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Therapist's effect on children's therapeutic alliance: A naturalistic study

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Abstract

Objectives: The therapeutic alliance (TA) has been shown to be a predictor of psychotherapy treatment success. In the case of psychotherapy with children, there is a dearth of information on TA's role. The aims of the paper are: (1) To estimate the therapist effects on children TA; (2) to investigate if therapists' TA predicts children's TA; (3) to analyze if children's age and sex predict children's TA; (4) to evaluate if the therapist's characteristics predict children's TA.

Methods: The sample consisted of 77 children undergoing psychotherapy in Argentina, and the therapists (N = 29) providing services to those children. The assessment tools utilized for the study included the Therapy Alliance Scale for Children and the Personal Style of the Therapist Questionnaire (PST-Q).

Results: Findings indicated that 2% of the children's TA was explained by the therapists (ICC = 0.02), while 17% of the therapists' TA was explained by the therapists (ICC = 0.17). Therapists' TA predicted children's TA. Children's age and sex did not have an effect on their own TA. Moreover, therapists with more experience achieved higher scores of children's TA. Finally, the Operative dimension of the PST had a negative effect on children's TA (i.e., therapists who prefer more spontaneous interventions over structured

ones may experience higher levels of therapeutic alliance with child patients).

Conclusion: We found a positive effect of the therapist's TA on children's TA, especially in the preference for using more spontaneous intervention techniques. We discuss the implications of the findings on the training of psychotherapists who provide services to children.

KEYWORDS

children, psychotherapy, therapeutic alliance, therapist's effects

1 | INTRODUCTION

The therapeutic alliance (TA) has been found to have small to moderate effect sizes as a predictor of treatment outcome in child psychotherapy (Bose et al., 2022; Karver et al., 2018). The reported impact variabilities of the TA have depended on the study design, the child's symptomatology, and the treatment characteristics (Bickman et al., 2012; Clark, 2013; Fjermestad et al., 2016; Kazdin & McWhinney, 2017; Shirk & Karver, 2011; Shirk et al., 2011; Zorzella et al., 2017). The TA has been associated with symptom reduction in children, improvements in family interaction patterns, and better training in parenting skills (Duppong Hurley et al., 2013; McLeod et al., 2016, 2017; Nuñez Hidalgo & Gómez Penedo, 2019).

When measuring TA in children population, there are different sources that can be used such as the children, their parents, the therapists, and external raters. Different studies showed direct correlations among the different perspectives indicating that, when assessing the TA, the different sources are congruent (Accurso & Garland, 2015; Bickman et al., 2012; Fjermestad et al., 2016; McLeod et al., 2017; Zorzella et al., 2017). Consistent with this finding, a meta-analysis reported no differences in the perception of the TA between parents and therapists, and between children and therapists (Karver et al., 2018). Nevertheless, another meta-analysis suggested that children and parents tend to rate TA higher than therapists (Roest et al., 2023).

The most widely used model for conceptualizing the TA is Bordin's (1979) transtheoretical model, which consists of three factors: therapeutic bond, agreement on therapeutic goals, and agreement on therapeutic tasks. However, in child psychotherapy patients usually do not request psychological care for themselves, therefore some difficulties appear when applying this model (Cirasola et al., 2021). Because of this, patients' parents are usually the ones negotiating therapeutic objectives and tasks with the therapist (Castro-Solano, 2017; Nuñez Hidalgo & Gómez Penedo, 2019). Notwithstanding this, the therapeutic bond remains present and is central to child therapy (Shirk & Karver, 2011). Therefore, one of the great challenges for child therapists is to build rapport with youths who do not request psychotherapy (Karver et al., 2019; Ng et al., 2021; Núñez et al., 2021).

