a moderator variable (Karver, Handelsman, Fields, & Bickman, 2005). Thus, the current study seeks to bring two largely distinct literatures together to examine the impact of both treatment protocol and therapeutic alliance on youth treatment outcome.

The Therapeutic Alliance: Historical Perspective, Definition, and Related Constructs

The role of the therapeutic relationship in psychotherapy has garnered attention from practitioners and scholars throughout the relatively short history of psychotherapy, dating at least back to Freud. Freud viewed the client-therapist relationship as the warm and positive component of transference, largely dependent on the client’s friendly and positive feeling toward the therapist, and less so on the therapist’s views on and behaviors toward the client (Freud, 1958/1913). In Freud’s view, the client-therapist relationship, if sufficiently positive, allows the therapist and client to band together against the client’s neurosis, and thereby, is a rather powerful agent of change (Freud, 1958/1913; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). The importance of the therapeutic relationship was reasserted in the literature, albeit very differently, with the emergence of humanistic, client-centered therapy. Indeed, Rogers instead conceptualized the client-therapist relationship as one of the key components of successful therapy (Horvath & Symonds, 1991; Rogers, 1957). Rogers believed that the quality of the therapeutic relationship is largely dependent on the therapist’s ability to be empathic and demonstrate unconditional positive regard toward the client. The term “working alliance” was coined by Bordin in a landmark 1979 piece on the subject, which
he described as “the key curative feature” of psychodynamic psychotherapy (1979).

Within a little over a decade, however, Horvath and Symonds (1991) described the working alliance as a “pantheoretical construct” that transcended therapeutic orientation and appeared in the literature of psychoanalytic, psychodynamic, client-centered, and cognitive-behavioral traditions.

Regarding definitions, the psychotherapy literature has been inconsistent in its terminology for what might be referred to broadly as “therapeutic relationship variables,” but some distinctions can be made. The terms “therapeutic relationship” and “therapeutic bond” typically refer to the affective bond between client and therapist (Martin, Garske, & Davis, 2000; Shirk & Karver, 2003). The therapeutic alliance, however, is viewed by those who study it closely as a more complex and nuanced construct (Bordin, 1979; Martin, Garske, & Davis, 2000). With regard to adult clientele, experts typically agree that the therapeutic alliance includes three dimensions: bond, referring to the affective aspect of the alliance, task, referring to the degree of agreement between client and therapist on session tasks, and degree of agreement on treatment goals (Bordin, 1979; Horvath & Symonds, 1991; Martin et al., 2001). When the therapeutic alliance is examined with youth, however, as is the case in the current study, the goals dimension is often folded into the task dimension or left out altogether (e.g., McLeod & Weisz, 2005). Corroborating this conceptualization, factor analysis of therapeutic alliance in youth suggests the presence of only the bond and task dimensions (Chu & Kendall, 2005). The under emphasis on the goal dimension in youth psychotherapy may be a reflection of the fact that youth-parent disagreement on treatment goals is very common and perhaps to be expected (DiGiuseppe, Linscott, & Jilton, 1996; Karver et al., 2006; Yeh & Weisz, 2001).
Few consistent distinctions are identifiable between what different authors refer to as the “therapeutic alliance,” “working alliance,” and “helping alliance.” For the purposes of the current paper, the term “therapeutic alliance,” or simply the “alliance,” will be used throughout, and it will be defined as the collaborative and affective bond between therapist and client and their ability to agree on treatment goals and tasks (Martin, Garske, & Davis, 2000; McLeod & Weisz, 2005).

It may be important to draw some distinctions between therapeutic alliance and two other closely related constructs not yet mentioned: treatment involvement and treatment engagement. In youth psychotherapy, treatment involvement may be defined as the youth’s willingness to participate in therapy activities or tasks, disclose information about the self, ask questions, and “mentally engage” the therapeutic material (Chu & Kendall, 2004; see also Braswell, Kendall, Braith, Carey, & Vye, 1985). Some authors use the terms treatment involvement and treatment engagement interchangeably (Chu & Kendall, 2004). For the purposes of the current analysis, however, treatment engagement will be considered a broader construct. Specifically, treatment engagement will be defined as involving not only involvement in treatment sessions, but a more generalized application of therapy skills and constructs, such as doing treatment homework or practicing in between sessions, making treatment a priority in one’s life, and/or having a sense of investment in the therapy process (Shirk & Russell, 1996).

The distinction between treatment involvement and engagement on one hand, and therapeutic alliance on the other, is subtle but significant. Treatment involvement and treatment engagement are one-sided, defined by the youth’s behavior only, whereas therapeutic alliance is defined by the behavior of both members of the dyad, youth and

Furthermore, whereas treatment involvement is defined by engagement in therapeutic tasks, and treatment engagement is defined by generalization of this task engagement, therapeutic alliance is defined by both task engagement and a relationship component. It is possible to have high treatment involvement or engagement and low therapeutic alliance. For example, one could imagine a youth with selective mutism who dislikes her therapist, but desperately wants to be able to talk to other kids so that she can make friends, and as a result, does what her therapist asks and speaks out loud in their sessions together. The converse, low treatment involvement or engagement and high therapeutic alliance is more difficult to imagine, because in theory, alliance requires involvement and/or engagement.

**Therapeutic Alliance and Adult Treatment Outcome**

The therapeutic alliance bears a modest but consistent relation to treatment outcome in the adult treatment literature. The alliance-outcome relation has been examined in two major meta-analyses with adults. In 1992, Horvath and Symonds conducted the first such analysis, examining 24 studies based on 20 distinct data sets. Twenty-one of the studies were published, whereas 3 of the studies were not. Horvath and Symonds sought to achieve the dual purposes of (1) determining the overall alliance-outcome correlation as an estimate of effect size across the 24 studies, and (2) examining potential moderators of the alliance-outcome relation. The overall weighted alliance-outcome correlation in the meta-analysis was .26, indicating a small effect size, according to Cohen’s (1992) effect size criteria, in which .20 signifies a small effect size, .50 a moderate effect size, and .80 a large effect size. They found this effect to be reliable.
across the studies included in the analysis. With regard to their examination of potential moderators of the alliance-outcome relation, Horvath and Symonds found a significant effect for informant, such that client and observer ratings of alliance were more predictive of outcome than therapist ratings. Other variables they examined, including type of treatment (i.e., cognitive, dynamic, Gestalt, or eclectic), length of treatment, publication status, and sample size, did not moderate the alliance-outcome relation.

In the second major meta-analysis of the adult alliance-outcome literature, Martin, Garske, and Davis (2000) examined 79 studies, 58 of which were published and 21 of which were not. Martin and colleagues generally followed the precedent set by Horvath and Symonds, seeking (1) to determine the overall effect size of the alliance-outcome studies in their sample and (2) to examine several variables as potential moderators of the alliance-outcome relation. The overall weighted alliance-outcome correlation in this meta-analysis was .22, indicating a small effect size. Martin et al. examined numerous variables that have been hypothesized to moderate the alliance-outcome relation, including informant (i.e., client, therapist, or observer), type of treatment provided (i.e., behavioral, cognitive, or psychodynamic), type of outcome measure, time of alliance measurement, and publication status. Martin and colleagues found that the alliance-outcome relation was consistent across these many moderator variables. Furthermore, a test of homogeneity indicated that the correlation represented a homogenous population, suggesting a consistent alliance-outcome relation across the studies examined.

The Importance of the Therapeutic Alliance in Youth Psychotherapy

The role of the therapeutic alliance in youth treatment is not as well-understood as its role in adult treatment, and it has received significantly less attention from researchers.
There is reason to believe, however, that therapeutic alliance plays just as important a role in youth treatment as it does with adults. Some would argue, in fact, that it is even more important with youth, for a number of reasons, the most fundamental of which is that youth typically do not refer themselves for treatment (DiGiuseppe et al., 1996).

Instead, they are referred by parents, caregivers, and teachers; in some cases, against the explicit wishes of the youth (McLeod & Weisz, 2005). When youth are essentially a captive audience in therapy, and even at times when they are willing attendees, they may disagree with their parents or therapist on the problem that brings them there (Hawley & Weisz, 2005; McLeod & Weisz, 2005). Disagreement on the goals of therapy, and on the tasks youth are asked to complete in furtherance of these goals, is also common (DiGiuseppe et al., 1996; Karver et al., 2006). Another source of difficulty in forging and maintaining the therapeutic alliance is the fact that youth, and adolescents especially, are at a point in their development when they are naturally beginning to seek increased independence. Suffice to say that the prospect of having an additional “authority figure” in their lives as a therapist may not be a pleasing one.

*Therapeutic Alliance and Youth Treatment Outcome*

As in the adult literature, the therapeutic alliance appears to bear a modest but consistent relation to treatment outcome in the youth treatment literature, although there is less evidence to support this conclusion with respect to youth psychotherapy. The alliance-outcome relation has been examined in two meta-analyses in the youth treatment literature, similar to the adult literature, although with fewer total studies and less specificity than the adult meta-analyses described above. In 2003, Shirk and Karver analyzed 23 studies examining what they referred to as “therapeutic relationship
variables” in relation to child and adolescent therapy outcomes. They sought to address two major questions: (1) the strength of the alliance-outcome relation and (2) the role of potential moderators of the alliance-outcome relation, including both substantive and methodological factors. Shirk and Karver used many of the same criteria in identifying studies as Horvath and Symonds (1991) and Martin et al. (2000) used in their meta-analyses of the adult alliance-outcome literature. They did, however, deviate significantly from the adult literature by including studies that examined a wider range of relationship variables than the alliance alone, since to do otherwise would have restricted their sample severely.

Interestingly, in spite of this relatively major difference, Shirk and Karver’s findings from the youth treatment literature were very similar to the meta-analyses with adults with regard to effect size. The weighted mean r after removing studies with inadequate data for effect size estimation (resulting in n = 20 studies) was .22. These results suggested a small effect size, consistent with the adult literature. One substantive factor was identified that moderated the alliance-outcome relation; type of problem area, which Shirk and Karver had divided into internalizing problems and externalizing problems. Notably, the authors found that studies involving youth with externalizing problems showed a stronger association between relationship variables and outcome than studies involving youth with internalizing problems, a difference that was statistically significant and reliable. Additionally, several methodological factors appeared to moderate the alliance-outcome relation; specifically, timing of relationship measurement, informant for relationship and outcome measurement, specific versus global measures of outcome, and shared versus cross-source measurement of relationship and outcome.
variables. Other variables that were examined but did not moderate alliance-outcome associations included age or developmental level of the child as well as type, mode, structure, and context of treatment. Ultimately, the results of Shirk and Karver’s meta-analysis were similar to the results of meta-analyses of adult treatment studies described above, although the quantity, methodological quality, and specificity of studies available was superior in the adult meta-analyses, especially Martin et al (2000).

