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# THE THERAPEUTIC RELATIONSHIP AS A CHANGE FACILITATOR IN CHILD PSYCHOTHERAPY: A MULTIPLE PERSPECTIVE STUDY OF CHILDREN, PARENTS AND THERAPISTS

BY
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To my most loved ones, Nicolás, Emilio and Cristóbal, who motivated, held and accompanied me with patience and love in this adventure.

To my dear parents, Cecilia and Tulio, who stimulated me with their brilliant and curious minds and big hearts to want to know more.

To the children that have trusted me as their therapist to help them.
To the children who need to trust another to heal and the big ones there for them.

*Nothing happens without at least one strand of relationship.*
*The relationship is something subtle.*
*It is the base of the therapeutic process and can, in itself, be powerfully therapeutic (...)*
*We meet as two separate individuals, neither superior to the other.*
*It is my responsibility to maintain this position.*
*I am as genuine as possible: I am myself.*
*(Violet Oaklander, 2006)*

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# OUTLINE

# 1. ABSTRACT

**Background**: The therapeutic relationship is crucial in the change process and involves the child, the therapist and the parents. Research that incorporates the perspectives of children, parents and therapists is of recent development and has underscored the therapeutic relationship as a central aspect of the therapeutic process. Aim: analyse how the therapeutic relationship with children and parents develops and facilitates therapeutic change, according to the perspectives of children, parents and therapists. **Methods**: three studies were conducted: a retrospective qualitative study of the experience of the therapeutic relationship of children, parents and therapists (N=36); a quantitative non-experimental and cross-sectional study of the relationship between the initial alliance and demographic and clinical variables (N=74); and a longitudinal qualitative study of the child-therapist and parent-therapist relationship as change facilitators, from the perspective of children, parents, and therapists (N=15). Both qualitative studies included semi-structured interviews and children's drawings. **Results**: At the onset of therapy, all participants reported a positive alliance, but children and parents' reports were significantly higher than the therapists. Children's age and symptomatology intensity impacted the initial valuation of the alliance. A positive therapeutic relationship with children and parents was gradually constructed, facilitated by individual and interactional aspects within participants. From the beginning, the therapists' close and flexible attitude improved motivation for psychotherapy among children and parents. Later, a positive, child-centred and affective therapeutic relationship fostered the child's trust with the therapist, promoting changes in children and socio-affective tools development. The parent-therapist relationship was also a change facilitator. **Conclusions**: The development of positive relationships required different and evolving dispositions from therapy main participants. A positive therapeutic relationship provided a healing, relational experience for children as it fully developed. A positive parent-therapist relationship was vital for changes to further progress.

# RESUMEN

**Antecedentes**: La relación terapéutica es crucial en el proceso de cambio e implica al niño/a, al terapeuta y a los padres. La investigación que incorpora las perspectivas de niños/as, padres y terapeutas es reciente y subraya la relación terapéutica como un aspecto central del proceso. **Objetivos**: Analizar la evolución de la relación terapéutica con niños/as y padres y su rol facilitador en el cambio terapéutico, desde las perspectivas de niños/as, padres y terapeutas. **Método**: Se realizaron tres estudios: uno cualitativo retrospectivo de la experiencia de la relación terapéutica de niños/as, padres y terapeutas (N=36); otro cuantitativo no-experimental y transversal de la relación entre alianza inicial y variables demográficas y clínicas (N=74); y un tercero cualitativo longitudinal de la relación niño/a-terapeuta y padres-terapeuta como facilitadores del cambio, desde la perspectiva de niños/as, padres y terapeutas (N=15). Ambos estudios cualitativos incluyeron entrevistas semi-estructuradas y dibujos de los/as niños/as. **Resultados**: Al inicio de la terapia, los participantes informaron una alianza positiva, pero el reporte de niños/as y padres fue significativamente mayor que el de terapeutas. La edad y la sintomatología de los/as niños/as influyeron en la valoración de la alianza. La relación terapéutica positiva se construyó gradualmente, facilitada por aspectos individuales e interaccionales de los participantes. Desde el inicio, la actitud cercana y flexible del terapeuta facilitó la motivación de niños/as y padres. Posteriormente, una relación terapéutica positiva, afectiva y centrada en el/la niño/a facilitó su confianza en el terapeuta, promoviendo cambios en los/as niños/as y el desarrollo de herramientas socio-afectivas. La relación padre-terapeuta fue un facilitador del cambio. **Conclusiones**: El desarrollo de relaciones positivas requirió disposiciones diferentes y progresivas de los participantes de la terapia. Una relación terapéutica positiva proporcionó una experiencia relacional sanadora para los/as niños/as cuando se desarrolló plenamente. Una relación positiva padres-terapeuta es vital para que los cambios avancen.

## 2. INTRODUCTION

Globally, child mental health is a public concern as one out of five children presents a psychiatric problem (World Health Organization, 2005). This number is slightly higher in Chile, where the prevalence of psychiatric disorders in children between 4 and 11 years old is 27.8% (Vicente et al., 2016) and represents a major group that requires mental health attention.

Extensive research findings have evidenced that psychotherapy is an effective practice in aiding mental health issues in adults (Lambert & Bergin, 1994; Lambert, 2015) and children (Fonagy et al., 2015). The effectiveness of psychotherapy has frequently been conceived as the reduction of symptoms; however, change solely conceptualised and measured through symptom improvement at the beginning and the end of psychotherapy has been questioned, as it does not consider the changes that for patients and therapists would be significant from their experience and in terms of clinical significance (Gómez & Roussos, 2012).

Within this knowledge, the questions that follow are: why psychotherapy is effective? how and why does change occur? (Elliott, 2010). To answer these questions, the research in this field has focused not only on the results but also on change processes, considering the mechanisms or factors that favour them and the evolution of change during the psychotherapeutic process (Krause & Altimir, 2016; Paz et al., 2021). Shifting the accent towards understanding change processes seeks to achieve a better grasp on how change occurs; in this regard, the need to incorporate the perspectives of psychotherapy participants has been emphasized (Elliot, 2008).

To investigate the active elements and mechanisms of change in psychotherapy, specific and common change factors have been outlined (Kennedy & Midgley, 2007; Krause, 2005; Wampold, 2015). Specific factors broadly refer to the techniques used within a particular theoretical framework, and common factors refer to transtheoretical aspects of psychotherapy practice shared by the diverse theoretical orientations. Regarding therapeutic change factors, common factors have shown a higher association with therapeutic change with adults than specific factors (Lambert, 2015). This conclusion has been referred to as the equivalence paradox or the “Dodo Bird Verdict”, meaning that outcome in psychotherapy depends more on nonspecific factors than on the specific frameworks within the different therapeutic schools (Horvath, 2018; Luborsky et al., 1975).

The therapeutic alliance has shown to be one of the most robust common factors that explain positive therapeutic outcomes, both in adults (Flückiger et al., 2018; Horvath et al., 2011) and in children and adolescents (Karver et al., 2018; Shirk & Karver, 2011). Thus, the therapeutic alliance has gained a central place in psychotherapy research in recent decades (Horvath, 2018). Historically, the therapeutic alliance has played a central role in the theories addressing the therapeutic process (Horvath et al., 2011) and has been a thoroughly explored topic in adult psychotherapy research (Horvath, 2018). However, in child psychotherapy research, the focus on therapeutic outcomes due to specific models has persisted, more than on the generic change factors observed in adult psychotherapy research (Kennedy & Midgley, 2007). In child psychotherapy, there has been scarce process research (Carlberg et al., 2009; Midgley, 2004) that focus on therapeutic interactions and the change processes experienced during psychotherapy (Krause, 2005). Moreover, compared to adult psychotherapy few alliance studies in child psychotherapy have been conducted (Clark, 2013; Shirk & Karver, 2011).

Although child psychotherapy research has evidenced a critical development in recent years (Schmidt & Schimmelmann, 2015) it is still relatively small in comparison to the quantity of research performed in psychotherapy with adults (Carlberg et al., 2009; Midgley, 2004); representing a rather new field. This detail may be unnoticed for those who conduct adult psychotherapy research; however, it is very relevant for child psychotherapy. Child psychotherapy involves specific aspects, such as the developmental aspects of childhood and the participation of parents in the therapeutic process (Midgley et al., 2018; Weisz et al., 2013). Therefore, not all the findings from research conducted in adult psychotherapy fit precisely in the practice with children; hence, child psychotherapy requires specific research within this consultation group (Baylis et al., 2011; Target, 2018).

In child psychotherapy, the therapeutic relationship has been conceived as a central issue in the therapeutic change process (Shirk & Karver, 2011). This relationship may be considered even more critical than in the case of adults, since children do not usually refer themselves to therapy and often attend treatment unaware of their problems or resistant towards change (Clark, 2013; Elvins & Green, 2008; Karver et al., 2006), and change motivation may reflect the interests of other actors in the child's life (Baylis et al., 2011). In this context, developing solid therapeutic relationships with children and their families may benefit engagement towards

therapy (Karver et al., 2006). Despite this understanding, research on child therapeutic relationships has been under viewed (DeVet et al., 2003; Hayes, 2017).

Another particular feature of child psychotherapy is that the therapeutic relationship transcends the usual patient-therapist dyad, since parents/caregivers are a third and equally important part of the therapeutic system. These relationships work in a triadic way, as each relationship influences the other two (Gvion & Bar, 2014). Relationships between parents and the child's therapist have been scarcely studied, even though the alliance with parents in child therapy has been associated with adherence (Hawley & Weisz, 2005), outcomes (DeVet et al., 2003; Marker et al., 2013) and with the child's therapeutic change (Karver et al., 2018).

When research focuses on child therapy relationships, the tendency has been to use instruments based on Bordin's (1979) therapeutic alliance model, adapted for this population (Clark, 2013). The alliance construct proposed by Bordin (1979) was conceived from psychotherapy developed with adults as a helping relationship that emphasises the patients' collaborative role (Horvath, 1994) and the adjustment of this concept in child psychotherapy may not be entirely accurate (Shirk & Karver, 2011). The possible low initial engagement of children in psychotherapy may affect their conscious collaboration in the process and the agreement on goals and tasks (Baylis et al., 2011; Shirk & Karver, 2011).

Considering the conceptual breach of the therapeutic alliance model in child psychotherapy, revisiting the therapeutic relationship concept seems necessary. A broad definition of the therapeutic relationship is the feelings and attitudes that therapists and clients experience for each other and the way they are expressed (Gelso, 2014). Although this definition seems appropriate for child psychotherapy, it shares one limitation with the therapeutic alliance concept: it does not contain the influence of parents or caregivers.

In the exploration of the role of the therapeutic relationship in the therapeutic process, scarce research has focused on understanding how the relational dimension is experienced by the main psychotherapy actors (Altimir et al., 2017; Bedi et al., 2005). In the case of child psychotherapy research, children provide valuable information regarding their therapies and their process of change (Alamo, 2019; Capella et al., 2016; Carlberg et al., 2009). In this direction, several authors propose that to favour children's expression it is essential to integrate

developmental-sensitive methodologies, such as play and drawings (Alamo, 2019; Capella et al., 2016, 2018; Carlberg et al., 2009; Midgley, 2004).

Child psychotherapy research that incorporates the participants' perspectives of the psychotherapeutic process considering as participants the children, the parents and the therapists is of recent development (Alamo, 2019; Gómez, 2006). Moreover, few qualitative studies that include the point of view of children have been conducted (Carlberg et al., 2009; Midgley, 2004). Research of the experiences of children who participate in psychotherapy has found that they underscore the therapeutic relationship as a central aspect of the therapeutic process (Alamo, 2019; Areas et al., 2020; Capella et al., 2015; Carlberg et al., 2009; Carroll 2002). Despite these findings, limited research has focused on the development of the therapeutic relationship in children under 11 years old (Noyce & Simpson, 2018) and no qualitative study has focused on the therapeutic relationship in child psychotherapy.

As mentioned previously, school-age children (Papalia & Martorell, 2015) represent a critical group in need of mental health services (Vicente et al., 2016). However, they have received less attention in terms of research into the nature of the therapeutic process (Kennedy & Midgley, 2007), entailing a critical problem in understanding *how* and *why* psychotherapy helps children to change. The therapeutic relationship has evidenced a central role in the change processes of children, and the crucial role of parents or caregivers has been underlined for child psychotherapy to work. Yet, the multiple perspectives of children, parents/caregivers, and therapists of the therapeutic relationship and the change processes have been less explored and seem crucial to understanding child psychotherapy.

The central question addressed in this doctoral thesis is *how the therapeutic relationship with children and parents/caregivers develops and facilitates change in child psychotherapy, according to the perspectives of children, parents and therapists*. To address this question, two consecutive studies were designed; the first to achieve a general comprehension of the phenomena under investigation - the therapeutic relationship -, and the second, to obtain a procedural view of the same. Qualitative and quantitative data were collected; however, this doctoral dissertation sustains most of its results on qualitative analysis of semi-structured interviews and drawings to grasp a comprehensive approach that focuses on first-hand information about the experience of main psychotherapy actors (Altimir et al., 2010).

Qualitative research seems to be a better fitted methodology for developing and modifying the rich theory grounded on data (Elliott, 2010). In this context, grounded theory methods were employed, which is fundamentally a naturalistic method, targeted to capture social life complexities as they take place (Rustin, 2016). Drawings were added as a data collection technique to incorporate children as informers of their therapeutic experience, and to support and expand their expression.

The first study was developed in the framework of a larger research project, titled "Success and failure experiences in psychotherapy - Construction of a comprehensive multidimensional model", led by Professor Mariane Krause from the Pontifical Catholic University of Chile. This project was conducted in Santiago, Chile, and was financed by the Chilean Government through the National Science and Technology Development Fund (FONDECYT). Participation agreements were established with 6 mental health centres of public, private and university settings. This study comprised diverse consultation groups: adults, adolescents and children with different disorders or difficulties (N=102).