Ryan et al. (2023) conducted a systematic review studying what characteristics of therapists were associated with children's therapeutic alliance. For this research, they divided the therapist's characteristics into stable (such as ethnic origin, sex, level of experience, and attachment style) or variable (such as their interpersonal style and their way of establishing the therapeutic alliance). The main results of this review showed that a secure attachment style of the therapist has been associated with the reduction of symptoms in children. Regarding the level of experience, more experienced therapists obtained more satisfactory results, except in the treatment of children with anxiety disorders. Also, sex-matching between therapists and their patients was not related to better therapeutic results and there was contradictory evidence about which therapist sex achieves optimal results. Furthermore, the review showed that the personal characteristics of the therapists were also related to the children's therapeutic alliance

(Ryan et al., 2023). The receptive capacity of therapists to children's feelings, promoting collaboration and asking respectfully, adapting sessions to the child's interests, being flexible, as well as offering feedback children's comments, has been shown to have a positive impact on the establishment of the therapeutic alliance. The authors concluded that these personal factors provided clear evidence regarding the development of the therapeutic alliance, and that therapists should be trained on them to the same extent as specific intervention techniques (Ryan et al., 2023). This is consistent with the results of de de Haan et al. (2013) where behaviors displayed in each session by the therapist showed a significant impact on children's TA, with medium to high effect sizes.

Qualitative studies have been carried out exploring what characteristics of therapists are perceived by children and their parents as facilitators of therapeutic change. The results pointed to therapists' playful attitude, and their interpersonal qualities such as being charismatic, trustworthy, open to listening, and respectful (Areas et al., 2020; Manso et al., 2008; Núñez et al., 2021).

In conclusion, quantitative and qualitative studies seem to underscore the role that some interpersonal characteristics of therapists in promoting children's therapeutic alliance. However, we were not able to identify studies that assessed systematically the therapist's overall style, beyond interpersonal features and their role in the therapeutic alliance. For these reasons, we turn to the Personal Style of the Therapist (PST) as a potential, relevant assessment tool.

2 | THE PST

The PST is defined as "the set of characteristics that each therapist applies in every psychotherapeutic situation, shaping its basic attributes. It is made up of the peculiar conditions that lead the therapists to behave in a particular way in the course of their professional work" (Fernández-Álvarez et al., 2003, p. 117). The PST is composed of five dimensions related to the various functions that make up a psychotherapeutic action. Each therapist's style of working falls somewhere on a continuum between two poles for each of the five dimensions.

The first dimension is labeled *Attentional*, and it refers to the therapists' way to search for therapeutic information. On one end, therapists may be more passive, open to listening and waiting until the patient offers key information; this is referred to as a broad attentional focus. On the other end, therapists may be more active and probe with specific questions; this is referred to as narrow focus. An example is: *I tend to be open-minded and receptive in listening rather than narrow-minded and restrictive*.

The second dimension is labeled *Operative*, and it refers to the ways in which therapists apply the various therapeutic interventions. Therapists can be more spontaneous, following their intuition, and even more creative with each patient. Or therapists may prefer to base their interventions on structured treatment plans, like manualized treatments, showing a high adherence to every step of the manual. An example is: *My interventions are mostly directive*.

The third dimension is labeled *Expressive*, and it refers to the way in which therapists work with emotional communication. Some therapists prefer to be closer to patients, using nonverbal communication to enhance a deeper emotional openness and are comfortable with the expression of intense emotions. Other therapists tend to behave in the opposite way, with more emotional distance, focusing on the technical aspects. An example is: *Real changes take place during highly emotional sessions*.

The fourth dimension is labeled *Engagement*, and it refers to how much therapists are involved in their daily work, and how psychotherapy has an impact on their daily lives. There are therapists with low engagement and others with high involvement. An example is: *Whatever happens to my patients has little influence on my personal life*.

The fifth, and last, dimension is labeled *Instructional*, and it refers to the way in which therapists establish the therapeutic setting, including schedule, fees, and frequency of sessions. Therapists could act in a flexible manner or be more structured and not change any of the rules. Some examples are *I am flexible about my working hours*; *I often see patients outside of the office setting*.

PST is a theoretical concept that was initially developed in Latin America; it has had a sizable volume of publications (Casari et al., 2018) and has been supported by psychometric studies on therapists of different nationalities (Moura de Carvalho et al., 2011; Prado-Abril et al., 2020; Silva Palma & Gondim, 2016). It has been recognized as a useful model to understand therapist's working style (Heinonen, 2015; Rihacek & Roubal, 2017; Zhou et al., 2021). Originally postulated as a transtheoretical variable, the PST has shown differences between professionals of different theoretical orientations (Quiñones et al., 2022) and is connected to the personality of the therapists (Casari et al., 2019). Moreover, Corbella (2019) found positive associations between the PST and the therapeutic alliance in adult patients. Nonetheless, PST has not been studied among child psychotherapists, nor has been its possible relation with the TA in children psychotherapy (Preve, 2015).