In the second meta-analysis in youth, Karver et al. (2006) sought (1) to examine the relation between broadly defined “therapeutic relationship variables” and treatment outcome and (2) to determine which therapeutic relationship variables appeared to be the most predictive of treatment outcome. Their broadened inclusion criteria included 29 relationship variables, which resulted in the identification and inclusion of 49 treatment studies that examined some aspect of the relationship variable-outcome relation. Karver et al. had two overarching objectives, the first of which was to determine the strength of the relationship variable-outcome relation. Across the 49 studies, the weighted effect size estimate was .17, which the authors noted was “surprisingly low” in light of previous findings with children. One study, however, appeared to have a disproportionate impact on the estimate, given an unusually large sample size, comprising about 40% of the youth in all 49 studies combined, and an unusually small effect size of .03 (Littell, 2001). Littell’s area of study differed substantially from most studies included in the meta-analysis, in that it examined the effect of family preservation services on subsequent familial involvement in the child welfare system rather than the effect of psychotherapy on youth psychopathology. Excluding the one study, the weighted effect size for the 48
remaining studies was .26, which was consistent with previous findings of a modest relationship variable-outcome relation with both youth and adults.

The second objective of Karver and colleagues was somewhat different than the other meta-analyses described: to elucidate the specific therapeutic relationship variables that best accounted for variability in outcomes. Therapist factors, including interpersonal and direct influence skills, were among the most robust predictors. Specific client factors also predicted outcomes, namely, both child and parent willingness to participate in treatment, as well as child and parent actual participation in treatment. Interestingly, Karver et al. found that the specific relationship variable of therapeutic alliance was less predictive of outcome, or evidenced a smaller effect size, across studies than the therapist and client variables just noted. They further indicated, however, that therapeutic alliance was consistent in its prediction of outcome across multiple, diverse treatment settings (i.e., outpatient, inpatient, home-based) and various different treatment modalities (i.e., psychodynamic, behavioral, family systems).

Two recent studies of the alliance-outcome relation in youth are worthy of specific attention, given that they were not included in the meta-analyses already discussed, and since some of the methodology for the current study was drawn from these studies. Specifically, both Hawley and Weisz (2005) and McLeod and Weisz (2005) examined the relation between alliance and outcome in samples of youth treated in community-based, “usual care” clinic settings. Both studies examined both youth-therapist and parent-therapist alliance, but only the youth-therapist alliance results more relevant to the current study will be reported here. Hawley and Weisz measured youth-therapist alliance using the Therapeutic Alliance Scale for Children (TASC; Shirk &
Saiz, 1993), a youth self-report questionnaire. McLeod and Weisz also assessed youth-therapist alliance using the TASC, as well as an independent observer behavioral coding system they developed, the Therapeutic Process Observational Coding System, Alliance Scale (TPOCS-A; McLeod & Weisz, 2005). Both studies used Child Behavior Checklist (Achenbach, 2001) scores to assess youth treatment outcome, and Hawley and Weisz (2005) also used the Youth Self-Report (Achenbach, 1995). Using multiple regression analysis, both Hawley and Weisz and McLeod and Weisz found that youth-therapist alliance bore a significant relation to youth treatment outcome as indicated by symptom improvement on the Achenbach scale(s), over and above the effect of initial symptom severity. The current study employed some of the measures and methods from these two studies.

Two newer studies, released since the current study was initiated, investigated youth-therapist alliance in samples of children with anxiety disorders only, and suggested a somewhat more complex picture than that which was initially conceptualized. Chiu et al. (2009) assessed the relation between the child-therapist alliance and symptom improvement among a group of youth receiving CBT for anxiety disorders. Interestingly, the quality of the child-therapist alliance early in treatment predicted symptom improvement at mid-treatment but not at post-treatment, although positive alliance shifts during treatment predicted better post-treatment outcomes. In another study utilizing CBT for youth with anxiety disorders, Liber et al. (2010) investigated the relation between treatment adherence, child-therapist alliance, and child outcomes. Although treatment adherence and child-therapist alliance were both high, neither predicted outcomes using traditional measures of change in child outcome measures. A re-analysis
of the data using reliable change analysis yielded no statistically significant results, but indicated a trend between stronger alliance and greater reliable change in child-reported anxiety symptoms.

The Relation between the Youth-Therapist Alliance and Other Important Treatment Variables

In addition to studies that examined the relation between alliance and treatment outcome as indicated by symptom improvement, there is other evidence that suggests that the alliance is clinically significant in its relation to youth treatment satisfaction, therapy retention rates, and anecdotal reports of both youth and therapists. A review of the literature on youth satisfaction with treatment services suggested an association between the youth-therapist alliance and youth treatment satisfaction. In a study described above, Hawley and Weisz (2005) found a significant relation between youth-therapist alliance and youth satisfaction with treatment services. Furthermore, three separate studies of different treatment satisfaction measures for youth suggested that the therapeutic alliance and/or the therapeutic relationship (depending on how these terms were defined in each study) was a distinct factor underlying youth treatment satisfaction (Brannan, Sonnichsen, & Heflinger, 1996; Garland, Saltzman, & Aarons, 2000; Shapiro, Welker, & Jacobson, 1997). Garland et al.’s results were especially interesting. In their factor analysis of a measure they had developed to assess youth treatment satisfaction, they identified a four-factor structure: counselor qualities, meeting needs, effectiveness, and counselor conflict. They noted that youth perception of the therapy relationship was represented by both the counselor qualities and counselor conflict factors. Garland and colleagues noted that youth perceptions of the therapeutic relationship, when combined
with youth perception of therapist skill, were more predictive of youth satisfaction with services than even their perceptions of whether or not their needs were met in treatment and their perceptions of treatment effectiveness.

Therapeutic alliance also appears to be associated with therapy retention rates. Attrition is a significant problem in youth psychotherapy, with the estimated rate of premature termination ranging from 28% to 85% (Armbruster & Kazdin, 1994; Garcia & Weisz, 2002; Weisz & Weiss, 1993). In a 2002 study conducted across ten community-based, usual care clinics, Garcia and Weisz administered a questionnaire to parents of 344 youth with recently closed cases to determine reasons for ending treatment, regardless of whether they completed their course of treatment or terminated treatment prematurely. They conducted a factor analysis of reasons for therapy termination among both completers and non-completers, and identified six reliable factors underlying termination. The factors included therapeutic relationship problems, family and clinic practical problems, staff and appointment problems, time and effort concerns, treatment not needed, and money issues. Their results indicated that therapeutic relationship problems accounted for the most variance (16%) in reasons for termination among both completers and non-completers. Garcia and Weisz further found that other than money issues, therapeutic relationship problems was the only factor that distinguished therapy completers from non-completers. It should be noted that the therapeutic relationship problems factor included both the youth-therapist and parent-therapist relationships, but the results are noteworthy nonetheless.

Although perhaps less convincing to the clinical scientist than objective measurement of the relation between alliance and outcome, youth and therapist reports
further support the importance of the youth-therapist alliance in psychotherapy. For instance, in a long-term treatment follow-up survey by Kendall and Southam-Gerow (1996), youth who had received treatment for anxiety in the preceding two to five years reported that their relationship with their therapist was highly important to their success in treatment. Granted, this study is retrospective in nature, and thus subject to bias; however, this is still a potentially significant finding, especially in light of the evidence already presented that the youth-therapist alliance is highly important to youth satisfaction with treatment. Practitioners also appear to view the alliance as an important factor in determining youth treatment outcomes. For instance, in a survey of practicing psychologists and psychiatrists, Kazdin, Siegal, and Bass (1990) found that the majority of the nearly 1200 practitioners surveyed regarded the alliance as important to therapeutic change and indicated that the alliance should be a clinical research priority.

*Treatment Protocol and Youth Treatment Outcomes: Evidence-Based Treatment and Usual Care*

As noted previously, the relation between treatment protocol and youth treatment outcome is well-established. Reviewing the hundreds of studies that demonstrate this point is well beyond the scope of this paper, but it may be useful to look at the aggregated effects of this work. Weisz, Doss, and Hawley (2005) examined hundreds of evidence-based treatment protocols for youth, and found a mean effect size of .50 to .80 for the effects of treatment protocol on youth treatment outcomes. By Cohen’s standards, effect sizes in this range indicate moderate to large effects of treatment protocols on youth treatment outcomes. Weisz, Jensen-Doss, & Hawley (2006) noted that in contrast, the few available narrative and meta-analytic findings on usual care in the literature suggest
an effect size that “has hovered near zero, suggesting no benefit of [usual care], on average” (p. 672). Framed differently, they suggested that usual care treatments perform about as well as waitlist control groups in trials of evidence-based protocols.

To explore these comparisons more directly, Weisz, Jensen-Doss, and Hawley (2006) conducted a meta-analytic review of evidence-based therapies versus usual clinical care for youth across a broad spectrum of problem areas, composed of 32 studies, including 36 evidence-based conditions and 35 usual care conditions. The mean effect size value at posttreatment for evidence-based versus usual care conditions was .30, indicating a small to medium effect size. The average youth treated with an evidence-based treatment was better off after treatment than 62% of those treated with a usual care treatment. These meta-analytic findings regarding the protocol-outcome relation have considerable clinical implications, suggesting that there is substantial room for improvement in everyday clinical care.

The Present Study

It is evident from the adult treatment literature that the therapeutic alliance bears a small but consistent relation to treatment outcome. Although the youth treatment literature is not as well developed, thus far the same relation appears to hold true for youth. Up until this point, however, the youth-therapist alliance typically has been examined in isolation from the evidence-based treatment literature. If treatment protocol is examined at all in a youth psychotherapy study, it is typically only as a possible moderator of the alliance-outcome relation. Even the most recent and methodologically sound studies on the subject (i.e., Hawley & Weisz, 2005; McLeod & Weisz, 2005) were conducted in usual care settings only. As such, the next logical step for the alliance-
outcome literature, as well as the EST literature, may be to examine the impact of both the youth-therapist alliance and treatment protocol (i.e., evidence-based versus usual care) on outcome in the context of the same study.

Given that the bulk of the available evidence suggests that treatment protocol accounts for more variance in youth treatment outcome than the therapeutic alliance (i.e., effect sizes of .30 to .80 for protocol as opposed to .22 to .26 for alliance), protocol was considered the primary predictor of outcome, before alliance, in the current study. It is important to note, however, that although treatment protocol and therapeutic alliance have both been examined in relation to treatment outcome, only the former typically is experimentally manipulated to determine differential effects on treatment outcome. To date there are no known studies that do, in fact, purposely manipulate therapeutic alliance to determine its effect on treatment outcome. The rationale may be related, perceptibly, to treatment acceptability. This is to say that it is unlikely that most parents would volunteer their child to be randomized to an unfriendly therapist who intends to forge a poor alliance with their child. One might further imagine that this would be unacceptable to adult clients as well.

The lack of experimental manipulation of alliance is a potential limitation of the current study and of the alliance literature more generally. It could, for instance, place a restriction on the range of the independent variable, and thus on its ability to predict the dependent variable, treatment outcome. Furthermore, causal inferences cannot be made with respect to a variable that is not experimentally manipulated. Viewed differently, though, the likely unacceptability of randomization to unfriendly therapists conveys an important point. This is to say that the layperson is likely to assume that a friendly, warm,
alliance-building therapist is more likely to get positive treatment outcomes than an unfriendly therapist. The gap between what the average parent might believe and what scientists have evidence for may be a marker for an area in need of more research. For this reason, the current study is an important next step toward bridging that gap in spite of, and with full recognition of, its methodological limitations.