Within this larger project, the first study of this thesis followed up on the experience of the therapeutic relationship of children between 6 and 10 years old, their parents and therapists, who participated in 12 psychotherapy processes (N=36). This study discusses the therapeutic relationship with school-age children, exploring how this relationship forms, develops and impacts the therapeutic process. It describes the components of the therapeutic relationship (Specific Aim 1) and the evolution of this relationship throughout psychotherapy (Specific Aim 2). It also analyses the therapeutic relationship elements that are associated as facilitators or obstacles for its formation and therapeutic change (Specific Aim 3) and the main convergences and divergences between children, parents, and therapists regarding these elements (Specific Aim 4). The principal product of the first study included in this thesis was the paper titled “Therapeutic relationship in child psychotherapy: integrating the perspectives of children, parents and therapists”, published in January 2021 in the *Journal of Psychotherapy Research* (Núñez et al., 2021), whose first author was Lucía Núñez and was co-authored by Nick Midgley, Claudia Capella, Nicolle Alamo, Rose Mortimer and Mariane Krause.

The second study was conducted independently within this doctoral dissertation and incorporated the children, parents and therapists of 27 psychotherapy processes (N=74). This

study aimed at understanding the role of the therapeutic relationship with children and parents in the therapeutic change processes in different moments of psychotherapy. A mixed-method design was proposed, considering repeated quantitative and qualitative measures from the beginning to the end of psychotherapy. For the quantitative measures, the Strengths and Difficulties Questionnaire ([SDQ], Goodman, 1999) validated in Chile (Brown, 2012), the Therapeutic Alliance Scale for Children-revised ([TASC-r], Shirk & Saiz, 1992) and the Therapeutic Alliance Scale for Parents or Caregivers ([TASCP], Accurso et al., 2013) were employed. The two alliance scales were adapted within this dissertation for the Chilean population. This process implied that both scales were translated from English to Spanish and then back translated, generating a pilot version evaluated by expert reviewers. Subsequently, cognitive interviews were conducted with children, parents and therapists that did not participate in the study, producing final adapted. Four master's students in Clinical Psychology of the Pontifical Catholic University of Chile and a psychology undergraduate student at the University of Chile developed their dissertations within this study. A research team was generated with the masters' students, their supervisor and their committee professor.

Although repeated measures were considered in the initial design of this second study, it was limited in this regard, as only an initial and middle point of the therapeutic process were reported, and not the further phases of psychotherapy. This limitation derived in the first place from the social outburst that occurred in Chile in October of 2019, which implied the suspension of regular activities for months. Following this conflict, face-to-face psychotherapy was interrupted due to COVID-19 pandemic restrictions implemented in March 2020. These limitations implied design modifications and fewer participants than considered in the original study, so that the results are focused on data collected in the initial and middle phase of therapy.

The first product of this second study was the paper "Initial therapeutic alliance, clinical and demographic variables: an analysis from the perspectives of children, parents and therapists". This paper was submitted to *Revista Terapia Psicológica* (October 30, 2020) and is currently under revision. This quantitative study focuses on the relationship between the initial child-therapist and parent-therapist alliance and the children's age, sex, symptoms and the therapists' experience in 27 child-parent-therapist triads (N=74). It describes the therapeutic alliance at the beginning of psychotherapy (Specific Aim 2) and the main convergences and divergences between children, parents and therapists regarding the initial therapeutic alliance

(Specific Aim 4). The authors of this paper are Josefa Goic, Marcia Olhaberry, Constanza García, Carla Horta, Lucía Núñez (corresponding author) and Catalina Álvarez. The corresponding author, who was responsible for the design of this study, also revised and discussed the whole manuscript, and prepared the discussion and conclusion sections.

The second product of study 2 was the paper "The therapeutic relationship and change process in child psychotherapy: A qualitative, longitudinal study of the views of children, parents and therapists". This study focused on the child-therapist and parent-therapist relationship as change facilitators throughout psychotherapy, from the perspective of children, their parents, and their therapists. The subjective experiences of 5 child-parent-therapist triads (N=15) were explored at the beginning and after four months of psychotherapy through semi-structured interviews and drawings in the case of children (30 interviews). This work examined the main convergences, divergences and the critical elements among their views. It described the evolution of this relationship throughout psychotherapy (Specific Aim 2), analysed the elements of the therapeutic relationship with children and parents that are associated as facilitators or obstacles of therapeutic change (Specific Aim 3), and the main convergences and divergences between children, parents and therapists regarding these elements (Specific Aim 4). This paper was submitted June 18, 2021, to the special issue in research in child and adolescent psychotherapy of the *Journal of Research in Psychotherapy: Psychopathology, Process and Outcome (RIPPPO)*. The first author of this work is Lucía Núñez, and the co-authors are Sofía Fernández, Nicolle Alamo, Nick Migdley, Claudia Capella and Mariane Krause.

Another relevant products of this doctoral thesis were the book chapter "The therapeutic alliance in the child and adolescent practice", authored by Lucía Núñez & Juan Martín Gómez-Penedo (2019), published in the Handbook of psychotherapy and psychopathology in children and adolescents (Genise et al., 2019). And the book chapter "Drawings as a technique for research in child psychotherapy: a qualitative analysis proposal" authored by Nicolle Alamo, Lucía Núñez, Barbara Bräutigam & Mariane Krause, currently in press in the book *Anthology of children's drawings - approaches, potentials, limits* (Kekeritz & Kubandt, 2021).

The principal theoretical and empirical background of the developed studies are further detailed in the sections that follow.

## 2.1. The relational dimension in psychotherapy

### *2.1.1. The therapeutic relationship and alliance: conceptual background*

Historically, the therapeutic relationship has played a central role in the theories of the therapeutic process (Horvath, 2005). The importance of understanding the relationship between patient and therapist as a critical dimension of the therapeutic process goes back to Freud's work and has largely influenced the practice of psychotherapy (Clark, 2013).

Horvath (2000, 2018) reviews the development of the therapeutic relationship concept within psychoanalytic, cognitive-behavioural, and existential-humanistic frameworks, stating that it was Freud who advanced the idea that a good attachment between patient and analyst favoured a positive transference towards the analyst, investing the analyst with the authority and qualities of past significant relationships, and allowing patients to validate the analyst's interpretations. A good therapeutic alliance was required for the patient's initial trust and security in analysis; yet this alliance was based on the projection of past relationships, therefore it was not viewed as a real relationship since it should dissolve once successful interpretations of transference were addressed through analysis. According to Horvath (2000) Freud did not focus on the therapeutic alliance beyond transference; this task was undertaken by later psychoanalytic authors (i.e., Greenson, 1965), who considered that in addition to positive transference, a reality-based attachment component of the therapeutic relationship was present from the start, and the patient moved from one relational position to other through the therapeutic process. Horvath (2000) denoted that the further development of psychodynamic therapy went beyond the projective basis of analysis, as the reality-oriented elements of therapy, such as the social context, the real relationships and experiences, were underscored.

Revising the behaviour therapy framework, Horvath (2000) describes that this theoretical orientation emphasized the role of techniques over the relational aspects of treatment. The role of the therapist was to educate the patients in the acquisition of skills to change their problematic or maladaptive behaviours. This approach implied for the therapist a more distant role and a less involved therapeutic relationship. A positive therapeutic relationship from this perspective was understood as the result of the effectiveness of the therapist in helping patients

to overcome their problematic issues. Horvath (2018) notes that further developments of this theoretical orientation by cognitive behavioural therapists, incorporated a positive therapeutic relationship as a facilitating factor, as it created a trustful and safe environment that enabled clients to better accept the therapist's interventions and display a higher compliance towards therapy. Cognitive approaches also widened the behaviour therapy conception of the therapeutic relationship, understanding that a positive therapeutic relationship is a necessary element for the efficacy of therapeutic interventions (Horvath, 2000).

Carl Rogers's (1951) client-centred therapy framework located the therapeutic relationship in a qualitative different place than psychoanalysis and behavioural therapy, as Rogers stated that the helping relationship is more than a technique, encompassing a positive and healing function by itself (Horvath, 2000). This framework postulated that specific relational conditions offered by the therapist's -empathy, congruence, and unconditional positive regard- enabled the client's innate healing process to develop. From this approach, the therapeutic relationship accounts for therapy effectiveness and the responsibility of providing these conditions belong to the therapist; the client's collaboration and responsiveness are less discussed. Horvath (2000) notes that Rogers postulated that the therapist-offered conditions are transtheoretical and have equal relevance, regardless the specific used techniques. But as research in this matter developed, an interesting feature that emerged was that the client's subjective valuation of the therapeutic relationship had a higher influence in outcome than the therapist actual attitude. This finding stressed the importance of including the patient's contributing elements to the therapeutic relationship.

According to Horvath (2018), each one of these theoretical approaches nurtured the basic framework for the therapeutic relationship concept, but also presented contradictory views of the concept, which generated divisions in the research on the therapeutic relationship giving the researchers' theoretical background.

As psychotherapy research evolved, and the study of the effectiveness of psychotherapy gained relevance, the need for a comprehensive, pan-theoretical, and operational definition of the therapeutic relationship grew (Horvath, 2000). In this context, Luborsky (1976) and Bordin (1979) provide a reconceptualization of the relational aspects of therapy through the therapeutic alliance concept (Horvath, 2000; Krause et al. 2011). Luborsky (1976) extends the concept

beyond its psychodynamic roots, emphasizing the collaborative relational elements at the core of all helping contexts. Within this notion, Bordin (1979) introduces the working alliance model as a conceptual frame for relational aspects of therapy; his construct of the therapeutic alliance is guided by four basic assumptions: a) the therapeutic alliance plays a fundamental role for all psychotherapeutic schools, differing primarily by the type of alliance they require; b) the effectiveness of therapy derives significantly from the strength of the alliance; c) different approaches to psychotherapy are distinguished based on the demands they make on patient and therapist; d) the strength of the therapeutic alliance arises as a function of the particular match between the specific demands of the alliance and the personal characteristics of patients and therapists (Baylis et al., 2011; Núñez & Gómez-Penedo, 2019).

Bordin's (1979) model of the therapeutic alliance rephrases three main elements of the therapeutic relationship: agreement in goals and in tasks, and the therapeutic bond. The agreement on the therapeutic goals between patient and therapist implies they safeguard the achievement of therapy goals; the consensus on the tasks between patient and therapist mean they assume the responsibility for the tasks performed, and the affective bond between patient and therapist encompasses the complex network of positive personal attachment between both members of the dyad, including elements such as mutual trust, acceptance and confidentiality (Horvath, 1994). In Bordin's (1979) model, the quality of the alliance derives from the patient's and therapist's capacity to collaborate in the therapeutic tasks and goals and the quality of their bond. Some authors state that Bordin's definition highlights the alliance as an active ingredient of change in psychotherapy, emphasising that the dynamic negotiation process in the formation and maintenance of the alliance makes it healing in itself (Safran, & Muran, 2006).

It has been noticed that the pan-theoretical concept of the therapeutic alliance seems to transcend the difference between the technical and the relational aspects of therapy (Krause et al., 2011). However, the therapeutic alliance may acquire different emphases according to the techniques developed within specific theoretical frameworks of therapy (Horvath, 2000), undermining the pan-theoretical feature of Bordin's definition. In this sense, Horvath (2000) concludes that the relationship elements of early phases of different forms of therapy are more similar than in later phases of therapy, as the therapeutic tasks used within each framework, the extension of therapy and the degree of specificity of the desired outcome may impact how the relationship develops.

Although there is currently no consensus on the most appropriate definition of the alliance, many researchers within various therapeutic schools have adopted Bordin's (1979) pan-theoretical, acute definition (Horvath, 2018; Safran & Muran, 2006) to study the relationship between alliance and outcome (Baldwin et al., 2007). However, it has been noted that Bordin (1979) avoided an essential theoretical problem in his model, by not addressing how consciously or unconsciously transferential is the collaborative process (Horvath, 2000).

Nevertheless, the therapeutic alliance model described above has faced some critiques (Núñez & Gómez-Penedo, 2019). First, the expanded embrace of Bordin's (1979) model to study the therapeutic alliance has represented some significant limitations, as this model emphasizes the role of conscious or rational collaboration, underestimating the influence of unconscious factors in therapists and patients, affecting the research field solely based on this model (Safran & Muran, 2006). Second, Bordin's conceptual definition of the therapeutic alliance brought the distinction between the relationship and strategies or interventions to a vaguer point, in particular in regard to the bond component, but also in the agreements on tasks and goals, as they are defined as relational accomplishments, but their building and maintenance are interpreted as central interventions (Horvath, 2018). Thirdly, the focus on tasks, goals, and bond narrows the exploration of the alliance on issues that are most often related with the early phases of therapy and may obtain lesser prominence in the further development of the therapeutic process (Horvath, 2018). Moreover, Horvath (2006) adds as a critique to the research field the treatment of the alliance concept as a stable phenomenon, overlooking the fact that the therapeutic relationship evolves over time. In this direction, the meta-analysis developed by Flückiger et al., (2018) concluded that when the alliance is measured late in therapy it has a stronger association with outcome than when assessed in the initial or middle phases. Hence, the evolution of the alliance throughout the treatment (Roussos et al., 2016) and a more dynamic understanding of the previous aspects of patients and therapists that influence the relational encounter have been underscored (Gómez et al., 2018).

The use of Bordin's therapeutic alliance concept as an operationalized substitute of the therapeutic relationship has been questioned also by leading researchers in the field (Gelso, 2019; Horvath, 2005). At this point, it is interesting to note that some authors have further developed the therapeutic relationship concept (e.g., Gelso, 2014). However, the therapeutic relationship concept also exhibits definition discrepancies and seems to depend on the

theoretical background of the researcher conducting the study (Kennedy & Midgley, 2007). In general terms, the therapeutic relationship definition contains the therapeutic alliance, emphasizing the inclusion of the affective quality of the relationship, plus other relevant elements of the relational dimension (DeVet et al., 2003; Gelso, 2019).

Gelso (2014) proposes an accurate and theoretically neutral definition of the therapeutic relationship (Norcross, 2011). He initially outlines the therapeutic relationship as: *the feelings and attitudes that therapists and clients experience for each other, and the way they are expressed* (Gelso & Carter, 1994). Later, Gelso (2019) extends the definition of the therapeutic relationship as: *"a function of the feelings, attitudes, and behaviour that both the patient and the therapist carry with them into the work and then experience with and enact toward each other during the therapy sessions, and even outside of sessions"* (p.1); this definition is delineated in terms of the patient's and therapist's inner experience and behaviour with each other. This definition includes the real relationship, the working alliance, and transferential and countertransferential components, organized in a tripartite model (Gelso, 2014).