PST offers a way to study the therapist's effect, that is "the conjecture that some therapists achieve better therapy outcomes with their patients than do other therapists" (Wampold & Owen, 2021, p. 300). Wampold and Owen indicated that the therapist effect in naturalistic settings is even larger than in control settings (ICC = 0.06), therefore it is more important to be studied in the former settings. Accordingly, the therapist's personal style is worth studying as a relevant factor to understand children's therapeutic alliance in naturalistic settings. In short, the overall aim of this study was to analyze the therapists' contributions to TA in children undergoing treatment in Argentina. The specific aims of the study were: (i) to estimate the therapists' effects on children therapeutic alliance, (ii) to analyze if therapists' therapeutic alliance predicted children therapeutic alliance; (iii) to determine if children's age and sex predicted children's therapeutic alliance; (iv) to investigate if the therapists' characteristics predicted children's therapeutic alliance.

3 | METHODS

3.1 | Participants

A total of 77 children participated in the study. They were receiving psychotherapy from different private outpatient clinics in Argentina. As inclusion criteria, patients needed to have a neurotypical development (i.e., not presenting intellectual disabilities or autism spectrum disorder), and undergone at least three individual psychotherapy sessions at the beginning of the study. All the children were referred for psychotherapy by their parents. In addition, there were 29 psychotherapists (92% female) who treated those children. The characteristics of the patients and the therapists are specified in Table 1.

Psychologists in Argentina typically obtain their license upon completion of their *licenciatura* degree (a 5-year degree following a high school diploma). While psychologists in Argentina are not required to complete further coursework in psychotherapy, many choose to do so. Such training can be obtained through universities, public health centers, or private mental health training centers. Out of the 29 therapists in this study, 17 had done brief, additional courses (58.6%), 14 held a *specialization* in psychotherapy (48.3%), and one held a master's degree (3.4%).

3.2 | Measures

3.2.1 | Therapeutic alliance scale for children

The Therapeutic Alliance Scale for Children (TASC; Shirk & Russell, 1996; Shirk & Saiz, 1992) is a self-report measure designed for children aged 8–15 years. It consists of 12 items that are answered in a Likert scale ranging from 1 (*strongly disagree*) to 4 (*totally agree*). Total scores range from 12 to 48, with the higher score indicating higher perceived alliance value (Kazdin et al., 2006). Following the conceptualization of the therapeutic alliance proposed by Bordin (1979), the instrument includes items that distinguish between affective bonding (e.g., "I like my

TABLE 1 Demographic information about the children and the therapists.

Children (*N* = 77)		
Gender	Female	37.7%
	Male	62.3%
Age	Min–max	7–12
	M (DE)	9.66 (SD = 1.42)
Time in therapy	<1 month	2.6%
	1–3 months	33.8%
	3–6 months	26%
	6–12 months	24.7%
	>1 year	13%
Problem referred by the parents	Anxiety problems	18.2%
	Mood problems	31.2%
	Behaviors problems	24.7%
	Fear and phobias	28.6%
	Social relationship problems	16.9%
	Learning problems	10.4%
	Other problems	13%
Therapist (*N* = 29)		
Gender	Female	92.2
	Male	7.8
Age	Min–max	28–54
	M (DE)	35.50 (6.09)
Frequency of cases treated	1	24.14%
	2	31.03%
	3	20.69%
	4	17.24%
	≥5	6.9%
Years of clinical practica	<5	40%
	5-oct	36.7%
	>10	23.3%
Theoretical approach	Cognitive behavioral	53.3%
	Integrative	13.3%
	Psychoanalytic	23.3%
	Systemic	10%

therapist"), and perceived agreement on goals and tasks (e.g., "I think that my therapist and I work well together on my problems"). The scale has adequate psychometric properties, with sound evidence of reliability (Creed & Kendall, 2005; Hawley & Weisz, 2005; Langer et al., 2011), convergent validity with similar scales (Accurso & Garland, 2015; Fjermestad et al., 2016; McLeod et al., 2017), and predictive validity with therapeutic outcomes (Hawley & Weisz, 2005; Kazdin et al., 2005). The reliability indexes range between $\alpha = .88$ and $\alpha = .93$ (Creed & Kendall, 2005; Hawley & Weisz, 2005). For this study we used self-reported versions for children (TASC-C) and therapists (TASC-T).