The current study was conducted in a sample of youth with internalizing problems as their principal problem area. Youth with principal externalizing behavior problems were not included in the current study. This is not to say that alliance may not bear a significant relation to outcome in the treatment of externalizing behavior problems (indeed, evidence to the contrary was presented previously); rather, it reflects a methodological problem. In evidence-based treatment for disruptive behavior problems in youth, it is typically the parents, not the youth, who meet regularly with the therapist. Clearly, one would not expect youth-therapist alliance to play a strong role in outcome when the youth barely, if ever, meets with the therapist, although parent-therapist alliance certainly may play an important role. In contrast, in usual care treatment for disruptive behavior problems in youth, it is typically the youth, not the parents, who meet regularly with the therapist. It is evident that youth-therapist alliance and parent-therapist alliance reflect two different relationships, and thus should not be considered equivalent to one another. Suffice to say, parent-therapist alliance is a different construct, and should be examined in its own right, but so stands the rationale for restricting the current study’s sample to youth with internalizing behavior problems as their principal problem area.

The primary purpose of the current study is to determine whether the strength of the therapeutic alliance predicts variance in outcome over and above that predicted by
treatment protocol (i.e., evidence-based versus usual care conditions) and initial symptom severity among youth with internalizing behavior problems and disorders.

Methods

Participants

Participants included 75 youth, ages 7 to 13, referred for outpatient mental health services and enrolled in the Child System and Treatment Enhancement Projects (STEPS) Clinic Treatment Project (CTP), a randomized controlled trial conducted at two sites, Honolulu, Hawaii and Boston, Massachusetts, between 2005 and 2008. The present study constituted just one small part of the trial. The overarching purpose of the CTP was to determine what clinical practices work best and are most sustainable in community agency settings. In order to be included in the sample, youth had to meet two gated sets of criteria, one for the larger clinical trial under which the current study was conducted, and one for the current study, as detailed below.

Larger trial sample. Youth first were required to have met intake criteria for, enrolled in, and completed the Child STEPs CTP between January 1, 2005 and July 1, 2008. The CTP was conducted at seven community clinics in the greater metropolitan areas of Honolulu, Hawaii and Boston, Massachusetts. Inclusion criteria for Child STEPs required that the youth, parent or guardian, and/or the intake interviewer report that the youth had emotional or behavioral problems in at least one of the following three areas at intake: (1) anxiety, (2) depression, and/or (3) disruptive behavior problems. No diagnosis was required for inclusion, although inclusion criteria necessitated at least one identified problem area, validated by clinical or borderline clinical scores on corresponding problem scales of youth- or parent-report measures. Specifically, youth were only eligible
for the CTP if they received an intake T-score of 60 or greater on at least one scale from the following measures: the Child Behavior Checklist (CBCL; Achenbach, 2001), Youth Self-Report (YSR; Achenbach, 1995), and/or the Revised Child Anxiety and Depression Scales (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000).

**Current study sample.** Youth in the Child STEPs CTP had to meet several additional criteria for inclusion in the current study. Specifically, youth must have had an identified principal internalizing behavior problem at intake and must have completed the Child-Therapist Alliance (CTA; Chorpita & Weisz, 2005) questionnaire at discharge to be included in the study. For reasons noted previously, youth with principal disruptive behavior problems were excluded from the current study. Additional exclusion criteria included autism-spectrum disorders, thought disorders, mental retardation, imminent risk of suicidality such that crisis intervention was warranted at intake, and principal problem area or diagnosis of attentional difficulties or hyperactivity/impulsivity.

**Demographic information.** The sample consisted of 49 males (65.3%) and 26 females (34.7%). Participants were between the ages of 7 and 13, with mean age 10.7 years ($SD=1.7$). Parental marital status was as follows: married, 40.0%; divorced, 20.0%; never married, 16.0%; separated, 9.3%; widowed, 6.7%; and living with partner, 5.3%. Marital status of parents was not reported for 2.7% of cases. Median household income was $20,000 to $39,000. Income data was not reported for 5.3% of cases. Ethnic composition of the sample, as reported by parents or guardians, was as follows: Caucasian ($n=39; 52.0$%), Multiethnic ($n=25; 33.3$%), African American ($n=6; 8.0$%), Latin American/Hispanic ($n=3; 4.0$%), Asian American ($n=1; 1.3$%), and Pacific Islander ($n=1; 1.3$%). Fifty-six percent ($n=42$) of participants received services at the Boston site,
and 44% \((n=33)\) of participants received services at the Honolulu site. The primary problem area for each participant was identified at intake, falling broadly into the categories of anxiety \((n=45; 60.0\%)\) and depression \((n=30; 40\%)\).

**Measures**

*Child-Therapist Alliance (CTA; Chorpita & Weisz, 2005).* The CTA (see Appendix A) is a 9-item youth self-report measure of therapeutic alliance, developed by adapting the 7-item Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992) for use in Child STEPs. The TASC has demonstrated favorable psychometric properties in clinically referred youth, including good internal consistency \((\alpha = .72 - .93)\) and good test-retest reliability \((r = .65 - .79)\); (DeVet, Kim, & Charlot-Swilley, 2003; Hawley & Weisz, 2005; Shirk & Saiz, 1992). The TASC has further demonstrated moderate to strong correlations with parent-reported youth-therapist alliance (DeVet et al., 2003), therapist-reported youth-therapist alliance (Shirk & Saiz, 1992), and independent observer coding of youth-therapist alliance (McLeod & Weisz, 2005).

The TASC was modified in three ways to create the CTA. First, the wording of the four anchor phrases was modified to be comprehensible to youth as young as eight years old. Specifically, the anchors for the TASC prior to modification were as follows: 1 = not like you, 2 = a little like you, 3 = mostly like you, 4 = very much like you. The anchors were modified for the CTA to the following: 1 = very true, 2 = mostly true, 3 = mostly false, and 4 = very false. Second, item prompts were modified from the present tense to the past tense, given that the CTA was only administered following discharge from treatment. The third and final modification consisted of adding 2 items to the 7-item TASC to create the 9-item CTA. The two items were added because the 7-item TASC, as
originally written, captured only the “bond” dimension of the therapeutic alliance. Items 8 and 9 were added to tap the “task” dimension, which has become an accepted dimension of therapeutic alliance in the years since the TASC was first developed (McLeod & Weisz, 2005). CTA items 8 and 9 read as follows: “My therapist and I agreed on what we should work on (and talk about) in therapy,” and “My therapist listened to me in deciding what to talk about in therapy.”

In scoring the CTA, greater scores indicate a more negative youth-therapist alliance for 6 of the 9 items. For items 2, 5, and 7, however, greater scores indicate a more positive youth-therapist alliance. As such, these items must be reverse-scored by subtracting the numerical responses from 4. After items 2, 5, and 7 have been reverse-scored, the three adjusted item scores and the remaining six item scores are summed to yield a total score. Total scores on the CTA can range from 9 to 36, with lower scores indicating a more positive youth perspective on the therapeutic alliance. Given that the CTA was developed from the TASC specifically for the purposes of Child STEPs, information with regard to the psychometrics of the CTA is unavailable. In order to determine the reliability of the CTA, its internal consistency evaluated as part of the current study (see Data Collection section below).

*Therapy Process Observational Coding System—Alliance Scale (TPOCS-A; McLeod, 2001).* The TPOCS-A is a 9-item measure of therapeutic alliance designed to be completed by independent observers on the basis of session observation. The measure is available in identical youth and parent forms, the choice of which is based on identification of the primary client participant in the treatment session, or the specific alliance the observer is evaluating (i.e., youth-therapist alliance or parent-therapist
alliance). For the purposes of the current study, since youth-therapist alliance was the construct of interest, only the youth form of the TPOCS-A was used (see Appendix B). The TPOCS-A consists of two subscales based on the two principal dimensions of therapeutic alliance, “Bond” and “Task,” consisting of 6 and 3 items, respectively. An example “Bond” item is “To what extent did the client demonstrate positive affect toward the therapist?” A sample “Task” item is “To what extent did the therapist and client work together equally on therapeutic tasks?”

Items are scored on a 6-point Likert-type scale from 0 = not at all to 5 = great deal. Three of the Bond items and 1 of the Task items were stated such that a higher score indicated a poorer alliance rating (e.g., “To what extent did the client act in a hostile, critical, or defensive manner toward the therapist?”). As such, prior to calculating the TPOCS-A total score, these 4 items are reverse-scored. The 5 standard score items and the 4 reverse-scored items are then summed to create the TPOCS-A total score.

McLeod & Weisz (2005) examined the psychometric properties of the TPOCS-A in some detail, and found them to be generally favorable. Interrater reliability based on the full tapes was acceptable (i.e., intraclass correlations of at least .40) for all of the items on the child form. Internal consistency for the measure was high for the child form (alpha = .95). Its convergent validity with another measure of the same construct, the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992), as measured by correlation between measures, was moderate for child-therapist alliance and the child form , $r = .53$ (n=21, p < .02). With respect to predictive validity, McLeod and Weisz examined the role of the child-therapist alliance during treatment as measured by the TPOCS-A and found it was not predictive of improved scores on Child Behavior
Checklist Internalizing Scale scores or Children’s Depression Inventory Scale scores, but it was predictive of improved scores on the State-Trait Anxiety Inventory for Children. Generally speaking, McLeod and Weisz suggested that the psychometrics of the TPOCS-A and its initial findings with regard to the alliance-outcome relation made it a measure worthy of further use and investigation.

*Child Behavior Checklist for Ages 6-18 (CBCL/6-18; Achenbach, 2001).* The CBCL/6-18, hereafter referred to as the CBCL, is a 140-item parent-report questionnaire for parents and caregivers of youth aged 6 to 18 (see Appendix C for a sample). It is appropriate for use at a fifth grade reading level and above. The CBCL scoring profile, which is normed on a non-clinical sample of 1,753 youth, provides raw scores, T-scores, and percentiles for the following scales: three competence scales, Total Competence, eight syndrome scales, six DSM-oriented Scales, Internalizing Problems, Externalizing Problems, and Total Problems. The CBCL has good internal consistency (α = .78-.97), test-retest reliability (r = .95-.1.00), and interrater reliability (κ = .93-.96; Achenbach & Rescorla, 2001).

The CBCL is composed of two major sections, a 20-item section that assesses youth competencies and a 120-item section that assesses for youth emotional and behavioral problems. For the purposes of the present study, only the 120-item problem section of the CBCL was administered. The problem section consists of 118 brief descriptions of specific emotional and behavioral problems, plus 2 open-ended items for reporting additional problems. The parent or caregiver is instructed to indicate how true each item is on the following scale: 0 = not true (as far as you know), 1 = somewhat or sometimes true, 2 = very true or often true. The problem section of the CBCL takes
approximately ten minutes to complete. In the current study, given the focus on youth with internalizing difficulties and disorders, the Internalizing Problems scale score was used as the primary indicator of symptom improvement and, hence, of treatment outcome.