The real relationship entails how patient and therapist feel and connect to each other, and it works as the foundation of the therapeutic relationship upon which the therapeutic work develops. It refers to the personal relationship, defined by the degree by which patient and therapist are genuine with each other and perceive each other in an accurate and fitting manner. The real relationship composes two core qualities: genuineness, as the quality of being real, non-phoney with the other, and realism, which denotes perceiving the other in ways that fit the other, and not through projections based on personal issues (Gelso, 2019).

The working alliance is the dimension of the therapeutic relationship that directly addresses the work connection between patient and therapist. It is defined as the union of the patient's reasonable self with the therapist analysing self for the purpose of psychotherapy work. Therapists contribute to the working alliance by displaying a caring and understanding stance towards the patient's issues, showing an available attitude and presenting the therapeutic skills required to help the patient. On the other hand, the patient contributes by trusting the therapist skills and caring attitude and is willing to forge a more intimate work relationship (Gelso, 2019). The alliance tends to be strong from the initial phases of therapy; however, it develops in a non-linear path, evidencing stronger and weaker moments, that at more advanced phases of therapy

generates a stronger working alliance, so that to foster this positive evolution is one of the therapists' central tasks (Gelso, 2019).

Concerning the transference and countertransference component, Gelso (2019) states that transference is the experience and perceptions of patients of the therapist, which is shaped by the patient's psychological structure and past significant relationships. For this author, transference is present in all therapeutic orientations, but develops differently according to the specific orientation, being particularly relevant in psychodynamic therapy. From an integrative conception, countertransference is understood as the therapist's internal or explicit response to the patient, that is shaped by the unresolved past or current emotional conflicts or susceptibilities of the therapist. According to Gelso (2019), not all the therapist's reactions constitute countertransferential issues, and some belong to different dimensions of reactions.

The components of the therapeutic relationship are interrelated and present from the beginning of the therapeutic process, and even before, in patient's and therapist's fantasies about each other. The therapist theoretical orientation impacts how these elements manifest and develop during treatment and should be attended within all therapy orientations to favour successful processes (Gelso, 2014). Within this definition, Gelso (2019) places emphasis on the tension between technical and relational aspects of psychotherapy, as they are interrelated and show mutual influence during the process. He outlines that therapist techniques generally stem from the therapist theoretical orientation and are expressed as the operations utilized to advance in treatment and favour change. The quality of the therapeutic relationship impacts the techniques used by the therapist and vice versa. Regardless, the therapeutic relationship is not the same as treatment and techniques but relates to process and outcome directly (Gelso, 2014). Although Gelso's definition intends to be applicable to different therapy orientations, it extends earlier psychodynamic models of the relationship, specifically the transference and countertransference elements of the tripartite model (Horvath, 2018).

In Gelso's (2019) model, the author stresses that in brief or in more extensive therapy the therapeutic relationship may be expressed differently. He also discusses that the therapeutic relationship goes beyond the therapist's contribution, frequently conceived as the therapists-offered conditions described by Rogers (1951), as this relationship is a two-person phenomenon in individual psychotherapy.

Studies of the therapeutic relationship and alliance are usually conducted within adult therapy, and the applicability of these results to child psychotherapy has been stressed, considering some differential aspects of child psychotherapy, such as developmental features and the inclusion of parents or caregivers in the process (Shirk & Karver, 2011). The examination of these particularities and their implications for psychotherapy research are addressed in the following section.

### *2.1.2. The therapeutic relationship in child psychotherapy*

#### *2.1.2.1. Theoretical basis of the therapeutic relationship in child psychotherapy*

Within the theoretical basis of the therapeutic relationship in child psychotherapy, two foundational contributions stand out and have largely impacted child psychotherapy training and practice (Shirk & Karver, 2011).

The first contribution emerges from child psychoanalysis, initially from Anna Freud's (1946) work, who points out that an affective attachment between the child and the therapist is a prerequisite for all subsequent therapeutic work, as this connection allows the child to work intentionally on the therapeutic tasks. From this perspective, the bond is viewed as a path, a precondition, for elaborative therapeutic work (Shirk & Russell, 1996; Shirk & Karver, 2011). Anna Freud considered the evolution of the therapeutic relationship and the resolution of transference as significant changes, which should be taken into account for the positive effects of psychotherapy (Alamo, 2019). David Winnicott (1971) underlined the therapeutic bond as a reparative experience, that allowed children to obtain a basic feeling of trust and, from there, to deploy their creativity and continue their development (Alamo, 2019).

The second central conceptual contribution to the therapeutic relationship in child psychotherapy stems from Virginia Axline's (1957) child-centred play therapy model (Shirk & Karver, 2011). Axline (1957) emphasizes the healing nature of the therapeutic relationship, where the child's experience with a supportive, attuned, and non-judgmental therapist is conceived as a pivot for therapeutic change. From this perspective, the therapeutic relationship is conceived as healing by itself, in the same direction formulated by Rogers's (1951) regarding adult psychotherapy. Alamo (2019) notes that further developments of the humanistic-gestalt

approach (i.e., Violet Oaklander, 2006), emphasized the relationship between the child and the therapist in achieving and generating change; through an active role in this relationship, children will get to know, explore and experience themselves in the relationship with others, being able to connect with the present moment, promoting changes in themselves.

The development of family-systemic therapy also contributed to the understanding of the therapeutic relationship when working with children but in a different way; the responsibility for change is in the family system and not on the therapist-patient relationship, since changes in the family interactions are precursors of the child's change (Alamo, 2019).

An important contribution for understanding the relational aspects of child psychotherapy emerges from attachment theory and mentalization based treatment. Attachment between the primary caregiver and the child is essential (Fonagy et al., 2002), since in the context of early attachment relationships, children develop characteristic ways of relating to their inner and outer world (Duquette, 2010). In this direction, the significant other provides schemes in the management of distress and interaction; by integrating these attachment styles, internal self-regulation models are created in the child (Schore & Schore, 2007).

Mentalization is defined as a form of imaginative mental activity, based on the perception and interpretation of human behaviour, in terms of intentional mental states (Fonagy et al., 2002). This ability allows to efficiently interpret actions in a wide span of situations and is strongly influenced by early experiences and genetic load. It involves self-reflection and interpersonal components (Fonagy & Allison, 2012), that combined provide the child with the ability to differentiate internal from external reality, specifically delimiting internal mental and emotional processes from interpersonal nature communications. In this way, understanding the self, as a mental agent, arises from the interpersonal experience, particularly from primary object relations (Fonagy et al., 2002). Attachment supports mentalization, and the parental function is fundamental for this process, where a secure relationship offers the possibility of exploring the adult's mind (Fonagy & Allison, 2012).

Mentalization can be seen as one of the common factors in different psychotherapy models, since psychotherapy opens the potential to recreate an interactional matrix where mentalization develops and grows (Fonagy & Allison, 2012). What brings closer the different approaches to the concept of mentalization is the commitment to the subjective understanding

of the relational context, recognizing the importance of having 'the mind of the child in mind' (Midgley & Vrouva, 2012).

In the context of psychotherapy, the attachment relationship between patient and therapist is decisive, as the therapist acts as an interactive regulator of the patient's psychobiological states (Schore & Schore, 2007). From the attachment theory perspective, in a meaningful therapeutic relationship the therapist undertakes the role of an attachment figure or secure base, in a concrete and symbolic way. The therapist containing presence, regularity, predictability and warmth, provides the needed security to explore the patient inner and relational world (Holmes, 2015). The therapeutic relationship draws a bridge between the patient's inner and external world, where the presence of a consistent and genuine therapist creates a representation of himself in the patient's inner world, staying also as an external different entity (Duquette, 2010).

Similar to primary attachment relationships, a therapeutic relationship that favours affective bonding can become part of the child's internalized relational resources. The relational plot of therapy opens the possibility for the patient to experience new intersubjective contexts, which are characterized by a therapist who is simultaneously thinking and containing the child (Holmes, 2015). Moreover, psychotherapy provides an opportunity for the child's own expression in a warm and secure place, but also offers the possibility to forge a new object relationship, where the therapeutic relationship offers a healing experience that is not always conscious or visible. Mirroring affects, together with objective and effective interpersonal relationships, aid the child to be known and the opportunity to know the other too, as an independent person with his own will and feelings (Spitz, 2007).

Each individual has an impact in the meeting with the other, and just as the therapist can influence the relational matrix of the child, the patient also affects the therapist. The therapist, as an adult figure, has the possibility of modulating that emotional impact, being able to metabolize and return a processed relational offer. In this way, empathy regulates this encounter, based on the ability to anticipate the needs of the other (Holmes, 2015). In psychotherapy, the therapist's ability to recognize himself and the child as mindful, mutually influential subjects, whose mental states underlie behaviour, is a fundamental aspect in the construction of the therapeutic bond (Fonagy, et al., 2002). From this approach, it is expected that through

psychotherapy the child develops the ability to recognise, cope and regulate emotions, attune with others, and understand complex social interactions (Midgley et al., 2017).

Fonagy & Allison (2014) underline the social dimension of mentalization within the therapeutic relationship as key to open patients to the social knowledge that may change the perception of themselves and their environment. Mentalizing in therapy may restore the patients *epistemic trust*, the belief in the authenticity and relevance of information transmitted interpersonally, favouring their ability for social understanding. In this sense, therapeutic change is based on the capacity of the therapeutic relationship to create a potential for learning about oneself and others in the world outside of therapy.

Mentalization-based treatment with children incorporates the work with parents as a fundamental part of the treatment, focusing on the parental reflective stance. Interventions with parents pursue to develop or regain the ability in parents to look at the child's experience in a more holistic way, beyond the child's behaviour, favouring in parents the awareness of their affections and behaviour, especially during conflicts with their children, and encouraging parent-child interaction, where the child feels secure and contained; thus, facilitating self-regulation, self-knowledge and mentalization in children (Midgley et al., 2017). Interventions with parents can be an opportunity to support their capacity for mentalization, specifically through the development of greater sensitivity and parental reflexive function (Campbell & Simmonds, 2011). This approach relieves parents of ineffectiveness, anger and guilt feelings, allowing them to perceive that they can have a powerful, intuitive and empathic parental function (Sorensen, 2005).

The following sub-sections address the central conceptual considerations and empirical findings of the alliance research in child psychotherapy, and the principal concepts and research of the parent-therapist and parent-child-therapist relationship.

#### *2.1.2.2. The therapeutic alliance in child psychotherapy*

The relational aspects of child psychotherapy have been frequently studied through instruments based on the therapeutic alliance concept (Clark, 2013) and from the report of adults (therapist, parents) rather than children (Noyce & Simpson, 2018).

Research on the therapeutic alliance in child psychotherapy is largely underdeveloped compared with adult psychotherapy studies (Elvins & Green, 2008; Kazdin & McWhinney, 2018; Shirk & Karver, 2011). As with adults, the therapeutic alliance has shown to be a significant predictor of outcomes in psychotherapy with children and adolescents (Karver et al., 2018; Shirk & Karver, 2011). In synthesis, a positive therapeutic alliance has been associated with symptomatic improvements in children (Hawley & Weisz, 2005; Liber et al., 2010), greater motivation in patients to actively address their problems (Hawley & Weisz, 2005) and positive outcomes in the treatment of different disorders (Karver et al., 2018). As this alliance grows, more and various therapeutic changes have been observed (Karver et al., 2006).

The meta-analysis done by Shirk & Karver's (2011) on the association between the therapeutic alliance and outcomes in individual therapy with children and adolescents included sixteen studies, of which only four assessed the alliance with children and one within a mixed-age group. In agreement with Kazdin et al. (2006), they found a positive correlation between alliance and outcome (.22) with a 95% confidence interval. This value is similar to that obtained with adult population (Flückiger et al., 2018). These results reinforced the idea that the alliance is a significant predictor of therapeutic outcome in child and adolescent psychotherapy, within diverse child and adolescent therapeutic orientations. These authors highlighted that the alliance with children and adolescents and their parents were predictors of therapeutic outcome; thus, therapists must attend to these multiple alliances, and not only with the patient (Shirk & Karver, 2011).

Campbell & Simmonds (2011) studied the therapists' perspectives of the therapeutic alliance with children and adolescents, using a mixed methodological design. Their results indicate that within the components of the therapeutic alliance, the therapeutic bond was the most underlined aspect (68%), followed by the agreement in therapeutic goals (25%) and tasks (19%). When evaluating their own contribution, 65% of the participating therapists considered the bond they established as the most important element, followed by their personal traits (20.6%). Regarding children's contribution to alliance, therapists viewed the child's contribution to rapport (27%) and attachment style (20.6%) as the most influential aspects. In addition, therapists felt more confident of their ability to establish a positive alliance with children aged 6-11 and reported a better alliance with this age group compared to others. As for the parents, parental support was evaluated as the most critical aspect by 41% of the

participants, followed by the parent's relationship with the child (19%). In conclusion, from the therapists' perspective, the bond dimension of the alliance was predominant and based principally on the therapist's contribution. The parents' commitment and support to therapy were also highlighted as essential aspects for developing a therapeutic alliance with children and adolescents; the quality of the therapist's alliance with the parents contributed to the quality of the alliance with the children and adolescents.

Several studies have focused on the alliance within specific symptomatic groups and therapeutic orientations. For example, Kazdin & Durbin (2012) examined the alliance with children, referred for behavioural problems, within cognitive-behavioural treatment. They found a positive correlation between the quality of the child-therapist alliance and the extent of therapeutic changes at the end of treatment, and that pre-treatment intellectual and social abilities in children associated with a better child-therapist alliance but did not mediate the alliance-change connection. Marker et al. (2013) studied the therapeutic alliance in children and adolescents with anxiety disorders within manual-based family treatment, including multiple perspectives (therapists, children, adolescents, and mothers). Their findings were consistent with previous studies, and according to the various informants, a reciprocal relationship was observed between the therapeutic alliance and the treatment response, with a reduction in anxious symptoms leading to a better therapeutic alliance and vice versa. The authors highlight that therapeutic alliance measurements with children and adolescents from the perspective of their parents are scarce, even though it may be an essential factor in optimising treatment continuity and engagement in treatment-related tasks at home. Halfon et al. (2019) focused on psychodynamic therapy with children with internalizing and externalizing symptoms, concluding that constructing a positive alliance with children with externalizing symptomatology was more difficult than with children with internalizing symptomatology (Halfon, et al., 2019). Later, Halfon (2021) focused on the effects of psychodynamic therapy and the therapeutic alliance in children with problem behaviours, reporting that an increased use of psychodynamic therapy in the context of a high therapeutic alliance predicted fewer problem behaviours, whereas a low therapeutic alliance was associated with more problem behaviours compared to the high therapeutic alliance group.