3.2.2 | Personal style of the therapist questionnaire

The Personal Style of the Therapist Questionnaire (PST-Q, Castañeiras et al., 2008; Fernández-Álvarez et al., 2003) is self-reporting tool that consists of 21 items to be responded to on a Likert scale, ranging from 1 (*totally disagree*) to 7 (*totally agree*). The items are statements about the way the psychotherapist acts and represent the five dimensions previously discussed: Attentional (four items), Operative (five items), Expressive (five items), Engagement (four items), and Instructional (three items). The PST-Q has satisfactory psychometric properties regarding construct validity (through confirmatory factor analysis) (Casari et al., 2017), and convergent validity with the Aiglé Therapeutic Activity Observation Guide (Fernández-Álvarez et al., 2017). The internal consistency of the scale is also adequate (α Attentional = .71, α Operative = .75, α Expressive = .70, α Engagement = .72, α Instructional = .60; Castañeiras et al., 2008).

3.3 | Procedure

The research was approved by the Ethics Committee for Scientific and Technological Research of CONICET Mendoza. The recruitment procedure was direct, person-to-person contact with potential participant therapists. After indicating an interest to participate in the study, therapists signed a written informed consent. Then, they completed a demographic survey to indicate their sex, age, clinical experience, and theoretical orientation; they also filled out the PST-Q. After this, the psychotherapist selected child patients with a neurotypical development who had undergone treatment for more than three sessions. The therapists explained to the parents of potential participants the research aims and procedures; if in agreement, parents provided written informed consent. Once parents gave consent, each therapist gave the children a written assent form and the TASC (children version). Therapists explained to the children the instructions to complete the TASC-C and then we provided an online form for the children. They completed the TASC-C with their cell phone or on the therapist's computer. The TASC-C was self-administered, albeit therapists made themselves available for questions regarding the items. For each child who filled out the TASC, the therapist completed the TASC (therapist version) thinking in the overall therapeutic alliance with this patient. The therapist repeated this procedure with the different patients included in the study.

3.4 | Statistical analysis

Given that our study involved groups of patients nested within assigned therapists, we utilized multilevel models structured into two levels (Level 1: patients, Level 2: therapists). Multilevel models are well-suited for handling data dependencies arising from nested structures and can handle missing data in a manner like an intent-to-treat approach. This approach leads to more reliable parameter estimates (Gómez Penedo et al., 2019; Raudenbush & Bryk, 2002).

3.4.1 | Unconditional model

To estimate the therapist effects on the therapeutic alliance (i.e., percentage of variance explained by the therapists), we ran the following unconditional model and calculated intraclass correlation coefficients:

Level 1 Model

$$AT_{ij} = \beta_{0j} + r_{ij}.$$

Level 2 Model

$$\beta_{0j} = \gamma_{00} + u_{0j}.$$

3.4.2 | Conditional model

To estimate if there were therapists' characteristics that might predict the therapeutic alliance, we ran two different multilevel conditional models. In a first model we tested if therapist alliance significantly predicted the patient therapeutic alliance:

Level 1 Model

$$AT_{ij} = \beta_{0j} + \beta_{1j}*(\text{Therapist Alliance}) + r_{ij}.$$

Level 2 Model

$$\beta_{0j} = \gamma_{00} + u_{0j}.$$

In a second model we tested if children's age and sex significantly predicted their own therapeutic alliance. We ran this model to check if there were meaningful patient level variables that would need to be included as covariates in the model to estimate therapists' characteristic effects. Children's age and sex were included as level 1 predictors. We used the following equation:

Level 1 Model

$$AT_{ij} = \beta_{0j} + \beta_{1j}*(\text{Patient Age}) + \beta_{2j}*(\text{Patient Sex}) + r_{ij}.$$