The CBCL was selected from among several outcome measures for use in the current study. It was selected in part because of its strong psychometric support and wide usage around the world. Specifically, the CBCL Internalizing Problems Scale score has demonstrated 8-day test-retest reliability of 0.91 in a sample of 73 school-aged children. Meanwhile, cross-informant agreement among parents for the Internalizing Problems Scale Score among a sample of 297 school-aged children was $r = 0.72$. (Achenbach & Rescorla, 2001). With respect to validity, the CBCL Internalizing Problems Scale Score shows correlations of 0.83, 0.80, and 0.75 with the Internalizing scales of the Mother, Father, and Teacher portions of the Behavior Assessment System for Children (BASC; Reynolds & Kamphaus, 1992). In a sample of 65 children, Achenbach & Rescorla (2001) found a correlation of 0.59 between the Internalizing Problems scale and depressive disorder diagnoses. Furthermore, the sensitivity to change of the CBCL makes it a preferable measure to DSM-IV-TR diagnoses, which may not reflect small but significant changes in symptomatology. Additionally, the CBCL is empirically supported for use across the full age range of the current study, which is 8 to 13, unlike the Youth Self-Report (Achenbach, 1995), which is normed on youth aged 11 and older only. Additionally, the confound of common method variance resulting from the use of youth self-report measures for both therapeutic alliance and outcome was eliminated with the use of the CBCL, which is, of course, filled out by parents or guardians.
**Procedure**

Youth receiving services via the Child STEPs Clinic Treatment Project were assigned to one of three treatment conditions: (1) Standard condition, or evidence-based services that employed three standard manualized treatment protocols; (2) Modular condition, which included the same evidence-based practices as the manuals in the Standard condition but allowed flexibility in their selection and application per a general guiding algorithm; and (3) Usual Care condition, or treatment services as typically employed in the community agencies participating in the project. Youth were nested within therapists, within treatment locations, and within treatment conditions. Subsequent testing, conducted elsewhere, suggested that this nesting did not impact results (Weisz et al., in press).

(1) Standard. Youth randomized to this condition receive treatment from one or more evidence-based treatment manuals, depending on their primary problem area. Youth with principal anxiety difficulties and disorders receive treatment from a standard treatment manual, the *Coping Cat* (Kendall, 1994; Kendall et al., 1997). Youth with principal depressive difficulties and disorders receive treatment from a standard treatment manual, *PASCET: Primary and Secondary Control Enhancement Training* (Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003; Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997). Under the standard manualized protocol condition, if youth have problems in more than one area, they are treated initially with the manual best-suited to their principal problem area. If, when the therapist has administered this manual in its entirety, the youth continues to experience problems in other problem areas, their therapist administers another treatment manual in its entirety. As is the case with most
treatment efficacy trials, therapists in the standard manualized treatment condition are not

to switch to another manual mid-treatment.

(2) Modular. Youth randomized to this condition received treatment from a

modular treatment manual, MATCH-ADC: A Modular Approach to Treatment for

Children with Anxiety, Depression, or Conduct Problems (Chorpita & Weisz, 2005). The

MATCH Manual was designed to organize the procedures of standard manualized

protocols (e.g., PASCET) in a manner that allows for guided adaptation and

individualization to the client and offers considerable flexibility to the therapist. In the

MATCH manual, comorbidity can be addressed not through sequential full treatment

episodes each targeting a different problem area, but also by administering selected

procedures targeting specific sources of comorbid interference (e.g., handling sporadic

disruptive behavior in the course of using CBT to treat a primary focus of depression).

Therapist decision-making with regard to session content is guided by a coordination

model that specifies a default order of treatment modules similar to that of the standard

treatment manuals used in the Standard condition. Among the principal differences are

that treatment interference by other problem areas could be addressed immediately, not

only at the conclusion of a full treatment manual, that modules could be repeated until

mastery was achieved, modules could be omitted entirely if not appropriate to the child’s

focus of concern, and modules could be re-ordered, such that procedures typically

encountered late in the protocol could be positioned earlier that they could be of possible

benefit sooner in the episode of care.

(3) Usual Care. Youth randomized to this condition receive treatment according

to the typical practices utilized by therapists in the specific clinic to which they are
assigned. By the nature of the treatment condition, treatment in the usual care condition varies from clinic to clinic. Efforts to understand and characterize usual care treatment practices in the seven clinics in Child STEPs are underway, but results are not yet available. Previous research has characterized usual care treatment practices in other locations (e.g., Garland, Hurlburt, & Hawley, 2006).

Data Collection

Data for the present study were collected at three specific points in the course of the Child STEPs project. The first set of data was collected at intake, when both youth and parent participated in a diagnostic interview with an independent assessor (i.e., not the treating therapist) and completed various self-report measures, including the CBCL.

The second set of data was collected by coding session audiotapes of the third treatment session with the TPOCS-A for one third of the full sample (n = 25), selected at random. Given that the present study was not a psychometric evaluation of the TPOCS-A, the full sample was not subjected to this testing. Prior to coding these sessions, independent raters were trained to acceptable reliability in coding the TPOCS-A. The lead investigator and a doctoral-level psychologist served as the raters. The training process and standards for reliability were based on those identified in McLeod and Weisz’s (2005) psychometric study of the TPOCS-A, although they were somewhat less stringent since the current study is not a psychometric test of the TPOCS-A. Training consisted of reading the scoring manual, viewing specific sessions, and practicing scoring sessions. The predetermined requirement for interrater reliability for the current study was an intraclass correlation coefficient of greater than 0.60 for two consecutive sessions. Intraclass correlations for the first two sessions coded by both raters were both above
0.60, at 0.74 and 0.81, respectively, for an average of 0.77. Although technically the requirement for interrater reliability was met in the first two sessions coded by both raters, a third session was double-coded, yielding an intraclass correlation coefficient of 0.88. The average intraclass correlation coefficient for the double-coded sessions was 0.81. Once interrater reliability was achieved, 22 additional cases were randomly selected for coding with the TPOCS-A. In study analyses, results from 3 double-coded sessions were included given that they all yielded intraclass correlation coefficients above 0.60, and were represented with rounded mean scores on each TPOCS-A item to reduce measurement error. One third of the full sample was assessed for early alliance using the TPOCS-A \( (n = 25) \). Internal consistency was acceptable for the 25 cases (\( \alpha = .81 \)).

The third set of data was collected at the post-treatment assessment date, after the last treatment session has been completed. The youth and parent participated in another diagnostic interview with an independent assessor. They also completed various self-report measures, again including the CBCL, with the addition of the CTA.

**Results**

The means and standard deviations for the CTA, TPOCS-A, and CBCL Internalizing scale scores are displayed in the Table at the end of the paper.

*Basic Psychometric Properties of the CTA*

Given that the CTA represents a modified, previously untested version of a tested measure, basic analyses of the reliability and validity of the CTA were conducted prior to the primary analysis of interest in the current study. Since the CBCL is a measure that is widely recognized for its favorable psychometric properties, it was not subjected to such analyses.
Internal consistency analysis. In order to evaluate the internal consistency of the CTA, Cronbach’s alpha was calculated for the nine items. Given previous findings on the internal consistency of the TASC, from which the CTA was adapted, it was expected that the CTA would be found to have acceptable to good internal consistency in this sample (DeVet et al., 2003; Hawley & Weisz, 2005; Shirk & Saiz, 1992). Cronbach’s coefficient alpha was 0.86 for the 9 items, suggesting that, as expected, the CTA has acceptable to good internal consistency in this sample. Item-total correlations were examined to evaluate the quality of individual items, and all correlations were greater than 0.30.

Convergent validity analysis. The convergent validity of the CTA was assessed by determining its relation to the TPOCS-A in one third of the sample for the current study, approximately 25 randomly selected cases. After achieving acceptable interrater reliability (see the “Procedure” section for further detail), independent raters used the TPOCS-A to code audiotapes of the third treatment session for each youth in the subsample. Subsequently, the correlation between CTA scores and TPOCS-A scores was determined for the 25 cases. Given the result of the single previous examination of the relation between the TASC and the TPOCS-A, it was expected that there would be a moderate correlation between the CTA and the TPOCS-A (McLeod & Weisz, 2005). Contrary to expectations, the correlation between the CTA and the TPOCS-A child form was -.28 (n = 25; p = .18), indicating a weak convergence between the two measures of alliance. It should be noted that lower scores on the CTA and higher scores on the TPOCS-A both indicate stronger youth-therapist alliance, so a negative correlation was expected.

Hierarchical Regression Analysis Predicting CBCL Internalizing Problems Scale Scores
A hierarchical regression analysis was conducted to determine whether the strength of the youth-therapist alliance would account for unique variance in treatment outcome for youth with internalizing disorders, over and above that accounted for by initial severity and type of treatment protocol. The youth-therapist alliance was represented by CTA score at discharge. Initial severity of internalizing problems was represented by CBCL Internalizing Problems scale score at intake. Treatment outcome, as indicated by symptom reduction in internalizing problems, was represented by CBCL Internalizing Problems scale score at discharge.

The hierarchical regression analysis included four steps. Step 1 consisted of a multiple regression analysis conducted to predict CBCL Internalizing Problems scale score at discharge from CBCL Internalizing Problems scale score at intake. Step 2 was designed to determine whether dummy-coded treatment protocol (i.e., evidence-based [SMT or MMT] = 0, usual care = 1) would account for additional variance in CBCL Internalizing Problems scale score at discharge, over and above that accounted for by initial severity. Step 3 was designed to determine whether youth-therapist alliance, as represented by the CTA, would account for unique variance in CBCL Internalizing Problems scale score at discharge, over and above that accounted for by initial severity and treatment protocol. Step 4 tested for an interaction between treatment protocol and youth-therapist alliance, in order to determine whether there was an incremental effect of alliance in one treatment protocol group (i.e., evidence-based or usual care) over and above the other treatment protocol. A significant regression weight for the predictor product term (protocol by alliance) in this final step would indicate an interaction of treatment and alliance.
It was expected that initial severity of internalizing problems would significantly predict variance in post treatment scores. It was further expected that type of treatment protocol (i.e., evidence-based vs. usual care) would account for variance in discharge scores, over and above that accounted for by initial severity (Weisz, Jensen-Doss, & Hawley, 2006) as evidenced by a significant increase in the $R^2$ value. Furthermore, it was expected that youth-therapist alliance would account for unique variance in discharge scores, over and above that accounted for by type of treatment protocol and initial severity. It was expected that the unique variance predicted by youth-therapist alliance would produce a small but statistically significant change in $R^2$, in line with previous studies that did not control for treatment protocol (e.g., Hawley & Weisz, 2005; McLeod & Weisz, 2005; Shirk & Karver, 2003). No *a priori* hypothesis was asserted with regard to whether there would be an incremental effect of youth-therapist alliance in one treatment protocol group more than the other, given the dearth of literature on the subject.