Some studies have focused on the predictive value of the initial therapeutic alliance in child psychotherapy adherence, and mixed results have been reported. On one hand, the initial

strength of the alliance with children and adolescents showed no predictive value on the premature termination of therapy (Abrisami & Warren, 2013), and on the other hand, a positive alliance with children and parents was associated with higher adherence and completion of therapy (Hawley & Weisz, 2005).

Karver et al. (2018) conducted a new meta-analysis, examining the correlation between alliance and outcome for child and adolescent therapy. It composed 28 studies, with the mean age of participants being 12.38 years (SD=3.10). They found the therapeutic alliance had a small to medium association with outcome, and this value varied depending on diagnosis, type of therapy, study design and treatment setting. Within their central results, they concluded that although the therapeutic alliance is a critical factor in explaining why children and adolescents have such variability in treatment outcomes, patient's factors, such as stronger interpersonal tools and positive pre-treatment relationships (e.g., supportive, secure attachment) also have a significant impact in the therapeutic process. Parent's participation and the parent-therapist relationship facilitated the engagement to therapy and decreased the resistance to treatment.

Evidence originated from the informed research has been very significant to support the association between alliance and outcome in child and adolescent therapy, where parental support and alliance with their child's therapist has been a common highlighted element. However, the reported studies tend to base their results on instruments that measure the alliance within Bordin's definition, and the applicability of this concept in child psychotherapy practice has been stressed by various authors (Accurso & Garland, 2015; Baylis et al., 2011; Green, 2006; Shirk & Karver, 2011).

In this context, in it important to note that the therapeutic alliance concept derives from the adult setting, as a product of a helping relation that emphasizes patients' collaborative role (Horvath, 1994). Collaboration in child psychotherapy may be present in a different way than in adult psychotherapy, basically because children rarely refer themselves to treatment (Halfon, 2021) and therefore, may be less collaborative in an instance that was not pursued by them (Shirk & Karver, 2011). Likewise, the agreement in tasks and goals, two core aspects of Bordin's (1979) therapeutic alliance definition, may express differently in child psychotherapy. Generally, parents, caregivers or the educational system are those who consider that treatment is necessary for the child, following their therapeutic goals regarding the child's issues. These

goals do not always converge with the child's point of view, who can differ or even not conceive the need for treatment as they may be unaware of their problems; therefore, children have no treatment goals (Accurso & Garland, 2015; Karver, 2018; Shirk et al., 2011). The agreement in tasks also follows a conscious implication in psychotherapy, and as argued, children may not agree in tasks if psychotherapy does not make sense to them. This feature can result in a low initial engagement of children in psychotherapy (Baylis et al., 2011, Shirk & Karver, 2011). Some authors have chosen to define the agreement in tasks according to the degree of participation of children in therapeutic activities, and not by the level of explicit agreement about these tasks, thus distancing this aspect from the conscious component of the agreement by focusing exclusively on the collaborative trait of the patient (Shirk & Karver, 2011).

In addition, childhood is an intense developmental period characterised by constant change and growth. This developmental aspect influences the nature of children's problems, their cognitive abilities, their emotional development and consequently, how they relate to the therapist and the treatment process (Baylis et al., 2011). Younger children may have a lower understanding of the need for treatment due to their developmental stage, and older children may disagree with their parents on both the nature of their problems and the need for treatment. The focus of treatment may be complex and different in within the family members. Therefore, the therapeutic alliance with children may be complex and variable and, thus, critical to the therapeutic outcome (Green, 2006).

The therapeutic bond is the aspect of Bordin's therapeutic alliance concept that emerges with a higher correspondence between different patient's ages (Shirk & Karver, 2011) and current perspectives in child psychotherapy emphasize the emotional connection between patient and therapist. However, this bonding element transcends the child-therapist relationship, as the therapist must establish multiple alliances: at least with the child and with the parents (Green, 2006; Shirk & Karver, 2011). When discussing the therapeutic alliance with children, it is also necessary to consider the alliance with the parents, which affects the commitment to therapy and can support or undermine treatment, and thus it is associated with therapeutic change and adherence to treatment (Kazdin et al., 2006).

#### *2.1.2.3. The parent-child-therapist relationships in child psychotherapy*

The relational dimension of parents in their child's psychotherapy encompasses two central notions: first, the parent-therapist relationship is key for child psychotherapy process and change (Kazdin et al., 2018), and second, the child-parent-therapist is an interconnected triadic relationship in child psychotherapy (Gvion & Bar, 2014).

Gvion & Bar (2014) state that the inclusion of parents in child psychotherapy may be conducted in different ways, such as parent-child dyadic interventions, parallel therapy for the child and the parents, or the simultaneous treatment of children and parents by the same therapist. Within this last framework, three connections are actively involved: parent-child, child-therapist and parent-therapist. Children, parents and therapists observe the connection between the others. In this context, parents must authorize the child-therapist relationship, the therapist has to acknowledge the connection and history between the child and the parents, and the child needs to recognize the parent-therapist link. Parents may develop intense positive and negative emotions towards their child's therapist, as the therapist implicates in the family system. Feelings of exclusion may emerge in parents, as they are left out of the child's therapy sessions, and parents are required to trust their child to the therapist. This exclusion also allows children to express their inner world in a richer way. Parents provide information about the child's environment to the therapist, impacting the therapist's interpretation of the child's fantasy. At the end, parents are a fundamental part for the child's therapeutic changes.

Concerning these multiple connections, the study conducted by Devet et al. (2003) reviewed the therapeutic relationship from the perspectives of mothers and their children in therapy. Among their findings, the bond between mother and child was a predictor of the therapeutic alliance; thus, the child's well-being associated positively with the therapeutic relationship. Also, the effectiveness of therapy and the mothers' support in the process was positively associated with the therapist-child relationship. Therefore, children who have conflicts with their mothers had more difficulties establishing a solid therapeutic alliance, underscoring parental influence in shaping the therapeutic alliance of children.

Scarce studies have focused on the parent-therapist alliance in child psychotherapy (Kazdin & McWhinney, 2018). Research that examines this relationship usually adopts measures based on the therapeutic alliance concept, and some name this relationship as 'parental

alliance' (Shirk & Karver, 2011). Some studies have addressed only the parent-therapist alliance and others both the therapist's parallel relationship with the child and the parents or caregivers.

Parental alliance has shown an association with treatment commitment and maintenance and out session support, affecting the child's treatment outcome (Kazdin et al., 2006; Marker et al., 2013). Positive parental alliance has been associated with better parental skills and improved family interactions (Shirk & Karver, 2011) and when combined with a firm commitment to the child's therapy, it influences the quality of the therapeutic alliance with the child (Campbell & Simmonds, 2011; Kazdin et al., 2006).

Hawley & Wiesz (2005) studied the therapeutic alliance with children and adolescent and their parents and therapy retention, satisfaction, and symptom improvement. As part of their results, they found that the parent-therapist alliance was significantly related to therapy retention (higher family participation, less cancellations and no-shows, and therapist concurrence with termination); however, youth-therapist alliance did not associate significantly to therapy retention. Of note, they also found that youth–therapist alliance associated with a larger reduction in the severity of symptoms and not with parent-therapist alliance. These authors discus their findings in terms of the parent's role in child and adolescent therapy, noting that the parent–therapist relationship seems important for attendance, since parents are responsible for the transport to the appointments and may determine when to stop going to therapy, but concluded that a strong alliance with children and adolescents is vital for shaping their motivation to work and comply on therapeutic tasks.

The association between therapeutic alliance and outcomes in child and adolescent individual and family therapy from the perspective of therapists, parents, children, and adolescents was also studied by Kazdin et al. (2006). They noted that the child or adolescent therapeutic alliance and the parents-therapist alliance was related to change, the better the quality of these multiple alliances, the greater the changes in children and adolescents. Specifically, the therapist-parent alliance was associated with improvements in parenting skills and family interactions. The child, adolescent and parent assessment of the alliance tended to produce more consistent findings than valuations made by the therapist.

In the research developed by Accurso & Garland (2015), the temporal stability and degree of agreement between the therapeutic alliance with children and adolescents and with

caregivers was studied, as well as the demographic baseline and clinical predictors of an increased alliance and the different alliance trajectories over time. They collected longitudinal data from children, caregivers, and therapists within the context of therapy. The chief findings were that children and caregivers perceived a stronger and more stable alliance with their therapists, while therapists underestimated the extent to which families feel connected to them and tended to score lower the alliance than children, adolescents and caregivers. Within the children's and adolescents' factors, a more significant increase in the alliance with girls and patients with anxiety disorders was observed. Finally, caregivers reported a stronger alliance with less experienced therapists than with more experienced ones, which the authors discuss in terms of the burnout of therapists with more experience and the enthusiasm to create new therapeutic alliances in those with less experience.

The evolution of the therapeutic alliance with children and parents in cognitive-behavioural trauma focused therapy, from the perspectives of children, parents and therapists, was studied by Zorzella et al. (2017). They found that children's and therapist's ratings of the alliance were initially positive and significantly increased through therapy. Parent's initial ratings were also positive and remained stable across therapy. For the authors these findings are crucial in the context of child trauma-focused therapy, as past traumatic experience may negatively impact a child's ability to trust in others and feel safe, and results of this study evidenced the contrary. Moreover, these authors underscore that the significant positive increase in the therapeutic alliance from the perspectives of children and therapists supports the use of trauma-focused techniques.

Kazdin & McWhinney (2018) studied the parent-therapist alliance, the treatment barriers and the outcome in an intervention for oppositional, aggressive and antisocial behaviour of their children, focusing on parents as the central clients. Within their main findings, both parents' and therapists' ratings supported that the therapeutic alliance and the parents' lower perception of barriers to participation in treatment were related to better outcomes for parents. They also found that parents who presented pre-treatment variables, such as stronger interpersonal relationships, less stress, and better quality of life, formed better therapeutic alliances and perceived treatment to encompass fewer barriers.

The findings from the reported studies evidence the relevance of both child-therapist and parent-therapist relationships in child psychotherapy. Yet, few studies have addressed jointly the child-therapist and the parent-therapist relationship as a triadic setting and have focused even less on their mutual influence in the change processes in child psychotherapy. A multiple perspective approach in child psychotherapy research seems adequate to encompass the complexity of this therapeutic system (Alamo, 2019; Núñez et al., 2021).

## 2.2. Change processes in psychotherapy from the perspectives of participants

### *2.2.1. Subjective change in psychotherapy*

The evaluation of therapeutic change and how change is characterized, has been a central concern for psychotherapy research (Olivera et al., 2013). Change, which can be understood broadly as the growth in patients during treatment, has been studied through outcomes or symptom improvement within other conceptions (Roussos, 2013).

The tendency of psychotherapy outcome studies to measure change based on symptomatic improvements assessed though client's self-reports has been questioned, as it does not provide information regarding the process of how change occurs (Levitt et al., 2006). In this context, qualitative approach to adult patients' experiences of change has been underlined as an essential mean to further understand therapeutic change (Roussos, 2013). The appreciation for qualitative studies focused on the subjective experience of clients has grown, as it allows to explore the elements of change that are significant for clients (Levitt et al., 2006). Moreover, the analysis of clients' experiences is central to advance in the understanding of change processes in therapy (Elliott, 2008).

In this context, Elliott (2010) underlines the importance of conducting change process research (CPR), which denotes the study of the processes by which change occurs in psychotherapy, to deepen in the understanding of how changes happen. Within the strategies used for CPR, the helpful factors design focuses on asking clients about the features of therapy that helped them to change. This qualitative approach is considered most valuable for developing and modifying rich theory grounded in data concerning therapeutic change. When

considering changes that are meaningful according to the experience of patients and therapists and in terms of their clinical significance, the therapeutic change can be appear in different terms than symptom improvement (Gómez & Roussos, 2012).

The experience of changes of those who participate in psychotherapy has been referred as 'subjective change', which implies a process of transformation of the subjective perspective of how the patients regard themselves and their problems, their environment and their relationships with it (Gonçalves et al., 2009; Krause et al., 2006). Within this understanding, Krause (2005) defines psychotherapeutic change as "change in the subjective patterns of interpretation and explanation that lead to the development of new subjective theories" (p. 333). The process of change of the subjective patterns would evolve cyclically, in successive stages, beginning before the start of therapy and continuing after its end, combining both intra and extra therapeutic factors. This concept of psychotherapeutic change is generic and transversal to different psychotherapeutic orientations (Krause et. al., 2007).

Successful therapeutic change would be presented in a sequence of constructions of the patient concepts and theories in the course of therapy, which includes three central processes: first the association between symptoms, life experiences, motivations, emotions and behaviour; second, the creation of a subjective construct about oneself, biography and relationships with others; and finally, the construction of theories about themselves and the relationship with the world, including their own biography (Krause, 2005; Krause et al., 2007). Changes can be operationalized in generic change indicators, from the most initial indicators to those found in advanced stages of therapy (Krause et al., 2007).

Therapeutic change has also been described from a narrative framework, which complements the subjective change definition provided by Krause (2005). Within the narrative framework, psychotherapy clients are viewed as storytellers, where individuals shape their experiences as active narrators and build the meaning of their experiences in the form of self-narratives (Gonçalves et al., 2009). These self-narratives can be understood as rules of action or world visions, that play an important part in the person's self-organization, preventing chaos and conferring meaning to the self (Alves et al., 2014). However, these self-narratives are not always healthy, since they can become problematic when they restrict cognitive and affective diversity (Alves et al., 2014). The emergence of alternatives for problematic self-narratives is

termed as innovative moments (Gonçalves et al., 2009; Gonçalves & Ribeiro, 2012). From this perspective, psychotherapeutic change is the emergence of new self-narratives that constitute alternatives to the dominant discourse of the problem and the self, therefore, this change implies re-authorship in the process of construction and narrative constitution of the world and the self (Gonçalves et al., 2009).