Level 2 Model

$$\beta_{1j} = \gamma_{00} + u_{0j},$$

$$\beta_{1j} = \gamma_{10},$$

$$\beta_{2j} = \gamma_{20}.$$

The third model was fitted with therapist characteristics: therapist sex, age, and personal style and therapist alliance levels (grand-mean centered) as level 2 predictors. In case of significant patient characteristics, we would also include them in the model, as level 1 covariates. We used the following equation:

Level 1 Model

$$AT_{ij} = \beta_{0j} + r_{ij}.$$

Level 2 Model

$$\beta_{0j} = \gamma_{00} + \gamma_{01}{}^{*}(\text{Therapist Alliance}) + \gamma_{02}{}^{*}(\text{Therapis Age}) + \gamma_{03}{}^{*}(\text{Therapist Sex}) + \gamma_{04}{}^{*}(\text{Experience of Therapist} \quad 5 - 10) + \gamma_{05}{}^{*}(\text{Experience of Therapist} + 10) + \gamma_{06}{}^{*}(\text{PST Attentional}) + \gamma_{07}{}^{*}(\text{PST Instructional}) + \gamma_{08}{}^{*}(\text{PST Operative}) + \gamma_{09}{}^{*}(\text{PST Expressive}) + \gamma_{10}{}^{*}(\text{PST Engagement}) + u_{0j}.$$

Regarding therapist experience, we compared therapists whose experience was between 5 and 10 years, and therapists whose experience was more than 10 years, with therapists having less than 5 years of experience.

4 | RESULTS

The descriptive statistics of the TASC total score (for children and for therapists) and the PST-Q are presented in Table 2. All the subscales have acceptable values of Skewness and Kurtosis (±1.5) (George & Mallery, 2003). The mean scores of the children's report of the TASC is slightly higher than the therapist's report. Regarding PST-Q there are no norms for interpretation. Therefore, we compared the raw scores with the study of psychometric properties of the PST-Q (Castañeiras et al., 2008): Attentional (12.57), Operative (21.60), Expressive (16.77), Engagement (17.07), and Instructional (12.88). Using the *t* test for one sample, we compare the raw scores with the values of each dimension of the previous study (Castañeiras et al., 2008). As a result, three of the dimensions have significant differences: Operative ($p < .05$, $d = -0.26$), Expressive ($p < .001$, $d = 0.59$), and Engagement ($p < .01$, $d = 0.32$).

4.1 | Multilevel models

4.1.1 | Unconditional model

The model estimating children therapeutic alliance revealed a mean of 40.86, $\gamma_{00} = 40.86$, SE = 0.46, 95% confidence interval (CI): [39.93, 41.78], $t(20.47) = 88.09$, $p < .001$. Results showed that in a two-level unconditional model 2% of the therapeutic alliance's variance was explained by the therapists (ICC = 0.02).

The model estimating therapist therapeutic alliance revealed a mean of 38.46, $\gamma_{00} = 38.46$, SE = 0.63, 95% CI: [37.21, 39.71], $t(22.69) = 61.13$, $p < .001$. Results showed that in a two-level unconditional model 17% of the therapeutic alliance's variance was explained by the therapists (ICC = 0.17).

TABLE 2 Descriptive statistics of TASC measures and PST-Q.

	Min–max	Rank	*M* (SD)	Skewness	Kurtosis
TASC-C	28–47	19	40.89 (3.97)	−1.09	1.15
TASC-T	25–47	22	38.54 (4.69)	−0.497	−0.26
PST-Q_Attentional	4–20	16	11.74 (4.69)	0.007	−0.919
PST-Q_Operative	12–31	19	20.28 (4.94)	0.524	−0.488
PST-Q_Expressive	11–26	15	18.88 (3.55)	0.048	−0.106
PST-Q_Instructional	6–21	15	13.55 (4.30)	0.020	−1.163
PST-Q_Engagement	7–26	19	18.75 (5.21)	−0.545	−0.522

Abbreviations: PST-Q, Personal Style of the Therapist Questionnaire; TASC-C, Therapeutic Alliance Scale for Children—children report; TASC-T, Therapeutic Alliance Scale for Children—therapist report.

TABLE 3 Conditional model with children's age and gender.

	Parameters	
	γ	SE
Conditional effects model		
Intercept	43.85*	3.40
Patient age	−0.12	0.32
Patient sex	−0.19	0.92

*$p < .001$.