A multiple regression analysis was conducted to predict treatment outcome from initial severity. The results of this analysis indicated that initial severity accounted for a significant amount of variability in treatment outcome, $R^2 = .12, F(1, 73) = 9.86, p < .01$. A second multiple regression analysis was conducted to evaluate whether treatment protocol predicted outcome over and above initial severity. Treatment condition did not account for a significant proportion of treatment outcome after controlling for initial severity, $R^2$ change = .01, $F(1, 72) = .66, p = .42$. A third regression analysis was conducted to evaluate whether child-therapist alliance predicted treatment outcome, over and above initial severity and treatment protocol. Child-therapist alliance did not account for a significant proportion of treatment outcome after controlling for initial severity and
treatment protocol, $R^2$ change = .00, $F(1, 71) = .00$, $p = .97$. See also Table 2 for the results of the regression analysis. These results suggest that initial severity was the only significant predictor of treatment outcome. They further suggest that treatment protocol and child-therapist alliance appear to offer little or no additional predictive power beyond that contributed by initial severity. The interaction term was not computed due to the fact that the previous terms were not significant.

Discussion

The primary aim of the current study was to examine whether and to what extent the youth-therapist alliance would predict variance in treatment outcome over and above that accounted for by initial severity and treatment protocol (evidence-based versus usual care) in a sample of youth with internalizing behavior problems. The results indicated that whereas initial severity was predictive of outcome, treatment protocol was not, nor was therapeutic alliance. The association between initial severity and outcome was consistent with investigator expectation. The results with respect to treatment protocol and outcome, and therapeutic alliance and outcome, respectively, were inconsistent with expectations.

Evidence-based and usual care treatment protocols performed similarly with respect to outcome in this sample of youth with internalizing disorders. This finding was surprising given the vast literature on the efficacy and effectiveness of manualized treatment protocols for internalizing disorders as compared to usual clinical care. It was consistent, however, with the larger results of the Child STEPs clinical trial, which reportedly indicated no particular advantage of any condition from pre to post on the CBCL, apart from number of diagnoses, which was not tested in the current examination.
(B. F. Chorpita, personal communication, August 1, 2011). This is not to characterize the whole trial. Further exploration reportedly suggested that rate of change, especially earlier in therapy (at three and six month evaluations) in the evidence-based conditions, especially the Modular condition, was significantly steeper, such that youth in these conditions got better faster, and often were not even receiving therapy any longer by post-test (Weisz et al., in press).

More important to the current study, however, was the lack of a significant relation between youth-therapist alliance and outcome, over and above initial severity and treatment protocol, contrary to expectation. In fact, when the primary examiner factored out treatment protocol experimentally and calculated a simple regression to calculate the effect of alliance on outcome alone, over and above severity, the results were not significant. This was certainly not expected, given the previous studies showing an effect of alliance on outcome, independent of treatment protocol. A close reexamination of previous literature on the subject, however, suggests that this conclusion is not without precedent. Much of the literature on the subject has found a significant relation between alliance and outcome for youth psychotherapy in samples including youth with internalizing disorders (Hawley & Weisz, 2005; McLeod and Weisz, 2005; Shirk & Karver, 1993). Some studies identified alliance-outcome associations on some measures, but not others (Hawley & Weisz, 2005; McLeod and Weisz, 2005). Still others have found no significant relation between child-therapist alliance and outcome (Kendall, 1994; Kendall et al., 1997). The fact is, although research has clearly demonstrated an alliance-outcome relation in adult therapy, the evidence with respect to such a relation in youth therapy is mixed, especially with regard to internalizing disorders.
As such, the investigator must ask whether the alliance results in the current study, particularly the lack of a relation between alliance and outcome, over and above treatment protocol and initial severity, were the result of a methodological problem or a conceptual one.

**Methodological Issues**

Dependability of alliance assessment may have been an issue. According to Crits-Christoph and colleagues (2011), adequate measurement of the alliance-outcome correlation requires assessing at least 4 treatment sessions. According to these standards, the CTA was administered insufficiently to yield a dependent alliance score, and thus, a dependent alliance-outcome measurement. In other concerns, the CTA represented a significantly modified version of the TASC, an empirically supported measure of alliance. Adaptations to the TASC included revising the wording to be comprehensible to children as young as seven, modifying the anchors (from "not like you" to "very much like you", to "very true" to "very false), and adding items to reflect the Task dimension of alliance and not just the Bond dimension.

Of note, and contrary to expectations, the CTA did not demonstrate a strong correlation with the TPOCS-A in the one-third of the current sample with which the TPOCS-A was coded. This finding is not consistent with a similar analysis of the TASC and the TPOCS-A (McLeod & Weisz, 2005), the results of which indicated a moderate to strong correlation between the measures. The TPOCS-A was not modified at all from previous studies demonstrating significant empirical support for its validity as a measure of therapeutic alliance. One might note, however, that previous studies of the convergent validity of the TASC and the TPOCS-A included TPOCS-A ratings from throughout the
treatment process, and not just of early sessions, increasing the chances of convergence. Nevertheless, it is certainly possible that adaptations to the TASC in the creating the CTA may have reduced the validity of the measure. Furthermore, the TPOCS-A may have been a better choice as the primary measure of alliance, given its capacity to assess early alliance and rule out a relation to outcome that could be associated solely with symptom improvement by the end of treatment. The TPOCS-A was not selected as the primary measure of alliance in the current study, however, in part because of concern on the part of the primary investigator that the youth-therapist bond aspect of the alliance may not best be assessed by an outside observer as opposed to a member of that relationship. One could easily imagine that the TPOCS-S, a scale that has since been introduced to observe and measure therapeutic techniques utilized in therapy sessions, is highly appropriate as an observer-operated measure (McLeod & Weisz, 2010), but perhaps less so as a primary measure of a construct such as the alliance, of which a primary factor is the bond between two independent parties.

Another possible methodological issue with respect to the current study was the fact that treatment outcome was only represented by scale scores on a single measure, the CBCL Internalizing scale, albeit a measure with extensive empirical support as a measure of internalizing symptomatology. Upon closer examination, several previous investigations that found significant relations between alliance and outcome did not find such results with the CBCL Internalizing scale itself. Specifically, McLeod and Weisz (2005) did not find a significant relation between alliance, measured by the TPOCS-A, and change in CBCL Internalizing scale scores from pretreatment to post-treatment, although they found significant alliance-outcome relations on other measures of
internalizing symptomatology. Chiu et al. (2008) found that early alliance on the TPOCS-A was significantly related to CBCL Internalizing scale scores at mid-treatment only, with no significant relation at post-treatment. Hawley and Garland (2008) found that alliance among adolescents was associated with only marginally significant decreases on the CBCL. It is possible that another measure of youth internalizing symptoms, for instance, the RCADS or the RCADS-P, might better elucidate associations of interest with respect to alliance.

Additional methodological concerns are worthy of note. Even if alliance had been predictive of outcome, the measurement of alliance at post-treatment would not rule out the possibility that alliance scores reflect rather than contribute to change from pre-treatment to post-treatment. Furthermore, alliance was not experimentally manipulated in the current study, whereas treatment protocol was, restricting any conclusions that could be made with respect to alliance and outcome.

Previous studies on the alliance-outcome relation in internalizing disorders (Kendall, 1994; Kendall et al., 1997) have noted alliance scores that were generally high, but showed relatively little variability, as was the case in the current study. As Kendall and colleagues have noted, this suggests a strong child-therapist alliance across participants, but likely restricts predictive relationships with respect to outcome. Significantly, the major previous studies upon which the current study was modeled were composed of samples of youth with both internalizing and externalizing and internalizing disorders (Hawley & Weisz, 2005; McLeod & Weisz, 2005), whereas the current study was confined to the latter. As noted previously, this decision was taken in part to expand the relatively small literature on the alliance-outcome relation on internalizing youth, and
because evidence-based sessions for disruptive youth are largely conducted with parents and guardians rather than the child him or herself. Regardless of the rationale for exclusion, the only meta-analysis on the subject of alliance and outcome in youth has shown that externalizing disorders showed a stronger association with outcome than internalizing problems (mean = .30 vs. 10; Shirk & Karver, 2003). Several investigators posit that stronger child-therapist relationships are necessary to yield change in treatment for disruptive behavior disorders, that alliance ruptures are more common, and that there is greater variance in alliance scores among this group (Green, 2006; Kazdin et al., 2005; Kazdin et al., 2006; Shirk & Karver, 2003; Zack et al., 2008).

Of further note, in selecting a sample for the current study, it may have been wiser to restrict the sample to either youth with anxiety concerns or those with depressive problems, rather than collapsing across internalizing disorders. As a rule, previous investigations of the alliance-outcome relation have collapsed across externalizing disorders, whereas the limited number of studies of youth with internalizing disorders have not. The current study was innovative in doing so, but perhaps the precedent was established with good reason. It is possible that the alliance operates differently with anxiety as opposed to depression, and may be differentially related to outcome. Future studies with adequate sample size might differentiate between anxious and depressed youth, and youth who are both anxious and depressed, to investigate any differences in the alliance-outcome relation. This is especially true given the possible role of social desirability in the administration of the CTA. It is well-documented that youth with anxiety disorders report differently on several types of questionnaires based on the social desirability of their responses (e.g., Dadds et al., 1998), whereas this has not been
similarly demonstrated in youth with depressive disorders. The role of client characteristics in contributing to both alliance and outcome may also be noteworthy, especially the role of ethnicity, which is not well understood in its relation to alliance.

*Conceptual and Theoretical Issues*

With respect to the theoretical, one purpose of the current examination was to help lend clarity to this discussion of alliance and outcome among youth with internalizing behavior problems. Its null findings, taken in the context of similar studies, suggest that the matter is unresolved and thus discussion should be ongoing. Barber, Khalsa, and Sharpless (2010) examine the numerous possible roles of the alliance in relation to psychotherapy outcome—as a predictor, a moderator, a mediator, and as an outcome in itself. They conclude that alliance’s role might best be conceptualized as that of a general predictor and a potential mediator of outcome, but that to be examined appropriately, it must be measured at numerous intervals and prior to outcome. It should be noted that their paper was not focused on any specific population or problem area, but appeared generally to be applied to adult clientele. Nevertheless, the major points appear relevant regardless of age.

Chu and colleagues suggests that alliance may bear a critical role in treatment involvement and engagement, which in turn, appear associated with outcome at midtreatment (Chu et al., 2004; Chu & Kendall, 2004). Karver et al. (2008) posited a mediational model in which therapeutic engagement strategies predict therapeutic alliance, viewed as essential to the development of treatment involvement, which, in turn, predicts outcome. This model assumes that most of the association between alliance and outcome is accounted for by treatment involvement (Karver et al., 2008). Alternately, the
role of the therapeutic alliance may not be directly associated with outcome, but key to preventing attrition. In a factor analysis of reasons for ending youth health care treatment, therapeutic relationship problems accounted for the most variance, and was the only factor that distinguished therapy completers from noncompleters (Garcia and Weisz, 2002). Such evidence might suggest that alliance may not be directly associated with outcome, but may play an important role in treatment involvement, engagement, and retention, and thus bear an indirect association with outcome nonetheless.