Concerning psychotherapeutic change in children and adolescents from a narrative and subjective notion, Gómez (2016) defines psychotherapeutic change in children and adolescent, as a process of transformation that regards the vision of the self and the environment, starting with a gradual construction of new meanings and illustrative models about the problem, and a progressive construction of more enriched and flexible personal and relational narratives. This process may not be understood if not in dialogue with the family, particularly with the parental figures (Gómez, 2016), who constitute a framework, an initial space of socialization and environmental exchange that supports the achievement of developmental equilibrium (Sepúlveda, 2013).

As with adults, psychotherapeutic change in children and adolescents would take place in successive phases, in a nonlinear process (Gonçalves et al., 2009; Krause et al., 2007). Change is seen as an ongoing process, which continues throughout life (Altimir et al., 2010; Gómez, 2016; Krause et al., 2006). In an initial phase, it would relate to the acceptance of a 'problem' that generates affliction and needs help, as well as changes in the initial resistance, validating the therapeutic space as safe and helpful, where the therapeutic relationship plays a fundamental role (Gómez, 2016). In a second phase, young patients and their caregivers acquire a greater understanding about the 'problem' (Altimir et al., 2010; Gonçalves et al., 2009), connecting different lifespan and contextual elements, which influence its generation and permanence (Krause, 2005), gaining both youth and parents a greater sense of agency regarding the problem (Gonçalves et al., 2009). At this stage, the consolidation of the therapeutic alliance provides a comfortable setting for more intense work (Carlberg et. al., 2009; Fernández, 2013). In the final phase, there would be greater understanding and wellbeing regarding the 'problem', consolidating new aspects of the self and the environment, in a progressive construction of an alternative narrative. It could imply a future projection of the self, where the changes experienced during psychotherapy are applicable to other contexts (Altimir et al., 2010; Gonçalves, 2002; Gonçalves et al., 2009; Krause et al., 2006).

The therapy experiences of participants have been of growing interest, as they provide a complementary and deeper understanding of how and why change occurs. Moreover, Krause (2005) underlines that to grasp the subjective change processes of those who participate in psychotherapy, it is key to start from the also subjective experiences of the therapeutic relationship. In the next section, some key studies with adults, and research on the subjective experiences of participants in child psychotherapy are revised.

### *2.2.2. The perspectives of participants in psychotherapy research*

Qualitative methods have been signalled as an optimal way to explore client's experiences in psychotherapy (Elliott, 2008), and as a vital complement of quantitative data (Olivera et al., 2013). Moreover, when accessing topics such as the therapeutic relationship and change processes from the client's perspective, qualitative method enables a direct approach to personal narratives and phenomenological experiences (Krause et al., 2011).

In this direction, Levitt et al. (2006) explored what adult clients find helpful in psychotherapy, and within their main results the therapeutic relationship outstands as one of the more extensive categories mentioned by the participants. Some important aspects for clients of the therapeutic relationship were that the therapist assumed a role as significant other in their lives, and that the therapist was understanding, impartial and reliable. The authors conclude that this positive transference with the therapist tended to strengthen the therapeutic relationship. Authors also concluded that the initial dependency towards the therapist allowed adult? clients to individuate from other significant persons in their lives, and that this dependency diminished as the client became more self-reliant.

Regarding the therapeutic alliance, Krause et al. (2011) revised five large studies of adult patients' and therapists' views of the alliance, focusing on the similarities and differences within their perspectives. Some important results of this review were that clients and therapists underscored the affective bond and its emotional expression to develop a good therapeutic relationship and for therapy to continue. In addition, the experience in clients of acceptance, trust and understanding from the therapist, as well as a non-critical stance in the therapist, were crucial elements for a positive therapeutic relationship. The therapist expertise was viewed by adult? clients as an important feature for the alliance to develop, which implied that some clients

did not value young, inexperienced therapists. Therapists, on their side, highlighted client's commitment -and their own- and their collaboration in the helping process. Finally, the therapeutic alliance was seen as an evolving phenomenon throughout therapy.

In the study by Olivera et al. (2013), they conducted a qualitative research of 17 former adult psychotherapy client's, addressing their subjective experiences of change, consulting reason, the therapeutic relationship and its termination. Concerning the therapeutic relationship, most of the participants that identified they had changed reported a good therapeutic relationship as well. Participants frequently expressed a good valuation of their therapists; they shared personal interests or beliefs with them and valued the therapist non-offensive attitude towards them. Adult clients underlined feeling good, understood, supported, or confident with their therapist. The clients who expressed that they did not perceive change, also expressed not having a good relationship with their therapist.

The qualitative research conducted by Altimir et al. (2017) focused on the therapeutic relationship form the subjective perspective of adult and child patients and therapists in several clinical contexts: a 7-year-old child diagnosed with attention deficit disorder, a 29-year-old woman diagnosed with a personality disorder and a 22-year-old man diagnosed with schizophrenia. Their main results were that the patient-therapist relationship comprised two domains of experience: a) a technical dimension, characterized by differential asymmetric roles, where the therapist assumes an active and knowledgeable role and the patient a more receptive and help-seeking role. This domain provides the structure of the helping relationship an is more stable through the process; b) an affective dimension that emerges gradually within the structure provided by the technical domain, characterized by the growth of genuine feelings between patient and therapist, generating a more symmetric encounter. This domain is the core of the therapeutic relationship according to participants and fosters the building of trust in the therapist, which is valued as a key element for a successful therapeutic process. Finally, the termination of therapy represented a difficult separation process specially for patients. The authors discuss the importance of both domains in their model and relate the described technical dimension within the therapeutic alliance concept, while the affective dimension resembles the real relationship described within Gelso's (2014) components of the therapeutic relationship. This affective dimension strengthens and gains prominence as the therapy advances.

Regarding the therapeutic relationship, although a large extent of research in the therapeutic alliance has been conducted (Horvath, 2018), scarce studies address how this complex relationship is subjectively experienced and understood by those who participate in therapy (Bachelor & Salamé, 2000; Bedi et al., 2005; Krause et al., 2011). Research of the subjective experiences in child psychotherapy is a newer and less explored field, as it requires a specific approach and methodology innovations that are discussed in the following sections.

### *2.2.3. The perspectives of participants in child psychotherapy research*

Research that incorporates the perspectives of participants in child psychotherapy is of recent development, and there are scarce studies that directly address the experience of children in psychotherapy (Carlberg et. al., 2009). This scarcity occurs despite the importance of involving children in health decisions that concern them (Davies & Wright, 2008), and in spite of that they provide valuable information about their therapy, their process of change and what they consider facilitates or obstructions in the process (Alamo, 2019; Carlberg et al, 2009; Capella et al., 2018). In this context, there seems to be an important debt in incorporating children's views in dialogue with the other participants of psychotherapy.

The limited research that has been directly conducted with children derives from several issues. For instance, process and outcome research in child psychotherapy has historically sustained on the report of parents and therapists, leaving out children's meanings in relation to their own process, under the belief that children are not able to give legitimate comments about their experiences (Gibson & Cartwright, 2014) or that these measures are not very objective or too superficial (Midgley et al., 2006). However, these assumptions could respond to flaws in research methodologies.

Including the narratives of children who participate in psychotherapy has been also underlined by innovative social research frameworks, which stress the importance of focusing on children's voices. This perspective has been the base of the new sociology and anthropology of childhood, which criticizes an adult-centred approach, and seeks for new research methods that reduce that adult's "voice-over" children's perspectives and experiences (Luttrell, 2010).

As already mentioned, qualitative research in child psychotherapy has developed more recently (Carlberg et al., 2009; Midgley, 2004). The creation of strategies that enable children

to express themselves in a more comfortable manner, integrating expression forms closer to those used by this age group, such as play and drawings, and not only verbal language, seems vital to rescue their own vision of psychotherapy (Carlberg et al., 2009). These age-sensitive methodologies allow access to other forms of registration and conceptualization used by children (Midgley, 2004).

Within the methodological innovations, several techniques have been proposed, such as play, drawings and picture productions (Alamo et al., 2017; Capella et al., 2016; Carlberg et al., 2009; Carroll, 2002; Luttrell, 2010; Midgley, 2004). Drawings have been one of the most used tools, both for its clinical aspects and for research in child psychotherapy (Capella et al., 2015). Through drawings, children can communicate complex ideas and messages that would be difficult to express through their vocabulary (Malchiodi, 2003). However, their analysis has been traditionally sustained on the interpretation of projective elements, developed from an adult perspective, since most of the methods have aimed at uncovering the meaning of the drawings, rather than at encouraging participants to explain their graphic intentions (Driessnack, 2005). This approach may relocate the intended expression of the child's experience to the adult's interpretation of the child's production and may lead to take over the child's experience. In this direction, Capella et al. (2015) emphasize the need to build bridges between the subjective perspective of children and the subsequent interpretation of adults, exploring the use of drawings as a complement to narrative production, in order to achieve a better understanding of children's meanings of their psychotherapeutic process.

Within this line of research, some studies have focused solely on children's current and adult's past experiences in psychotherapy and other studies have encompassed a dyadic or triadic approach including children, parents', and therapists' perspectives of psychotherapy.

Within the study of the subjective experience of children, Carroll (2002) explored the experience of children and pre-adolescents who participated in play therapy. The author interviewed the therapists, the children and the pre-adolescents, with the support of play material. Concerning the consultation reasons and expectations, most children and pre-adolescents could communicate some initial problems, but not all children were clear or remembered their expectations, being their main concern not to get bored. Regarding the process of psychotherapy, children generally had a positive appreciation of the experience. Also, the

possibility of playing and talking was seen as a gratifying aspect, although lived with certain ambivalence: as uncomfortable when the therapist only asked about a specific topic but as soothing when they are allowed to talk about their problems. The young patients also underlined relaxation and play techniques.

Midgley & Target (2005) studied the retrospective experiences of adult's who participated in child or adolescent psychoanalysis, reporting that these adults recalled feeling relieved by being in analysis due to difficulties in their lives, even when many did not remember specifically what difficulties they experienced. Several of these participants stated they did not understand at that moment why they were taken to therapy, as nobody explained to them the reasons for this act. Some participants, the younger ones when attending therapy, recalled playing, feeling free and positive towards the therapist and the therapy experience. Others evoked mixed feelings towards the therapist, and negative affects emerged when difficult issues arose in therapy, such as when they felt questioned or not understood, or directly disliked the therapist as a person. Within the authors conclusions, participants who went to analysis at younger ages recalled better overall experiences than those who were older. They also stressed that children's understanding of why they go to therapy must be addressed during the process.

Carlberg et al. (2009), explored the psychotherapy expectations and experiences of children who attended psychodynamic therapy, using semi-structured interviews before and after treatment, a self-esteem questionnaire, drawings and a game. Their results highlight that the children reported improved interpersonal relationships, emotional well-being, improved mood and self-concept, and the development of self-control strategies. In addition, these children felt hopeful about the future and expressed feelings of greater happiness.

In their study, Capella et al. (2016) explored the experience of 20 children and adolescents between 8 and 18 years old, about the recovering process from sexual abuse, once they successfully completed psychotherapy in public maltreatment programs. In this qualitative study, interviews with children were supported with drawings. Their results show that participants' narratives of recovery involve an improvement of psychological wellbeing. Furthermore, they felt better prepared to confront future challenges, feeling empowered and able to retake control of their lives. The psychotherapeutic process was crucial for overcoming sexual abuse; participants highlighted the construction of the therapeutic relationship, where the

therapist emotionally supports and listens to the patient. Interviewees emphasized verbal and nonverbal strategies, such as play and drawing. These aspects were relevant for children and were seen as helpful for self-expression such as speaking.

In a later study, Capella et al. (2018) examined the meanings of psychotherapeutic change in children and adolescents who had experienced sexual abuse. They conducted in-depth interviews and drawings to 10 children and adolescents who were between 6 and 16 years-old during psychotherapy. Within their core findings, they report that children and adolescents viewed psychotherapy change as a gradual progressing process, noting affective changes as they felt a higher emotional well-being, improved relationships with friends and family, fewer behavioural issues, cognitive changes such as increased reflective skills, and school related changes such as a better academic performance. Regarding the abusive experience, only some participants noted changes. Finally, the authors reported an improved attitude of these participants towards therapy, since they felt more comfortable and trusted the therapeutic space. Children and adolescents also noted changes in their parents or caregivers, reporting more caring and less hostile attitudes of their mothers with them, and relief as participants felt better. Change was supported by intra and extra therapy aspects, such as talking, playing, and laughing with the therapist, a trust-based therapeutic relationship and the support of family and friends. On the contrary, the rotation of therapists and inefficient legal processes hindered changes.

In Alamo's (2019) report, she studied in 12 psychotherapeutic triads the subjective experience of change in child psychotherapy, particularly the contents and evolution of change from the perspectives of children parents and therapists, to generate a change model in child psychotherapy. Follow-up semi-structured interviews were developed with all the participants, and drawings concerning therapeutic changes were included in the case of children. The core results of this study were that the changes viewed by participants were expressed at different levels by the children, parents, family, school context and therapeutic setting. Changes also developed within five core dimensions: affective, cognitive, behavioural, identity and interpersonal relationships. Affective changes in children were those mostly identified by participants, followed by behavioural and interpersonal relationships, then identity and cognitive changes. These levels of change relate and influence each other. Parent's and family interrelated changes was another relevant finding of this study, which describes mainly cognitive changes in parents as they widen their perspectives and understanding of their child's

issues, integrating their own influence in their child's problems that related with acknowledging that they may have difficulties themselves or in their parenting style. Behavioural, identity and affective changes in parents were also addressed in this study, through a better management of their child's difficulties and a more empowered parental self-concept and relief concerning the consulting reason. Changes, expressed in improved family interactions, were also described, but only by parents and therapists. Finally, the changes described in children and parents generated and helped each other. An interesting change content found in this study concerned the therapeutic setting, mainly an improved attitude in children and parents towards psychotherapy and the construction of trust in the child-therapist relationship as psychotherapy develops.