4.1.2 | Conditional model

In these models, we analyzed (i) if therapists' therapeutic alliance predicted patient therapeutic alliance, (ii) if children's age and sex predicted children's therapeutic alliance and might need to be considered when exploring the effect of therapist's characteristics, and (iii) if there were therapist characteristics that predicted the therapeutic alliance.

4.1.2.1 | *Therapists' alliance as a predictor of patient's alliance*

The model with therapist alliance showed a significant effect of the therapist alliance on the children therapeutic alliance score ($\gamma_{01} = 0.26$, SE = 0.43, 95% CI: [0.08, 0.45], $t(74) = 2.87$, $p < .01$). One unit increase in the therapist alliance implies a 0.26 greater patient alliance level.

4.1.2.2 | *Children's age and sex as predictors of the alliance*

The complete results of these models are presented in Table 3. The models with the children's characteristics showed no significant effect of either the age or the sex of the patient on the therapeutic alliance.

4.1.2.3 | *Therapist's characteristics as predictors of the alliance*

Full results of this model are reported in Table 4. In the models with the therapist characteristics, there was also a significant effect of the therapist alliance on the children's therapeutic alliance score ($\gamma_{01} = 0.35$, SE = 0.09, 95% CI: [0.17, 0.52], $t(77) = 3.95$, $p < .01$). One unit increase in the therapist alliance implies a 0.35 greater patient alliance level. We did not find significant effects of therapist age or sex. However, there was a significant effect of the therapist's years of experience ($\gamma_{05} = 4.59$, SE = 2.23, 95% CI: [0.13, 9.05], $t(77) = 2.06$, $p < .05$). The group with more than 10 years' experience had a 4.59 great alliance compared to the group with 5 to 10 years of experience. Also, there was an inverse effect of the Operative PST on the TA ($\gamma_{08} = -0.39$, SE = 0.15, 95% CI: [−0.68, −0.10], $t(77) = -2.66$, $p < .01$). One unit increase in operative style implies a decrease of 39 in the alliance level.

5 | DISCUSSION

The aims of this paper were: (i) To estimate the therapist effects on children therapeutic alliance, (ii) to analyze if therapists' therapeutic alliance predicts children therapeutic alliance; (iii) to analyze if children's age and sex predict children therapeutic alliance; (iv) to analyze if the therapist's characteristics predict children's therapeutic alliance.

Regarding aims one and two, we need to consider the discrepancy between therapist's effect on the prediction of therapeutic alliance. The therapist predicts 2% of children TA and 17% of therapist TA. This result could be explained by several factors. The children's perception of TA is a better predictor of treatment outcome than the therapists' perception of TA (van Benthem et al., 2020). Although there is an association between the different

TABLE 4 Conditional model with therapist characteristics.

	Parameters	
	Γ	SE
Conditional effects model		
Intercept	49.15***	7.81
Therapist alliance	0.35***	0.88
Therapist age	−0.28	0.40
Therapist sex	1.41	1.87
E5 − 10	−0.75	1.15
E + 10	4.59	2.23*
PST-Q Attentional	0.36	0.50
PST-Q Instructional	0.12	0.14
PST-Q Operative	−0.39	0.15**
PST-Q Expressive	0.16	0.13
PST-Q Engagement	0.01	0.10

Abbreviations: E5 − 10, between 5 and 10 years of clinical practice; E + 10, more than ten years of clinical practice; PST-Q, Personal Style of the Therapist Questionnaire.

*$p < .001$; **$p < .01$; ***$p < .05$.

perspectives of the TA (Accurso & Garland, 2015; Zorzella et al., 2017), usually it is not statistically strong as expected (Roest et al., 2023). A possible explanation is that children do not understand the concept of TA in the same way that therapists do (Horvath, 2018), because for the children the TA is essentially a positive bond with the therapist (Núñez et al., 2021).

It is reasonable to expect that the therapists' self-reported therapeutic alliance would be more predictive on their own therapeutic alliance than on children's therapeutic alliance, given that the same subjects are being analyzed. In child therapy, assessments should consider multiple perspectives, including those of therapists, parents, and patients (De los Reyes et al., 2023). Nevertheless, even in research where the same measure is applied to all participants (e.g., TASC), the effect sizes tend to be small (McLeod et al., 2017).