Hatcher and Barends suggest that examining alliance separately and on the same level as technique “confuses two levels of thinking” (p. 292, 2006). They suggest that alliance is a superordinate concept to therapy, “actualized in therapeutic techniques, client participation, and the dyad’s relational features” (p.292). Hatcher and Barends argue that the alliance, which they define as the degree to which the dyad is engaged in collaborative, purposive work, is established differently dependent upon therapeutic therapeutic technique. Their doctoral student, Minonne, took these theories to his doctoral dissertation, based on an NIMH study among adults with depressive disorders. Minonne (2008) examined the interactions between alliance, adherence, and outcome across CBT, IPT, a medication condition, and a placebo condition. The results were interesting, suggesting that the flexible application of treatment manuals in some conditions (i.e., CBT), but the more standard application in other conditions (i.e., IPT) appeared to enhance alliance and, in turn, outcome. In this manner, he argued, alliance and outcome were linked, but differentially depending upon treatment technique. Interestingly, the argument by Hatcher and Barends would suggest disapproval of the current study on the grounds that it put alliance and technique on the same level. Their own argument,
however, and that put forward by Minonne would suggest curiosity, and eventually, 
disappointment, at the outcome of the interaction term in the current study, in which the 
investigator was attempting to examine alliance in standard vs. modular vs. usual care 
approaches.

Strengths and Limitations

With respect to strengths, the current study represents the first effort to examine 
the effects of the youth-therapist alliance on outcome over and above randomly assigned 
treatment protocol. It is also the first such examination conducted across both evidence-
based and usual care conditions, as previous studies of alliance have examined the 
alliance-outcome relation exclusively in usual care settings (Hawley & Weisz, 2005; 
McLeod & Weisz, 2005) or CBT/manual-based settings (Chiu et al., 2009; Liber et al., 
2010). The present study also took a multi-informant, multi-method approach to 
assessment, incorporating youth, parent, and observer perspectives across various 
response formats, including both global and more specific questionnaires and session-
based observations, and reducing common method variance and the likelihood of Type 1 
error. The current study was also innovative in the composition of its sample, with nearly 
one half of the participants representing minority groups, one third of whom self-
identified as multiethnic. With respect to the larger study in which the current study took 
place, it should be noted that across groups, youth got better on the outcome measure of 
note, the CBCL Internalizing Scale, and that in the current study, CTA scores suggested 
that alliance was uniformly high across the youth-therapist dyads in these groups. 
Whereas these positive results made it difficult to examine the primary questions of
interest, they suggest change regardless of group which must be recognized in clinical research.

The major limitations of the current study have been discussed at some length but are nonetheless enumerated here. First and foremost, the timing of the alliance measure was unfortunate. By placing it at the end of treatment rather than toward the beginning, causality was unclear (e.g., high alliance could simply have been the result of a positive outcome), and alternative explanations were ruled out once the primary interpretation sought in the current study was no longer possible. The selection of the previously untested CTA as the alliance measure was likewise problematic. The decision to focus on youth with primary internalizing problems was defensible, but the tendency for alliance to be uniformly high among such youth might have been taken into consideration, and could represent a ceiling effect. For instance, it may have been preferable to obtain therapist and parent ratings as well to balance high child alliance ratings, or to focus on unusually low ratings or alliance ruptures in order to elucidate exceptions to the rule.

*The Current Study*

In the current study, child-therapist alliance did not predict variance in outcome over and above that predicted by initial severity and treatment protocol, and even treatment protocol did not predict variance over and above initial severity. The results of this examination pose questions with regard to evidence-based versus usual care treatments for youth, but more relevant to the current study, with respect to the association between alliance and outcome. Amid mixed findings of previous examinations of therapeutic alliance in youth with internalizing disorders, the results of
the current study indicate a need for further research to clarify the role of the child-therapist alliance with respect to treatment outcome.

**Future Studies**

Several considerations might maximize the utility of future research on this subject. First, repeated assessment of both alliance and outcome throughout the treatment process may most effectively assist in identifying alliance-outcome relations, especially the effects of early alliance, which may be most critical and evocative of change. Second, measurement of related constructs, including treatment involvement and engagement, might elucidate the relative importance of these constructs in relation to alliance and the role of possible mediators and moderators. Third, multiple methods and multiple informants should be utilized for each construct of interest, such that the eccentricities of a single measure do not confound the measurement of an important construct. Fourth, future research should establish temporal precedence of both alliance and related constructs with regard to outcome, such that any relation detected might allow for further examination as a mechanism of change. Fifth, future research might examine the ethnicity of therapists, clients, or the gender/ethnic match between therapists and clients to determine if this impacted alliance or outcome on any level. Finally, focusing on those cases in which alliance was low may be of assistance in controlling for the uniformity of the alliance-outcome relation Kendall noted in his work with internalizing youth (1994; 1997).

Scientific psychology's focus on the establishment of evidence-based treatments has advanced the field tremendously. The movement toward dissemination and implementation of these treatments is increasing that effect exponentially. Identifying the
relational techniques that best advance the treatment technology can only maximize these effects and the number of children and families who might benefit from them.
References


Alliance after Evidence 52


Revitalizing Treatment and Research. New York: Guilford.


### Table 1

**Means and Standard Deviations for Alliance and Outcome Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Time</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBCL Internalizing</td>
<td>Pre-treatment</td>
<td>68.68</td>
<td>8.55</td>
</tr>
<tr>
<td></td>
<td>Post-treatment</td>
<td>57.36</td>
<td>10.46</td>
</tr>
<tr>
<td>CTA</td>
<td>Post-treatment</td>
<td>1.72</td>
<td>0.58</td>
</tr>
<tr>
<td>TPOCS-A</td>
<td>3rd session</td>
<td>3.46</td>
<td>0.67</td>
</tr>
</tbody>
</table>

**Note.** CBCL = Child Behavior Checklist; CTA = Child-Therapist Alliance; TPOCS-A = Therapy Process Observational Coding System-Alliance Scale. For the purpose of comparison, the TPOCS-A at post-treatment in McLeod & Weisz (2005) was also not significant, and not even reported. The CTA, as a new measure, did not have psychometrics available for the purposes of comparison.
Table 2

*Summary of Hierarchical Regression Predicting Strength of the Youth-Therapist Alliance*

<table>
<thead>
<tr>
<th>Step</th>
<th>$\beta$</th>
<th>$R^2$</th>
<th>$R^2 \Delta$</th>
<th>$F \Delta$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.35</td>
<td>0.12</td>
<td>0.12</td>
<td>9.86</td>
<td>&lt; 0.00</td>
</tr>
<tr>
<td>2</td>
<td>0.35</td>
<td>0.13</td>
<td>0.01</td>
<td>0.66</td>
<td>0.42</td>
</tr>
<tr>
<td>3</td>
<td>0.35</td>
<td>0.13</td>
<td>0.00</td>
<td>0.00</td>
<td>0.97</td>
</tr>
<tr>
<td>4</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Note.* Step 1 is Initial Severity; Step 2 is Treatment Protocol; Step 3 is Therapeutic Alliance; and Step 4 is the Interaction of Protocol X Alliance. Step 4 was not computed due to the insignificant results of Steps 2 & 3.
Appendices
Appendix A: Child-Therapist Alliance
**Child-Therapist Alliance**

1. I looked forward to meeting with my therapist.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

2. When I was spending time with my therapist, I wanted the sessions to end quickly.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

3. I liked spending time with my therapist.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

4. I liked my therapist.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

5. I’d rather have done other things than meet with my therapist.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

6. I feel like my therapist was on my side and tried to help me.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

7. I wished my therapist would leave me alone.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

8. My therapist and I agreed on what we should work on (and talk about) in therapy.

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<thead>
<tr>
<th></th>
<th>2</th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>

9. My therapist listened to me in deciding what to talk about in therapy.

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very true</td>
<td>Mostly true</td>
<td>Mostly false</td>
</tr>
</tbody>
</table>
Appendix B: TPOCS-A Coding Manual
SCORING MANUAL

FOR THE

THERAPY PROCESS OBSERVATIONAL CODING SYSTEM FOR CHILD PSYCHOTHERAPY ALLIANCE SCALE

BRYCE D. McLEOD (2005)
# Table of Contents

<table>
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<th>Page</th>
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</thead>
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</tr>
<tr>
<td>II. General Instructions</td>
<td>4</td>
</tr>
<tr>
<td>A. Procedural Guidelines</td>
<td>4</td>
</tr>
<tr>
<td>B. Scoring Strategies</td>
<td>4</td>
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<tr>
<td>B. Coder Caveats</td>
<td>5</td>
</tr>
<tr>
<td>III. Alliance Subscale</td>
<td>6</td>
</tr>
<tr>
<td>Part I: Bond</td>
<td>7</td>
</tr>
<tr>
<td>Part II: Task</td>
<td>10</td>
</tr>
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</table>
I. INTRODUCTION

The scoring manual is designed to provide coders with a comprehensive guide for scoring tapes of psychotherapy sessions using the TPOCS Working Alliance Scale (TPOCS-A). The manual serves as a companion document for training new coders to use the TPOCS-A, as well as a reference document for trained coders to use while scoring sessions. As such, this manual contains a thorough description of each item and provides additional information to help the coder make scoring decisions in an informed and reliable manner.

This manual is organized in accordance with the presentation of rating items on the TPOCS-A. The General Instructions section provides an overview of scoring strategies and coder caveats to help coders acquire and maintain coding reliability. Then, the Working Alliance Subscale and TASC Subscale sections provide detailed item descriptions. These sections are presented in the following format:

(a) The item as it appears on the TPOCS-A.
(b) Brief description of the item.
(c) Supplemental coding information.
II. GENERAL INSTRUCTIONS

This section provides an overview of scoring guidelines intended to help coders score therapy sessions in an efficient, standardized, and reliable manner. Coders should read this section carefully. It is important to become thoroughly familiar with the coding guidelines before scoring therapy tapes.

A. PROCEDURAL GUIDELINES:

1. **Rate Client and Therapist Behavior**: Codes are required to rate the working alliance along two dimensions: (1) **Client behavior** (e.g., client actions and statements), and (2) **Client and therapist interactions**.

2. **Frequency and Intensity**: Most items require the coder to score the frequency and/or intensity of client behavior. **Frequency** is defined as the number of times the client engaged in a behavior. **Intensity** is the amount of effort or the force the client places in the behavior when it occurs. Each item description provides guidelines for weighing the relative importance of frequency and intensity. In order to determine how much weight to assign the two dimensions (i.e., frequency and intensity) for each item, coders will have to rely on their training, item descriptions, familiarity with the scale, and experience in coding tapes.