A recent qualitative study conducted by Areas et al. (2020) with children aged 6 to 11, focused on the perception of children of change within their therapeutic experience through interviews. Within the core results, most children expressed that they changed due to psychotherapy, and that psychotherapy helped them specially with their mood state and emotional issues. However, many children were not able to recall why they participated in psychotherapy. Children also underlined the trust in their therapist, allowing them to open with them, having fun in this relationship and affection towards the therapist, and playing together in some cases. They had a positive appreciation of their therapists and viewed them as persons who could help them with their psychological issues. Children also recalled drawing, playing, and talking with the therapist as the main activities developed in therapy. However, the authors stressed that children generally responded briefly to the interviewer's questions, and sometimes could not coherently justify their answers.

Research in child's subjective experiences in psychotherapy has underlined the therapeutic relationship, however no study focuses specifically on how the therapeutic relationship in child psychotherapy children and parents/caregivers develops and facilitates change from the perspectives of the main actors of the therapeutic process, which comprises the central research question of this thesis.

# 3. AIMS, GUIDING QUESTIONS AND HYPOTHESIS

To address the central research question of this doctoral thesis, the following general and specific aims were outlined. This aims guided the development of two studies, the first a qualitative retrospective study, informed in paper 1, and the second a mixed-method longitudinal study, reported in paper 2 and 3. The aims of this thesis and the guiding questions and hypothesis of each study are detailed in this section.

## 3.1. General Aim

Develop a comprehensive model of the role of therapeutic relationships in child psychotherapy in change processes from the perspective of children, parents and therapists.

## 3.2. Specific Aims

1. Describe the components of the therapeutic relationship with children and their parents, according to the perspective of children, parents, and therapists.
2. Describe the evolution of the therapeutic relationship in different moments of psychotherapy, according to the perspectives of children, parents and therapists.
3. Analyse which aspects of the therapeutic relationship in child psychotherapy are associated, as facilitators or obstacles, with the therapeutic change, according to the perspective of children, parents and therapists, considering different moments of psychotherapy.
4. Analyse the main convergences and divergences between children, parents and therapists about the components, evolution and facilitators and obstacles of the therapeutic change associated with the therapeutic relationship.

## 3.3. Study 1

### *3.3.1. Qualitative guiding questions: Paper 1*

***"The therapeutic relationship in child psychotherapy: Integrating the perspectives of children, parents and therapists". This paper approaches specific aims 1, 2, 3 and 4.***

- How are the child, the therapist and the parents described? Does this description change in different moments of the psychotherapeutic process?
- How is the therapeutic relationship described? Does this description change in different moments of the psychotherapeutic process?
- Which aspects of the therapeutic relationship are conceived as facilitators or obstacles of the therapeutic process?
- How do the different relationships affect each other?
- Do the child/therapist/parents change their relational offer during the process?
- Is the therapeutic relationship more relevant for the process in different moments of psychotherapy?
- Is the therapeutic relationship more relevant for therapeutic changes in different moments of psychotherapy?

## 3.4. Study 2

### *3.4.1. Hypothesis: Paper 2*

***"Initial therapeutic alliance, clinical and demographic variables: an analysis from the perspectives of children, parents, and therapists". This paper addresses specific aims 1 and 4.***

H1: A higher rating of the initial therapeutic alliance from the child's and parent's perspective is expected when the therapist has fewer years of experience.

H2: A higher rating of the initial therapeutic alliance from the therapist's and child's perspective is expected in older patients.

H3: A higher rating of the initial therapeutic alliance is expected from the therapist's, patient's and parent's perspective when the patients present internalizing symptomatology.

H4: The therapist's experience, the child's age and symptomatology type are expected to significantly explain the quality of the initial therapeutic alliance between therapist and patient, from all perspectives.

### *3.4.2. Qualitative guiding questions: Paper 3*

***"The therapeutic relationship and change process in child psychotherapy: A qualitative, longitudinal study of the views of children, parents and therapists". This paper approaches specific aims 2, 3 and 4.***

- What do children and their parents think and feel about attending psychotherapy? What are their motivations?
- What are their expectations of change, of the process and of the therapeutic relationship?
- How are the therapist, the child and the parents at the beginning and after four months of therapy? Do they change?
- How are the child-therapist and parent-therapist relationships at different points in the therapeutic process? What feelings arise in these relationships?
- How do children-parents-therapists interact?
- How is the child-therapist and parent-therapist relationship constructed?
- What are the perceived changes in the child, and in the parents? How do they value the whole psychotherapy process?
- What elements of the therapeutic relationships facilitate or hinder the therapy process and the changes in children and parents?
- What other elements facilitate or hinder these changes?

# 4. PAPERS

In this section, the papers originated within this doctoral research are presented and contain the results of this thesis.

## 4.1. Thesis paper 1: The therapeutic relationship in child psychotherapy: Integrating the perspectives of children, parents and therapists.

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# The therapeutic relationship in child psychotherapy: Integrating the perspectives of children, parents and therapists

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**Abstract**

This study addresses the therapeutic relationship in child psychotherapy, through an exploration of the experience of the main actors engaged in child psychotherapy. Objectives: To describe and analyse the therapeutic relationship integrating the views of children, parents and therapists. Methods: This study employs a qualitative methodology, assuming a discovery-oriented approach which draws from grounded theory. Twelve psychotherapy triads participated, composed of children aged 6 to 10, their parents and psychotherapists. Semi-structured follow-up interviews were conducted (N=36), including a drawing in the case of the children. Results: A positive therapeutic relationship with children and parents was viewed as a gradually constructed process, based on a positive emotional encounter between participants. It was facilitated primarily by the therapist's commitment and playful stance, the child and

therapist mutual involvement, and the parent's collaboration. These aspects entailed a trustful, validating and caring relationship, that shaped children and parents' motivations towards therapy and facilitated change. Conclusions: From a multiple-perspective approach, therapy was conceived as a relational experience. The development of positive relationships required different and evolving dispositions from therapy main actors. Therapists' genuine feelings and engagement in therapeutic activity seem central, underlining the importance of addressing relational aspects in child therapy research and training.

**Keywords**: child therapy, therapeutic relationship, therapeutic alliance, qualitative methods, multiple perspectives.

**Clinical and methodological significance of this article:** This study contributes to deepen the understanding of the therapeutic relationship in child psychotherapy, as it has been an under viewed research topic in comparison with adult settings. Clinical contributions focus on understanding the therapeutic relationship as a co-constructed process between the participants of psychotherapy. Children and parents tend to have initial reticence towards therapy, and the therapist has a central role to facilitate their engagement in the process. The construction of a positive therapeutic relationship sustains on the quality and nature of the therapeutic encounter, underlining the mutual joy of playing and being together as a core element of the therapeutic experience. Implications for training of child therapists focus on the importance of constructing positive relationships both with children and parents, the assumption of an evolving disposition through the therapeutic process, genuineness as a facilitator of the therapeutic relationship and the relevance of the termination of psychotherapy for children. Methodological contributions sustain on a multiple perspective and in-depth approach, integrating and contrasting the experiences of children, parents and therapists. Additionally, a developmental sensitive methodology is incorporated, as children's perspectives are interviews were supported by drawings, facilitating their participation and expression.

## Introduction

The relationship between patient and therapist is considered a central aspect of all psychotherapy and the quality of that relationship has proven to be one of the factors most robustly associated with therapeutic outcome in adults (Safran & Muran, 2006). The conceptualization of the therapeutic relationship in the literature is quite diverse, as it depends

on the researcher's theoretical background (Hayes, 2017; Kennedy & Midgley, 2007). One transtheoretical definition of the therapeutic relationship is proposed by Gelso (2014) as: 'feelings and attitudes that therapists and clients experience for each other, and the way they are expressed', encompassing the real relationship, the therapeutic alliance, plus transferential and countertransferential components, organized in a tripartite model.

The relational aspects of therapy have been frequently studied within the framework of the therapeutic alliance, often drawing from Bordin's (1979) transtheoretical alliance model (Altimir et al., 2017; Wilmots et al., 2019). This model contains three interrelated dimensions: agreement in goals, in tasks, and the therapeutic bond (Bordin, 1979), and emphasizes the role of patient's conscious or rational collaboration (Safran & Muran, 2006). The therapeutic alliance has shown to be a robust predictor of outcomes in psychotherapy with children and adolescents (Kazdin et al., 2006; Shirk & Karver, 2011). However, the applicability of the concept of a 'therapeutic alliance' in child psychotherapy practice has been debated, as it is not clear that children are able to 'collaborate' with the therapist or 'agree on goals and tasks', as outlined within Bordin's alliance model (Elvins & Green, 2008; Karver et al., 2006). In this sense, the concept of the therapeutic relationship provides a broader framework for the examination of the relational aspects of child psychotherapy, which is the focus of this study.

Conceptualisations of the therapeutic encounter often share the idea of psychotherapy as a two-person relationship: patient and therapist. However, child psychotherapy contains multiple levels of relationships: at least one between child and therapist, and others among parent(s)/caregiver(s) and therapist (Gvion & Bar, 2014; Hayes, 2017, Karver et al., 2018). These multiple relationships can be conceived as a triadic relational connection, as each relationship influences the others (Gvion & Bar, 2014). The few studies conducted about the relationship between parents and the child's therapist have reported that the parent's degree of participation in their child's therapy is associated with outcome (DeVet et al., 2003, Karver et al., 2018). The quality of the relationship between parents and their child's therapist is linked with the parent's commitment and extra-session support, affecting the child's therapeutic change (Kazdin et al., 2006; Marker et al., 2013). A positive alliance with parents is associated with improved parental skills and family interactions (Kazdin et al., 2006), and influences the quality of the therapeutic alliance with the child (Campbell & Simmonds, 2011; Kazdin et al.,

2006). Positive alliance both with children and parents support adherence to treatment, preventing early dropouts (Hawley & Weisz, 2005).

However, the valuation of therapeutic aspects may change according to who reports them (Accurso & Garland, 2015; Carroll, 2002; Stith et al., 1996). In the case of research on relationships in child psychotherapy, it has been based mainly on parents' and therapists' reports (Noyce & Simpson, 2018); children have been excluded generally as valid informers of their own psychotherapy experiences, because of the belief that they are unable to provide legitimate comments about their experiences (Gibson & Cartwright, 2014), or that their views would be considered too superficial (Midgley et al., 2006). Yet contemporary social research frameworks criticize an adult-centred approach, advocating new methods that 'lift up' children's perspectives and experiences (Luttrell, 2010). Researching children's views of psychotherapy requires the development and use of innovative research methods that enable children to express themselves in a safe and age-appropriate way (Carlberg et al., 2009; Midgley, 2004).

Overall, studies of children's experiences of therapy have found that children underline the therapeutic relationship as a central aspect of the therapeutic process and change (Alamo, 2019; Capella et al., 2015; Carlberg et al., 2009; Carroll 2002; Kazdin et al., 2006; Stith et al., 1996), as children emphasized the value of a therapist who emotionally supports and listens to them (Capella et al., 2015), and in some studies suggesting that the element they liked most about therapy was simply spending time with their therapist (Carlberg et al., 2009). Despite these findings, few researchers have studied the development of the therapeutic relationship with children under 11 years old (Noyce & Simpson, 2018). This matter is particularly relevant to Chile, considering that in this country the prevalence of psychiatric disorders in children between 4 and 11 years old is 27.8% (Vicente et al., 2016). This value is slightly higher than the 20% prevalence reported worldwide (World Health Organization, 2005), and represents a significant group that requires mental health attention.

This study focuses on middle childhood (6-11 years old) also referred to as 'school age children' (Papalia & Martorell, 2015), as they are a group that has received less attention in terms of research into the nature of the therapeutic process (Kennedy & Midgley, 2007). Therefore, this paper addresses the therapeutic relationship with school age children, seeking to understand how this relationship shapes, evolves and impacts the therapeutic process. The study

is based on the perspectives of children, parents and therapists, as first-hand informers of their therapeutic experiences.

## Methods

This study employed a qualitative design, assuming a discovery-oriented approach which draws on grounded theory (Corbin & Strauss, 2008).

### Setting

The study reported here was part of a larger research project titled "Success and failure experiences in psychotherapy - Construction of a multidimensional comprehensive model", financed by the National Science and Technology Development Fund of the Chilean Government. This larger project was conducted in Santiago, Chile, and comprised diverse consultation groups: adults, adolescents and children with different disorders or difficulties (N=102). Mental health in Chile is primarily provided though outpatient public and private services, and for the larger study participation agreements were established with 6 mental health centres of public, private and university settings.

### Participants

Inclusion criteria for this study were that children were between 6 and 11 years old and had attended a minimum of six therapy sessions with at least one of their parents involved in the process. Exclusion criteria was the presence of cognitive impairment in children. Seventeen children had taken part in the larger project; of them, twelve met the inclusion/exclusion criteria for this study. Fifteen parents who actively accompanied their child's therapeutic process, and nine psychotherapists were included, as two of them had more than one case, adding a total of thirty-six participants.

Each child had been referred to a child and adolescent mental health service for a range of reasons: externalizing problems (ADD, emotional dysregulation, oppositional defiant behaviour), internalizing problems (anxious and/or depressive symptoms, social inhibition) and because of the impact of child abuse (emotional, physical or sexual abuse). Parents were involved in individual and joint sessions with their children. Most therapies ended with an agreed discharge but in one case the family dropped out. The therapists represented diverse

clinical orientations and professional experience, including systemic, psychoanalytic and cognitive constructivist approaches. Therapeutic interventions were offered through individual and family sessions, including directive and nondirective play, art and narrative techniques. Therapies were open-ended and lasted from 1.5 to 28 months; they are described as long when they continued for more than 6 months. Table I includes details about participants, length and frequency of therapies.