The results of this study are also consistent with previous findings suggesting that children tend to perceive a stronger TA than their therapists (Shirk et al., 2010). On the one hand, as children compare TA with the rest of their daily relationships with other adults, like their parents, they show more affection for their therapist. On the other hand, therapists compare the TA with each different child patient, showing lower scores (Roest et al., 2023). It is not only a greater appreciation of TA from the children's perspective, but also a different interpretation of what TA is (Horvath, 2018). Moreover, it has been reported that the notion of TA by patients tends to change over time towards an integrated concept and not separated into factors (Flückiger et al., 2022).

Another finding is that children had a lower range of values in the TASC-C compared to the range of values of the therapist in the TASC-T. There is greater variability in the responses of the therapists and greater uniformity in the responses of the children, even having a higher mean score. It has been reported that children tend to answer the TA self-report questionnaires at the extremes of each question, giving higher values and lower range in the values of the responses, commonly referred to as a *ceiling effect* (Shirk et al., 2010). This is in line with another study that reports greater variability in TA among therapists when compared to child patients (McLeod et al., 2017).

Regarding our third aim, and as it is shown in the results, children's age and sex did not have a significant effect on children's TA. These results are in contrast with other studies that report higher TA values in girls than in boys,

and higher TA scores in children than in adolescents (Figueiredo et al., 2019; Whitehead et al., 2019). However, this discrepancy could be related to some limitations regarding the distribution of these variables among the sample in the present study, specifically in children's age. As the ability of abstract thinking changes quickly between seven and 12 years, it is not a uniform sample of children's age, which could explain the nonsignificant results. Besides, we did not analyze the effect of children's age and sex on therapists' therapeutic alliance.

Regarding the fourth aim, to test the eventual effects of the therapist's personal style on the TA, age, sex, and years of experience of the therapist were also included as predictors, finding only significant effects in the analysis of the years of experience. Concerning therapists' sex, there are contradictory results for the achievement of better TA scores in child psychotherapy depending on the sex of the therapist or the compatibility between the sex of therapists and patients (Ryan et al., 2023). When considering the therapist's age, no specific studies were found that analyzed this variable in child psychotherapy. However, in adult psychotherapy this demographic variable had shown no significant effects (Wampold & Owen, 2021). Finally, in line with our results, previous research found that years of clinical experience were related to better TA values. Ryan et al. (2023) found that the patients of therapists with highest levels of experience have more sessions attended, which is another measure of therapeutic outcomes. In the present research, the therapist with more than 10 years of clinical experience had cases with more time in treatment (30% of cases had more than 1 year in treatment) compared with the rest of the sample (31% of the cases had less than 3 months under treatment).

With respect to the PST, the results showed that the Operative function had a negative impact on the therapeutic alliance as perceived by children. Specifically, the negative effect suggests that therapists who prefer more spontaneous interventions over structured ones may experience higher levels of therapeutic alliance with their young patients (Fernández-Álvarez & García, 2019). Based on these findings, it can be inferred that child psychotherapists are more likely to exhibit creativity and spontaneity in their therapeutic interventions.

In previous studies, it was found that the Operative function acts as a moderator on the resistance of adult patients: more resistant patients with less prescriptive therapists (meaning lower values of the Operative function) achieve a better therapeutic alliance and better results. This means that there is no optimal way to perform the Operative function, but it is according to the degree of reactance of the patient (Corbella, 2019). Meanwhile, Casari (2019) compared the PST profile in therapists serving adult patients versus therapists who treated children and adolescents. The latter scored significantly lower in the Operative function, meaning that they had a greater preference for spontaneous interventions when treating children and adolescents.

Is it possible to be a psychotherapist who implements evidence-based approaches (Ng et al., 2021) and at the same time use personalized treatment designs? The personalization of treatments considers not only the interventions that have proven effective for certain clinical conditions but also considers the characteristics of the patients that can achieve better therapeutic outcomes (Cohen et al., 2021). There have even been successful experiences in the personalization of treatments in child psychotherapy, considering the characteristics of the patients (Langer et al., 2022).