B. SCORING STRATEGIES:

1. **Scoring “Is” not “Ought”**: All scoring focuses upon client behavior. Thus, coders should only score what the client actually does in session, not what might have been done or should have been done. Thus, an item should only receive a positive score if that item is somehow represented in the client’s behavior (e.g., what the client does or says). Here is a brief summary of important guidelines for rating “is”, not “ought”:

   (a) Code only **client behavior**.

   (b) Rate only what a client **does**, not what you believe the client **should** have done, and not what you believe the client **intended** to do.

   (c) Never assume or guess what a client **might** be thinking. If there is no behavioral evidence, in the form of something the client says or does, then **do not give** the corresponding item a positive score.

2. **Jumping the Gun**: Since TPOCS-A items are scored on a global level, items are not scored until the entire session has been viewed. Client behavior that occurs later in the session may influence a coder’s estimation of behavior that takes place earlier. For example, a client who does not initially demonstrate positive affect towards the therapist may show more as the session progresses. However, re-estimation can work in reverse. A client who demonstrates positive affect early on may show less later in the session, so an early inclination to give high ratings may be reevaluated as the session progresses.

3. **Being Thorough**: Carefully read each TPOCS-A item every time an item is scored so that the full content is considered in formulating a final decision. When coding, always have a manual present and refer to it whenever there is any confusion about scoring an item.
Periodically review the General Instructions, Working Alliance Subscale, and TASC Subscale sections after training. Review helps ensure reliable ratings and protects against coder drift (i.e., helps prevent coders from inadvertently imposing their own definitions and standards on items). Finally, because scoring tapes is a demanding and work-intensive process, do not do other tasks when scoring.

C. CODER CAVEATS

1. **Avoiding Halo Effects**: Coders should be careful to avoid instances of “halo” effects. Halo effects refer to situations where the scoring for one item is biased or influenced by the scoring awarded to another item, or by a global judgment about the whole session. Halo effects come in many forms; here are some relevant examples:

   (a) A coder decides s/he really likes the client. As a result, the coder tends to give high scores on every item.

   (b) A coder is particularly impressed with a specific therapeutic segment. As a result, the coder gives high scores to many items.

   (c) A coder observes early on that, if the session were stopped, the client would receive low scores. Having formed a negative opinion, the coder does not give sufficient weight to behavior that appears later in the session. The coder therefore gives low scores for most items.

   (d) A coder decides s/he really dislikes the client. As a result, the coder tends to give low scores on every item.

   (e) A coder intentionally decides or unintentionally acts as though two different items naturally go together.

To avoid halo effects coders have to follow the consistent criteria provided by this manual. Coders must score each item as a separate, independent entity that is not influenced by other items. Essentially, coders should treat each TPOCS-A item as if it is completely uncorrelated with every other item even if that item appears to have similar characteristics.

2. **Call'em Like you See'em**: Please remember that not every aspect of the working alliance can be scored. The TPOCS-A is not an exhaustive list of all dimensions of the working alliance. Coders should therefore not stretch the assessment of client behavior just so it will fit into one of the items (even if it seems like a particularly potent therapeutic moment). When client behavior is forced to fit certain items (or vice-versa), coder reliability is severely compromised.
III. ALLIANCE SCALE

Rater Name: __________________

Session Date: __________________

Subject ID#: __________________

Session Number: __________________

Target Client: __________________

Instructions: Using the scale below, please indicate your judgment regarding four aspects of the session that you have just viewed. Please base all scores on the session as a whole. Place the appropriate number from the scale in the space provided next to each item.

1                2               3       4       5               6                    7
Not at           Some what         Considerabl y           Extremely
All

1. To what degree do you think this was a good session?

2. How involved were you in watching the videotape?

3. How much did you personally like the therapist in this session? (Do not consider other sessions in which you have viewed the same therapist.)

4. How much did you personally like the client in this session? (Do not consider other sessions in which you have viewed the same client.)
PART I: BOND

INSTRUCTIONS: Using the scale below, please indicate your judgment regarding the bond between client and therapist in the session that you have just viewed. For this scale, bond is defined as the extent to which the client and therapist develop a relationship characterized by: (1) Positive affect (e.g., liking, understanding, and caring), and (2) Mutual trust. For this scale, please base all scores on the entire session. Circle the appropriate number from the scale in the space provided.

A. To what extent did the client...

R1. ...indicate that s/he experiences the therapist as understanding and/or supporting?

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<tbody>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Great deal</td>
<td></td>
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</tbody>
</table>

ITEM DESCRIPTION: This item captures the extent to which the client indicates that s/he feels understood and appreciated by the therapist. The client may explicitly refer to the therapist's understanding and support (e.g., “I really like talking to you, you really understand me”), or may implicitly indicate feeling understood or supported by taking risks in therapy (e.g., elaborate further on the therapist's remarks and/or disclose feelings -- either verbally or in play).

When scoring this item, coders must consider how frequently and/or intensely the client indicates that s/he feels understood and appreciated in the session. A score of “5” implies that the client frequently indicates that s/he feels understood and appreciated (e.g., frequently elaborates on therapist comments), OR intensely indicates that s/he feels understood and appreciated during one segment of the session (e.g., discloses that s/he has been contemplating suicide).

R2. ...act in a hostile, critical, or defensive manner toward the therapist?

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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Great deal</td>
<td></td>
<td></td>
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</tbody>
</table>

ITEM DESCRIPTION: This item captures the extent to which the client interacts with the therapist in an angry or suspicious fashion. The client may be verbally hostile (e.g., “I hate you), critical (e.g., “Why do you always ask the same stupid questions”), or defensive (e.g., “Why do you keep asking me that”). The client may also be physically hostile (e.g., throws items at the therapist).

When scoring this item, coders must consider how frequently and/or intensely the client interacts with the therapist in a hostile, critical, or defensive manner. A score of “5” indicates that the client is frequently hostile, critical, or defensive throughout the session (e.g., frequently states that s/he does not like therapist) OR is intensely hostile, critical, or defensive during one segment of the session (e.g., intensely yells that s/he thinks the therapist is a “No good idiot”).
R3. …demonstrate positive affect toward the therapist?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Somewhat</td>
<td></td>
<td></td>
<td></td>
<td>Great deal</td>
</tr>
</tbody>
</table>

**ITEM DESCRIPTION:** This item captures the extent to which the client demonstrates that s/he likes and/or cares for the therapist. The client may verbally report that s/he likes the therapist (e.g., “I really like you”), or non-verbally demonstrate that s/he likes the therapist by smiling, laughing, or being physically oriented towards the therapist.

When scoring this item, coders must consider how frequently and/or intensely the client demonstrates that s/he likes the therapist. A score of “5” indicates that the client frequently demonstrates that s/he likes the therapist throughout the session (e.g., frequently smiles and laughs) OR intensely demonstrates that s/he likes the therapist during one segment of the session (e.g., intensely states that s/he really likes the therapist).

R4. …share his/her experience with the therapist?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Somewhat</td>
<td></td>
<td></td>
<td></td>
<td>Great deal</td>
</tr>
</tbody>
</table>

**ITEM DESCRIPTION:** This item concerns the degree to which the client expresses his/her viewpoint to the therapist. The client may express his/her experience by freely, openly, and easily talking about hopes, dreams, and opinions.

When scoring this item, coders must consider how frequently the client expresses his/her experience when presented the opportunity (e.g., how often the client shares his/her experience when asked by the therapist). A score of “5” indicates that the client frequently expresses his/her experience throughout the session and does not resist, or have difficulty, expressing his/her experience when prompted by the therapist. That is, no aspect of the client’s experience is missing that would reasonably be expected (e.g., willing/able to describe what s/he did in a situation, but not how s/he felt).

R5. …appear uncomfortable when interacting with the therapist?

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<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Somewhat</td>
<td></td>
<td></td>
<td></td>
<td>Great deal</td>
</tr>
</tbody>
</table>

**ITEM DESCRIPTION:** This item concerns the degree to which the client appears uncomfortable, anxious, or awkward when interacting with the therapist. The client may explicitly state that s/he is uncomfortable interacting with the therapist (e.g., “I really don’t feel comfortable talking with you”), or implicitly indicate that s/he is uncomfortable by not interacting freely, openly, and easily (e.g., turning away from the therapist, not talking, not playing).

When scoring this item, coders must consider how frequently the client appears uncomfortable when interacting with the therapist. A score of “5” indicates that the client frequently appears uncomfortable interacting with the therapist throughout the session.
B. **To what extent did the therapist and client...**

R6. …appear anxious or uncomfortable interacting with one another?

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Great deal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ITEM DESCRIPTION:** This item concerns the degree to which the client and therapist have difficulty interacting because they are anxious or uncomfortable. The client and therapist may display discomfort through uncomfortable verbal exchanges (e.g., awkward silences or pauses in conversation), or uncomfortable non-verbal exchanges (e.g., difficulty playing).

When scoring this item, coders must consider how frequently the client and therapist appear anxious or uncomfortable when interacting with one another. A score of “5” indicates that the client and therapist frequently appear anxious or uncomfortable interacting with one another throughout the session.
PART II: THERAPEUTIC TASKS

INSTRUCTIONS: Using the scale below, please indicate your judgment regarding the therapeutic tasks in the session that you have just viewed. For this scale, therapeutic tasks are defined as: (1) The therapeutic interventions employed by the therapist, and (2) The client’s willingness to use or follow the therapeutic interventions. For this scale, please base all scores on the session as a whole. Circle the appropriate number from the scale in the space provided.

A. To what extent did the client...

R1. ...use therapeutic tasks to make changes outside the session?

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<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Somewhat</td>
<td>Great deal</td>
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ITEM DESCRIPTION: This item captures the extent to which the client uses therapeutic tasks to make changes, or find solutions outside the session. To use therapeutic tasks to make changes outside of the session the client must demonstrate that s/he has acted upon something learned in therapy to understand and resolve problems (e.g., “I used the reward chart this week to get my son to pick up his room”). That is, the client must report that s/he used a therapeutic task outside the session.

When scoring this item, coders must first consider whether there is clear evidence that the client acted upon something learned in therapy to make changes outside the session. If clear evidence exists, then coders must consider whether the client frequently and/or intensely uses therapeutic tasks to make changes outside the session. A score of “5” indicates that the client frequently uses the therapeutic tasks to make changes outside the session OR intensely uses the therapeutic tasks to make changes outside the session (e.g., provides a detailed account of how s/he used therapeutic tasks to make changes).

R2. ...not comply with therapeutic tasks?

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<tr>
<td></td>
<td>Not at all</td>
<td>Somewhat</td>
<td>Great deal</td>
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ITEM DESCRIPTION: This item captures the extent to which the client refuses to participate in the therapeutic tasks. The client may explicitly refuse to use therapeutic tasks (e.g., “I don’t want to play”; “I don’t want to talk to my mother about this problem”) or implicitly refuse to participate in therapeutic tasks by: (1) Not complying with therapist requests or directives (e.g., does not play with therapist, explore emotions), or (2) Disrupting therapeutic tasks (e.g., taps loudly on a table while the therapist asks him/her about feelings).