Table I. Participants demographic and clinical characteristics.

| | **Child** | | | **Parent** | | **Therapist** | | | | **Therapy** | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Sex | Age | Consulting reason | Age | Relationship with child | Sex | Age | Theoretical framework | Practice (Years) | Extent (Months) | Sessions (N) |
| **1** | M | 8 | Physical abuse | 38 | Mother | F | 28 | Systemic | 4 | 24 | 55 |
| **2** | M | 7 | ADD | 28 | Mother | M | 26 | Cognitive constructivist | 1 | 2.5 | 10 |
| **3** | M | 8 | Emotional dysregulation | 39 | Mother | F | 28 | Systemic | 5 | 11 | 26 |
| **4** | F | 6 | Emotional dysregulation | 29 | Mother/ father | M | 26 | Cognitive constructivist | 1 | 12 | 38 |
| **5** | F | 7 | Anxiety | 51 | Mother | F | 28 | Systemic | 5 | 13 | 24 |
| **6** | F | 8 | Emotional abuse | 41 | Mother | F | 39 | Psychoanalytic | 15 | 28 | 75 |
| **7** | M | 10 | Anxiety and depression | 29 | Mother | F | 22 | Systemic | 1 | 26 | 45 |
| **8** | F | 10 | Defiant oppositional behaviour | 35 | Mother | F | 24 | Psychoanalytic | 1.5 | 14 | 42 |
| **9** | M | 8 | ADD, defiant oppositional behaviour | 39 | Mother | F | 27 | Cognitive constructivist | 1 | 15 | 37 |
| **10** | F | 10 | Sexual abuse | N/I | Mother/ father | F | 32 | Psychoanalytic | 8 | 3 | 10 |
| **11** | M | 10 | Anxiety and depression | 47 | Mother | M | 26 | Cognitive constructivist | 1 | 1.5 | 6 |
| **12** | M | 8 | Social inhibition | 37 | Father | F | 28 | Systemic | 5 | 7 | 17 |

## Data collection method

### *Individual semi-structured interviews*

Individual interviews were carried out separately with the parent, child and therapist. An interview topic guide was created for the broader research project previously mentioned. It

included an opening question about the global experience of the recent therapy, and then deepened through open-ended questions organized in six topics: diagnosis, expectations, therapeutic process, therapeutic relationship, outcome and ending process. The interview guide followed the same structure for children, parents and therapists, and was adapted for each perspective using age-appropriate language and depending on the specific roles that each participant had in psychotherapy.

Regarding the therapeutic relationship, the guiding questions for the child interview were: *What did you think about your psychologist? How was he/she? How did you feel with him/her? Were there changes? How did you get along with him/her? How were your feelings towards him/her? What did you like most/least about him/her? What did you liked/disliked doing with him/her? Did the psychologist sometimes talk to your mom/dad? How did your mom/dad get along with him/her? How was your mom/dad towards him/her?*

***Drawings supporting children's narratives***

In addition to the interviews, children were invited to draw pictures to enable a richer understanding of their experiences of therapy. The drawing included in this study was: "My psychologist and me", developed by the first author; the interviewer requested that the child draw him/herself with their therapist during therapy. The drawing activity took place as part of the interview; interviewers engaged with children's spontaneous verbalizations about their drawings and asked questions about what they drew, such that the drawing exercise and the interview topic guide were in constant dialogue.

**Procedure**

Participants were contacted at the beginning of psychotherapy, asking for the child's informed assent and parents and therapist informed consent to take part in this study. Participants were contacted within three months of therapy ending, for those who had given consent at the start of therapy. Individual semi-structured interviews were carried out with all participants in the same mental health centre where their therapy was conducted, with the exception of the drop out case which took place at the child's home. Children's interviews were supported with drawings and were led by trained child psychologists, who had not been involved with their therapies. Interviews were audio recorded, and transcribed using Mergenthaler Norms

(Mergenthaler & Gril, 1996); a total of 36 interviews were completed, comprising 3 interviews per case.

### *Data analysis*

The interviews were analysed using grounded theory methods (Corbin & Strauss, 2008), starting with open coding, based on a concept-indicator model, where emerging concepts from verbal and visual data were labelled as they related to individual events (indicators), and then were developed and categorized based on contextual and theoretical knowledge (Corbin & Strauss, 2008; Titscher et al., 2000). In addition, through an iterative process involving constant comparison, emerging concepts were categorized and organized in a hierarchical structure, and memos were written to record how concepts and categories develop and interrelate (Titscher et al., 2000). Following open coding process, axial coding of data was executed, in order to map relations between concepts and categories (Titscher et al., 2000). The coding process was supported by ATLAS.TI v7 software for qualitative data analysis.

To ensure intersubjective validation of findings, a triangulation strategy was implemented, whereby five coders participated in the analysis of qualitative data and then compared findings and sought agreement (Flick, 2018). This process seeks to reduce coder bias and enrich the coding process, as it allows several perspectives to be considered in the identification and interpretation of categories (Altimir et al., 2017). Interviews were also grouped and analysed by case, creating a summary for each case of the most relevant aspects of the participants' narratives.

Drawings were incorporated at two stages of the analysis: first as part of overall verbal data, as children's spontaneous comments and answers related to their drawings were part of the transcription. And in a second stage, through a specific qualitative analysis method developed by some of the authors of the study (Alamo, 2019; Núñez et al., 2018) summarized in Table II. The analysis of children's interviews and drawings were integrated through methodological triangulation (Flick, 2018).

## Ethical considerations

The study was granted ethical approval from the Scientific Ethics Committee in Social Sciences, Arts and Humanities of the Pontifical Catholic University of Chile. The identity of participants has been removed to ensure confidentiality.

Table II. Qualitative analysis guidelines for therapeutic process-outcome drawings. *

| Steps of analysis | Elements of analysis |
|---|---|
| 1. Context of the drawing | 1.1 What does the drawing respond to (instruction)? |
| | 1.2 When was the drawing done (temporality)? |
| | 1.3 Where was the drawing done (context)? |
| 2. Content of the drawing | 2.1 Central theme/Gestalt: What does the drawing convey, narrate or represent in its totality? |
| | 2.2 Central figure(s): Perception or representation of oneself and others in the drawing. |
| | 2.3 Environment: Perception or representation of the environment/context in the drawing. |
| | 2.4 Interaction: Relationship between the graphic elements represented (between figures and with environment). |
| | 2.5 Colour: its use as a tool for the child's graphic expression. |
| 3. Verbal narrative developed through the drawing | 3.1 Child's spontaneous narration and responses to open questions about the drawing |
| 4. What does it express beyond verbal narrative? | 4.1 Does the drawing add new elements to what the child said verbally? What does it contribute? |

*(Alamo, 2019; Núñez et al., 2018)

## Results

Overall, participants described a positive therapeutic relationship between the child and the therapist, and they tended to express positive valuations of the therapeutic process. Consequently, the findings from this study are particularly illustrative of what makes a good, rather than poor, therapeutic relationship.

A positive therapeutic relationship was described by participants as a dynamic, constructed process that involved all actors, with children, therapists and parents participating in different ways (Figure 1). The therapist assumed the initial lead, encouraging the child to express freely and take ownership of the therapeutic space, and interacting with the child through a playful stance. This attitude facilitated the child's participation as it opened a positive

emotional experience for the child based on play and having fun with the therapist. This interaction enabled the construction of a trusting and validating therapeutic relationship. Parents constructed a collaborative relationship as well with the therapist, as they felt the therapist was committed to their case, validated and supported them and their child, interacting with them in a kind and professional way. A positive therapeutic relationship also shaped a higher motivation towards therapy, overcoming possible initial reticence in children and parents. In longer therapies this relationship enhanced identity and relational changes in the child.

To deepen the understanding of the construction of a positive therapeutic relationship, the core features of this process are presented in detail and organized in four themes: a) a new encounter: meeting an adult who intends to help, b) a mutually involved encounter: having fun and playing together, c) construction of a trustful, supportive and caring relationship, d) role of the therapeutic relationship in shaping children and parents' motivations towards therapy and as a facilitator of change.

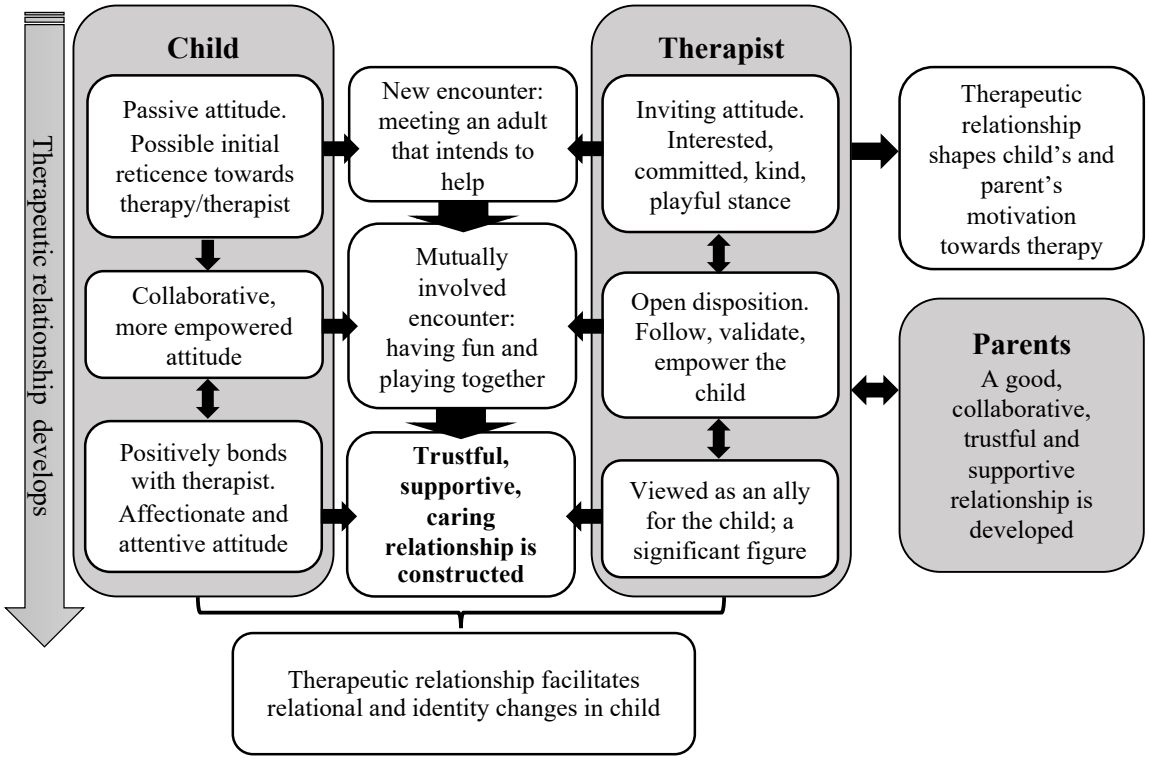


Figure 1. Construction of a positive therapeutic relationship.

### a) A new encounter: meeting an adult that intends to help

Therapists' characteristics and attitudes were described variously by participants, as children and parents often answered questions about the therapeutic process by referring to the therapist. Therapists played a leading role in inviting the child to interact, as they were viewed by participants as interested, affectionate and kind towards the child. In addition, the therapists' playful stance was described, as they connected in a way that was appropriate given the child's age and developmental stage. This description largely matched the therapists' own descriptions of their practice and how they aimed to be:

> "like an adult who wants to be with her, who wants to connect with her from her own language, respecting her (…) and a very playful therapist, because as I invited her to be more childish, it made me also be quite playful and fun".

Children and parents also identified professional qualities and more personal traits of therapists than did therapists themselves, describing therapists as competent, affable, friendly and nice people, who treated them well. Parents also highlighted the willingness of therapists to do more than expected from their professional role, and some parents valued their ability to communicate information about their child in a clear way, as well as being receptive and non-judgemental.

Regarding children's disposition towards the therapeutic encounter, they were characterized as collaborative by therapists. However, children were described with a more passive role in the first sessions, which from the children's perspective related to a sense of anxiety about being alone without their parents, possible embarrassment, demotivation and insecurity regarding how the therapist would be, as well as concerns about the usefulness of therapy. Some therapists associated the child's passivity to over-compliance towards them. For example, one therapist described a girl in her first sessions:

> "She was not a very genuine girl in the contact, a girl with a slightly frozen smile, one of those girls that when you ask in the session "what would you like to do?", they answer: "whatever you want".

According to the participants, some children initially expressed aversion to participating in therapy, through a passive attitude in those with internalizing symptoms, and difficult and

confrontational attitudes towards the therapist in children with externalizing symptomatology. A therapist describes this experience as follows:

> "It was a case in which initially [child's name] could not stand much being in the consultation room, he constantly went outside (…). At the beginning creating the bond was tough (…) however, little by little this bond was established…".

Parents were described primarily by themselves and the therapists; children were less likely to spontaneously discuss their parents. Descriptions of parents underlined their collaboration and positive disposition and were characterized as motivated and committed, seeking help because they were concerned about their child's issues. However, as was the case for the children, this positive presentation was not always the starting point. It was observed that parents experienced initial mistrust towards the therapist, and doubts about the therapist's professional skills, mainly as a result of prior negative experiences with therapists or the therapist's young age.

**b) A mutually involved encounter: having fun and playing together**

Playful activities were viewed by children and parents as the core interaction in therapy. Children were described as experiencing good and happy feelings when interacting with their therapist, and therapists also recalled positive feelings when playing with the child. Therapists seek to validate and empower the child in the therapeutic encounter. Following the child's timings, rhythms and needs, was considered a facilitator of the relationship by therapists. In describing how they tried to be, therapists emphasized the importance of an open disposition, as this made space for the child's free expression and leading role. One mother described her daughter's experience as follows:

> "She loved it [therapy], it was like her space (...) she could "do and undo" (...) and she played, and she liked it because she made different things (...) [therapist name] let her control the situation a bit, and she liked that, she had a good time, it was her time to play, to express herself, then for her it was like super important".

As the therapist sought to connect with the child through a child-centred stance, children gradually felt that they could occupy the therapeutic space, express themselves more freely and enjoy being with the therapist. A therapist describes his stance as:

> "We started with free games. He brought some cards, which I think were a complete facilitator of our bond. We got on the floor, so he could teach me how to play. This interaction allowed me to get out of the expert role, of that distant role".

Consequently, a more empowered attitude in the therapeutic relationship was shown by the children. One therapist describes this process as:

> "He went from being tense, distrustful of the space and the things he could say or do, to lie on the floor if he wanted, or to play what he wanted, or if he didn't want to do certain things, I felt that he had the ability to express more, what was happening to him, what he felt…".