Therapeutic creativity, the use of other nonverbal resources like games, drawing, and the possibility of adapting sessions to the children's interests (Núñez et al., 2021; Ryan et al., 2023) are part of the Operative function. Perhaps the negative contribution on the TA that was found in the present study is related to the greater spontaneity of therapists' interventions with children. In fact, the concept of therapist's flexibility to adapt specific techniques to each case has been associated with better therapeutic outcomes (Chu & Kendall, 2009).

It might be important to consider specific and nonspecific treatment factors to increase the likelihood of success and enhance new scientific ways of seeing the therapeutic process (Castro et al., 2023). The Operative function of the PST may not only be related to the use of evidence-based interventions, but it could also be associated with the early stages of psychotherapy, including treatment planning. In natural settings, the problems are heterogeneous, like those present among the children in this study. Therefore, therapists need more resources to manage child problems; creativity and being more spontaneous seem to be necessary tools. Therefore, training

programs should consider the importance of therapists' interpersonal skills in child psychotherapy (Ryan et al., 2023).

This study has several limitations that would need to be addressed in future research on clinical settings. First, the naturalistic sample of patients gathered for this study ($N = 77$) might be underpowered. Thus, it might be that some predictors' effects were not detected due to power issues. When considering the estimation of the therapist effect it is important to consider that the number of patients treated by the therapist had a sizable range, and this could affect the analysis which, in turn, could explain the low rate of ICC explained by the therapist alliance. Future research would need to assess the replicability of these findings in a larger sample. Second, this is a cross-sectional study, and the TA was assessed on therapists and children who may have been in different moments of the treatment as we did not know the exact number of sessions of each child. Therefore, it might be important to consider children at the same stage of the therapeutic process in future studies. Third, and regarding the procedure, a bias selection is likely present due to certain therapists being personally contacted and invited to participate, and these therapists selecting certain patients to respond to questionnaires, an overall process that could be described as a double convenient sampling. To the extent that it was not possible to make a random selection of the sample, it is likely that therapists chose their best patient(s) to participate in the study, which, in turn, may have affected children's TA scores. Fourth, there was not a standardized assessment of children's symptoms, even though children's TA seems to differ according to their symptoms (Feindler & Smerling, 2022). Finally, we could not control the therapist's variables such as the theoretical orientation, years of clinical experience, and therapist's sex (92% of the sample identified as female). Also, we did not know characteristics of the therapeutic techniques applied, like parental training programs. It is important to consider all these aspects in future research to arrive at a more homogeneous sample.

All these limitations make it difficult to interpret and generalize the findings. However, we need to consider the importance of therapist effects on therapeutic outcomes, and the fact that it is even higher in naturalistic studies, achieving 21% of the variance (Johns et al., 2019; Wampold & Imel, 2015). Nonetheless, it is important to continue with these studies.

The major implications of this study are as follows. Therapists' years of clinical practice and their operational use of the PST have been found to have an effect on the therapeutic alliance with child patients. Therefore, training programs for child therapists should aim to promote creativity in treatment design, while also incorporating evidence-based practices. Therapists need to tailor treatment plans to fit the individual needs and characteristics of each child. Although age and sex did not have a significant effect on children's therapeutic alliance in our study, there may be other variables that should be considered when designing the most effective treatment for each child.

A second finding of this study is that the therapist's own perception of the therapeutic alliance predicts the perception of the alliance by the children. This highlights the importance for therapists to routinely measure their own therapeutic alliance throughout the course of psychotherapy. While it can be challenging to use assessment measures to evaluate patients, therapists can monitor changes in their own therapeutic alliance scores to stay aware of any significant changes that may be occurring. This knowledge can be useful for improving the therapeutic process and enhancing the overall outcomes for the child.

Finally, we would like to share some recommendations for enhancing the therapeutic alliance in child psychotherapy (Feindler & Smerling, 2022). First, it is crucial that all parties be clear about the therapeutic nature of the setting and that parents sign a written consent while also securing assent from the children. Second, it is important to dialog and reach consensus on the psychotherapy goals and how to accomplish them. Third, therapists want to help parents regulate expectations: psychotherapy is a process and requires parental collaboration. Fourth, therapists must be genuine with the patient; children appreciate therapists' honesty.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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