When scoring this item, coders must consider whether the client frequently and/or intensely refuses to use or participate in the therapeutic tasks. A score of “5” indicates that the client frequently refuses to use or participate in any therapeutic tasks OR intensely refuses to use or participate in a therapeutic task during one segment of the session (e.g., absolutely refuses to participate in a specific therapeutic task).
B. To what extent did the therapist and client…

R3. …work together equally on therapeutic tasks?

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<tr>
<td>Not at all</td>
<td>Somewhat</td>
<td>Great deal</td>
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**ITEM DESCRIPTION:** This item measures the degree to which the client and therapist work as a team on the therapeutic tasks. When the client and therapist work together on the therapeutic tasks the interaction is characterized by equal effort (e.g., therapist and client both exert the same level of effort on the therapeutic tasks) and responsive exchanges (i.e., verbal or nonverbal). For example, the therapist and client may elaborate further upon remarks, or help each one another complete the therapeutic tasks (e.g., suggest feelings, help build a house together).

When scoring this item, coders must consider how frequently and/or intensely the client and therapist work together on the therapeutic tasks. A score of "5" indicates that the client and therapist frequently work on the therapeutic tasks OR intensely work on the therapeutic tasks without evidence that either one put forth more effort, or that they were unable to work together. That is, the client and therapist do not engage in tangential or superficial interactions not related to the therapeutic tasks.
Appendix C: Child Behavior Checklist
Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

None ☐

a. __________________________
b. __________________________
c. __________________________

I. Compared to others of the same age, about how much time does he/she spend in each?

Less Than Average ☐ Average ☐ More Than Average ☐ Don’t Know ☐

II. Compared to others of the same age, how well does he/she do each one?

Less Than Average ☐ Average ☐ More Than Average ☐ Don’t Know ☐

III. Compared to others of the same age, how active is he/she in each?

Less Active ☐ Average ☐ More Active ☐ Don’t Know ☐

IV. Compared to others of the same age, how well does he/she carry them out?

Below Average ☐ Average ☐ Above Average ☐ Don’t Know ☐

Be sure you answered all items. Then see other side.
Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do not include brothers & sisters)

☐ None  ☐ 1  ☐ 2 or 3  ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do not include brothers & sisters)

☐ Less than 1  ☐ 1 or 2  ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

Worse  Average  Better

a. Get along with his/her brothers & sisters?

☐ ☐ ☐ ☐ Has no brothers or sisters

b. Get along with other kids?

☐ ☐ ☐

c. Behave with his/her parents?

☐ ☐ ☐

d. Play and work alone?

☐ ☐ ☐

VII. 1. Performance in academic subjects. Does not attend school because __________________________________________________________

Check a box for each subject that child takes

- Reading, English, or Language Arts
- History or Social Studies
- Arithmetic or Math
- Science
- Other academic subjects—example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., or other nonacademic subjects.
- Other academic subjects—example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., or other nonacademic subjects.
- Other academic subjects—example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., or other nonacademic subjects.
- Other academic subjects—example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., or other nonacademic subjects.
- Other academic subjects—example: computer courses, foreign language, business. Do not include gym, shop, driver’s ed., or other nonacademic subjects.

Failing  Below Average  Average  Above Average

2. Does your child receive special education or remedial services or attend a special class or special school?

☐ No  ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades?

☐ No  ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school?

☐ No  ☐ Yes—please describe:

When did these problems start? _______________

Have these problems ended? ☐ No  ☐ Yes—when?

Does your child have any illness or disability (either physical or mental)? ☐ No  ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.
Below is a list of items that describe children and youths. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know)  
1 = Somewhat or Sometimes True  
2 = Very True or Often True

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<thead>
<tr>
<th>Item</th>
<th>0</th>
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<tbody>
<tr>
<td>1. Acts too young for his/her age</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>2. Drinks alcohol without parents’ approval (describe):</td>
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<tr>
<td>3. Argues a lot</td>
<td>0</td>
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<td>4. Fails to finish things he/she starts</td>
<td>0</td>
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<tr>
<td>5. There is very little he/she enjoys</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<td>6. Bowel movements outside toilet</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>7. Bragging, boasting</td>
<td>0</td>
<td>1</td>
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<tr>
<td>8. Can’t concentrate, can’t pay attention for long</td>
<td>0</td>
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<tr>
<td>9. Can’t get his/her mind off certain thoughts; obsessions (describe):</td>
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<td>10. Can’t sit still, restless, or hyperactive</td>
<td>0</td>
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<td>11. Clings to adults or too dependent</td>
<td>0</td>
<td>1</td>
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<tr>
<td>12. Complains of loneliness</td>
<td>0</td>
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<tr>
<td>13. Confused or seems to be in a fog</td>
<td>0</td>
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<tr>
<td>14. Cries a lot</td>
<td>0</td>
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<tr>
<td>15. Cruel to animals</td>
<td>0</td>
<td>1</td>
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<tr>
<td>16. Cruelty, bullying, or meanness to others</td>
<td>0</td>
<td>1</td>
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<tr>
<td>17. Daydreams or gets lost in his/her thoughts</td>
<td>0</td>
<td>1</td>
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<tr>
<td>18. Deliberately harms self or attempts suicide</td>
<td>0</td>
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<td>19. Demands a lot</td>
<td>0</td>
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<tr>
<td>20. Destroys his/her own things</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>21. Destroys things belonging to his/her family or others</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>22. Disobedient at home</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>23. Disobedient at school</td>
<td>0</td>
<td>1</td>
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<tr>
<td>24. Doesn’t eat well</td>
<td>0</td>
<td>1</td>
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<td>25. Doesn’t get along with other kids</td>
<td>0</td>
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<tr>
<td>26. Doesn’t seem to feel guilty after misbehaving</td>
<td>0</td>
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<tr>
<td>27. Easily jealous</td>
<td>0</td>
<td>1</td>
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<tr>
<td>28. Breaks rules at home, school, or elsewhere</td>
<td>0</td>
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<tr>
<td>29. Fears certain animals, situations, or places, other than school (describe):</td>
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<tr>
<td>30. Fears going to school</td>
<td>0</td>
<td>1</td>
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<tr>
<td>31. Fears he/she might think or do something bad</td>
<td>0</td>
<td>1</td>
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56. Physical problems without known medical cause:

a. Aches or pains (not stomach or headaches)                        | 0 | 1 | 2 |
b. Headaches                                                        | 0 | 1 | 2 |
c. Nausea, feels sick                                               | 0 | 1 | 2 |
d. Problems with eyes (not if corrected by glasses) (describe):     |   |   |   |
| e. Rashes or other skin problems                                   | 0 | 1 | 2 |
f. Stomachaches                                                     | 0 | 1 | 2 |
g. Vomiting, throwing up                                            | 0 | 1 | 2 |
h. Other (describe):                                                |   |   |   |
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<tr>
<td>57. Physically attacks people</td>
<td>0</td>
<td>1</td>
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<tr>
<td>58. Picks nose, skin, or other parts of body (describe):</td>
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<tr>
<td>59. Plays with own sex parts in public</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>60. Plays with own sex parts too much</td>
<td>0</td>
<td>1</td>
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<tr>
<td>61. Poor school work</td>
<td>0</td>
<td>1</td>
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<tr>
<td>62. Poorly coordinated or clumsy</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>63. Prefers being with older kids</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>64. Prefers being with younger kids</td>
<td>0</td>
<td>1</td>
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<tr>
<td>65. Refuses to talk</td>
<td>0</td>
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<tr>
<td>66. Repeats certain acts over and over; compulsions (describe):</td>
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<tr>
<td>67. Runs away from home</td>
<td>0</td>
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<td>68. Screams a lot</td>
<td>0</td>
<td>1</td>
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<tr>
<td>69. Secretive, keeps things to self</td>
<td>0</td>
<td>1</td>
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<tr>
<td>70. Sees things that aren't there (describe):</td>
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<td>71. Self-conscious or easily embarrassed</td>
<td>0</td>
<td>1</td>
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<tr>
<td>72. Sets fires</td>
<td>0</td>
<td>1</td>
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<tr>
<td>73. Sexual problems (describe):</td>
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<tr>
<td>74. Showing off or clowning</td>
<td>0</td>
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<tr>
<td>75. Too shy or timid</td>
<td>0</td>
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<tr>
<td>76. Sleeps less than most kids</td>
<td>0</td>
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<tr>
<td>77. Sleeps more than most kids during day and/or night (describe):</td>
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<tr>
<td>78. Inattentive or easily distracted</td>
<td>0</td>
<td>1</td>
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<tr>
<td>79. Speech problem (describe):</td>
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<tr>
<td>80. Stares blankly</td>
<td>0</td>
<td>1</td>
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<tr>
<td>81. Steals at home</td>
<td>0</td>
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<tr>
<td>82. Steals outside the home</td>
<td>0</td>
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<tr>
<td>83. Stores up too many things he/she doesn't need (describe):</td>
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<tr>
<td>84. Strange behavior (describe):</td>
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<tr>
<td>85. Strange ideas (describe):</td>
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<tr>
<td>86. Stubborn, sullen, or irritable</td>
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<td>87. Sudden changes in mood or feelings</td>
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<tr>
<td>88. Sulks a lot</td>
<td>0</td>
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<tr>
<td>89. Suspicious</td>
<td>0</td>
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<tr>
<td>90. Swearing or obscene language</td>
<td>0</td>
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<tr>
<td>91. Talks about killing self</td>
<td>0</td>
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<tr>
<td>92. Talks or walks in sleep (describe):</td>
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<tr>
<td>93. Talks too much</td>
<td>0</td>
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<tr>
<td>94. Teases a lot</td>
<td>0</td>
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<tr>
<td>95. Temper tantrums or hot temper</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>96. Thinks about sex too much</td>
<td>0</td>
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<tr>
<td>97. Threatens people</td>
<td>0</td>
<td>1</td>
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<tr>
<td>98. Thumb-sucking</td>
<td>0</td>
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<tr>
<td>99. Smokes, chews, or sniffs tobacco</td>
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<tr>
<td>100. Trouble sleeping (describe):</td>
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<tr>
<td>101. Truancy, skips school</td>
<td>0</td>
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<td>102. Underactive, slow moving, or lacks energy</td>
<td>0</td>
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<tr>
<td>103. Unhappy, sad, or depressed</td>
<td>0</td>
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<tr>
<td>104. Unusually loud</td>
<td>0</td>
<td>1</td>
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<tr>
<td>105. Uses drugs for nonmedical purposes (don't include alcohol or tobacco) (describe):</td>
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<tr>
<td>106. Vandalism</td>
<td>0</td>
<td>1</td>
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<tr>
<td>107. Wets self during the day</td>
<td>0</td>
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<tr>
<td>108. Wets the bed</td>
<td>0</td>
<td>1</td>
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<tr>
<td>109. Whining</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>110. Wishes to be of opposite sex</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>111. Withdrawn, doesn't get involved with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>112. Worries</td>
<td>0</td>
<td>1</td>
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</tr>
<tr>
<td>113. Please write in any problems your child has that were not listed above:</td>
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