However, children usually said little about the therapeutic relationship beyond it being good. It was through their drawings that they highlighted joint activity as the core interaction of the therapeutic relationship, as they illustrated happy scenes with their therapists. When analysing the content of the drawing of "My psychologist and me" made during the interview by a 7-year-old girl (Figure 2), the central theme was a playful encounter between her and her therapist. Both figures displayed happy expressions on their faces, and flexible -ready to play- body postures, with the only distinction being the therapist's larger size. The environment was represented by a detailed doll house that occupied a central place between them. Their interaction was positive and mediated through play, in which they were mutually involved. The girl explained that they were 'playing house – and speaking like characters', referring to a pretend mode of speech. She expressed that they both felt 'good' playing in this way. The drawing is consistent with what was expressed verbally, but emphasizing symmetry in the figures position, attitude and affection, and that joint play mediates the relationship.

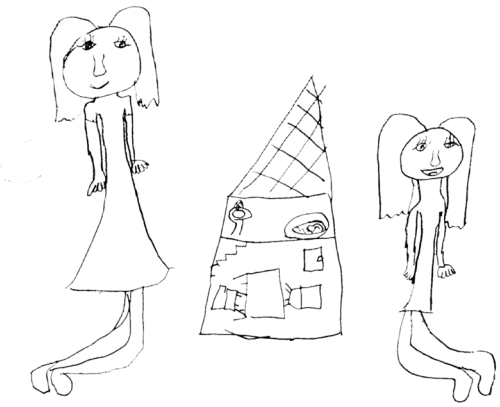

Figure 2. "My psychologist and me" drawing (7-year-old girl).

In the drawing of a 10-year-old boy of "My psychologist and me" (Figure 3), the central theme was the child and the therapist drawing together. Both figures are positioned backwards as they are facing a drawing board, with the same flexible and active body postures, and the therapist is bigger. The environment was represented by the drawing board in a central position. Their interaction is positive and mediated through drawing activity, in which they are mutually involved. The boy said about his picture that he felt 'good and comfortable' when drawing with his therapist. This drawing supports what was expressed verbally, but emphasises the equal level of involvement, joint and symmetric action in the therapeutic relationship, which focuses on the child's art interests.

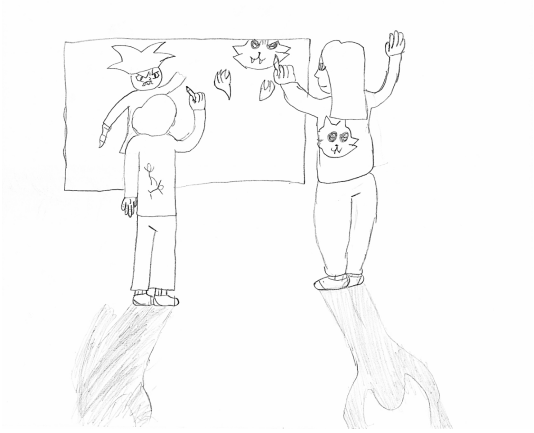

Figure 3. "My psychologist and me" drawing (10-year-old boy).

In both children's drawings, in addition to the expression of positive emotions, symmetric actions and involvement levels were described. In these cases, children completed long-term therapies, and the mutuality with the therapist represented in their drawings appeared in other children's drawings who also engaged in longer-term therapies. This mutual joy of playing together was also described by parents and therapists, and it suggested a symmetrical and positive emotional encounter between child and therapist. A mother of a 10-year-old girl put it as follows:

> "In the last session the psychologist made me come in before it ended, and she (child) was cooking with the psychologist. She was making food, had lunch with her (psychologist), had taken coffee and I arrived, I arrived for dessert (…) it was like she felt she was with another girl, I mean, I perceived that… it was like she played, but with another girl".

In briefer therapies, positive emotions were also represented in children's drawings, but the interaction was more asymmetric, focused on the therapist's leading role and the patient's following role, where the therapist was asking something or requesting the child to do a specific task, and the child was answering or performing what was enquired.

Whereas for children and parents, playing with the therapist was valued for the positive experience in itself; different conceptualizations and experiences of the role of play were shaped by the therapist's theoretical background. In general therapists suggested that playing was a fun activity that engaged and prompted children towards therapeutic-focused work. However, playing too much with the child made some therapists feel insecure about their professional duty, as one relatively inexperienced therapist explained:

> "The only thing we did was play. And I felt that I wasn't doing anything, because I thought… this boy comes to play, his parents are trusting me, and I don't know if this helps him (…) I tried to put some elements into his play (…) try to put some of the therapy in (…). So, when he began to bond, I began to tell him gradually "I don't want to play war anymore, let's do something else".

**c) Construction of a trustful, supportive and caring relationship**

When participants described the therapeutic relationship, the emotional quality of the encounter emerged as of primary importance; they indicated that it was a good relationship that comprised positive/happy feelings. A parent describes this relationship as:

"It was super good, he (child) liked to go. One day I told him we were going, and I saw that he got happy, and I said: "you like to go?" "Yes, I like it, because I have fun and play, we do fun things", and he also liked it because he could talk with her, then he felt good (…) He felt he could tell her anything (…) he could unburden…".

Core elements encompassed in the description of the therapeutic relationship, such as trust and affection, were built through an ongoing process as therapy developed. One therapist reflected about the construction of trust as follows:

> "Trust allowed him to bring his own topics, to go from being uncomfortable, from mistrust in the space with me, to being able to communicate his issues (…) when he told me things, he opened himself to me, I did not criticize him but accepted what he was showing me…".

As a result of an interactional process between child and therapist, a stronger emotional connection emerged, as a therapist explained:

> "In the beginning she arrived very over-adapted, to offer me something very correct, a correct girl (…) so we built a relationship where the main invitation was for her to be more like a child (…) to be able to express herself more freely. And when this was achieved it was a very strong relationship, in terms of atonement, complicity... a fun relationship, with lots of laughter, but also validation".

Progressively the therapist was held in mind by the child and the parents, and participants described that children cared for the therapist and the therapeutic space and talked about their therapist when at home. In longer therapies, therapists also underlined the child's affectionate and attentive attitude towards them, which was viewed as expression of a positive bond, as one therapist explained when describing the relationship:

> "I felt close to him (…) in general I think that there was trust, there was affection between the two of us (…) and that speaks to the fact that we had a good bond (…) he had the capacity to be able to express more (…) and to ask me things, about my nephews for example, so there was a good bond in that sense".

In longer processes, therapists were viewed as an ally by the children, as the therapist was a supportive figure for them. This aspect was expressed by one therapist as follows:

> "[Child's name] bonded a lot with me, so when her mother lost control, [child`s name] told her: "I'm going to tell on you to my psychologist (…) if you treat me badly, I will tell my psychologist." Then she began to express her needs, to set limits, even to her mother, which she did not do before".

The positive relationship described also created a significant loss once therapy ended, mostly in longer therapies. Children recalled feeling sad about not being able to see their therapist anymore, expressing that they would miss their therapist and wished not to be forgotten by them. A six-year-old girl recalled her feelings about the end of therapy:

> "I did not want to leave (...) but I gave him something we did (…) A drawing, I came here, and I gave it to him so he wouldn't forget me".

The relationship between parents and therapists was also described as a good by participants, characterized by parents and therapists as trusting, close, collaborative and supportive. A mother referred to the relationship with her daughter's therapist as:

> "A relationship of affection is created, because deep down you have to show yourself as you are, all your defects, what you do well, what you do wrong, and you have to be like an open book because if you don't, it doesn't work, then a bond is generated necessarily".

As in the therapeutic relationship with children, parents and therapists noted that parents' trust, closeness, affection and feeling supported developed over time. This process began with the parent's positive valuation of the therapist's commitment and interest towards their child. Other important elements identified by parents for the construction of a positive relationship with the therapist, included appreciation of the therapist's personal style, feeling comfortable with a therapist who listened in a receptive way and frequently helped with issues that went beyond the initial reason for consultation. Parents felt they were no longer alone with their child's difficulties, as the therapist shared a genuine concern for the child's wellbeing. Some parents also viewed this relationship as helpful for them, and positively valued this relationship.

**d) The role of the therapeutic relationship in shaping children and parents' motivation towards therapy and as a facilitator of change**

As previously described, a positive therapeutic relationship shaped children and parents' motivation and belief in therapy. Participants described that the initial reticence in children changed and they began to feel motivated to meet with the therapist. A 10-year-old boy describes this event in the following way:

> "At first, I was a little nervous, we didn't know each other, and then I got used to it, we started doing more sessions (…) but at first it was like 'ajj' (in rejection tone) and I thought "I don't want to go in"; like embarrassment and fear (…). I wanted to be with my dad, with my mom, and then I went in and realized that the lady was nice, that it was cool to be there, we drew together, which is something I love".

Parents went along with this process, as their initial reserve changed towards a positive disposition and validation towards the therapist, as they valued the therapist's attitude and approved the therapist's work. One mother recounted this experience as:

> "I was scared in the first session, I mean, I saw her so young (…) and my husband felt rejection too. (…) But when I listened to her and she paid close attention to what I was saying (…) and you realize that, that she understands you, helps you, and what she is saying really helps, because when you do that, it really (…) works, so that for me was incredible".

Parents responded to the therapist's dedication with a higher engagement in their children's therapy, committing to change and compliance towards the therapist's interventions and guidelines. The construction of a positive relationship with the parents, was viewed as a facilitator of the child's therapeutic process, as one therapist noted:

> "I think it influenced a lot, because if we had not formed a good bond, first they would have dropped-out long ago, and we could not have worked on certain topics (…) the fact that we had a good relationship enabled her in some sessions to highly encourage her son, she was super important, I felt she really supported his therapy".

Once a positive therapeutic relationship had shaped a higher motivation of children and parents towards therapy, it facilitated the development more extensive therapies. In these cases, the therapeutic relationship was viewed as a facilitator of change in children's self-concept and relational repertoire. The therapeutic relationship worked as a relational modelling tool for the child, as one therapist explained:

> "She became conscious that those little things that happened to her with me, also happened to her with her friends. So that we could address them for her other relationships. So, they were like small misunderstandings, but they were very useful for her to realize certain aspects of how she was behaving".

Some therapists underlined that the establishment of a relationship with someone who validated the child and focused on them beyond their difficulties or problems also worked as a facilitator of change in the child, as one therapist said:

> "I believe that being able to interact with him without this prejudgment that he's the bad boy (…), constructing a more positive relationship with him, with an adult that wasn't his parents or family. I think that having someone who could listen to him, who could understand him, who could play without scolding him or telling him what to do or not do, I think that helped him".

As children felt validated in the therapeutic relationship, they gained confidence in other contexts too. Children began to speak out their needs and feelings and strengthened their social skills. One boy described the therapist's help in the following way:

> "She helped me with my attitude, with my person, with myself, because before I was more fearful, I was shyer, I couldn't make friends, I only had two, and after I had more (…). And the therapy helped me because it helped me to find the confidence I needed to talk to other people".

Concerning parents, they appreciated that they were included in their child's therapy and reported that they also felt like patients in the relationship with their child's therapist. As therapist and parents established collaborative work, it facilitated that parents overcome their sense of ineffectiveness and insecurity, as they managed to deal with problematic issues with the therapist's help.

## Discussion

According to the perspectives of the main actors involved in this study, child psychotherapy was viewed as a relational experience, particularly by children and parents, who made no real distinction between therapeutic interventions and interactions. This coincides with Gelso's (2019) position, who argues that techniques and relationship are not separate entities, as their expression interrelates through the therapeutic process. In this sense, the use of play and playful activities as central therapeutic techniques in child psychotherapy, acquired a higher importance through their relational value in this study, as they facilitated a positive relationship between patient and therapist. This finding opens up a discussion about the role of play in child psychotherapy, as it extends its use beyond the technical dimension encompassed in each therapist's theoretical background, drawing attention to children's experience of play as part of the therapeutic encounter. How the therapist interacts during playful activities seemed central in this study, as the therapist's full engagement made it possible for the child and therapist to experience mutual involvement. This element emphasizes the role of the therapist's genuineness, broadly defined as the use of the real self and sincere behaviour in the therapeutic relationship. Gelso (2019) underlines the fundamental value of the real relationship in the psychotherapy relationship, considering genuineness as one of its basic qualities. The role of genuineness has been previously discussed in child-centred play therapy as a central aspect of the process (Blanco et al., 2014).

Concerning the formation and development of the therapeutic relationship, initial reticence among children and their parents towards the therapist and therapy were observed;

similar findings have been reported in previous studies (Elvins & Green, 2008; Karver et al., 2006; Shirk & Karver, 2011). However, as the therapeutic relationship was positively experienced by both children and parents, their motivation towards therapy increased, enhancing adherence to therapy (Hawley & Weisz, 2005; Karver et al., 2018). In this study, an improved relationship stemmed initially from the therapist's attitude and disposition. Gelso (2019) has underlined that similar features in therapists work as facilitative conditions of therapeutic change, but do not represent the whole relational dimension as they focus solely on the therapist's contribution.

Accordingly, the therapeutic relationship was viewed as a gradually co-constructed process, in which therapists, children and parents assumed different roles as it developed. This finding underlines the conceptualization of the therapeutic relationship as a dynamic process (Safran & Muran, 2006), which requires time to grow. In long-term therapies, particular affective phenomena were observed, such as the internalization of the therapist as a significant other and as an ally for the child. The advocacy role of the therapist has been previously described (Caroll, 2002), and seems particularly relevant when children require higher regulation of their caregivers. The internalization of the therapist as a positive figure for the child recalls elements of Attachment Theory; a core contention of this theory is that the therapist can undertake the role of an attachment figure within the relationship, and when this relationship favours affective bonding it can become part of the child's internalized relational resources (Holmes, 2015).

Regarding the therapy ending process, many children experienced mixed feelings as they missed their therapist once therapy had concluded. This result has been previously described, as patients often find it difficult to end the therapeutic relationship, involving loss and a mourning process for the child (Karush, 2014). This finding highlight that the ending of psychotherapy occupies a significant place in the overall therapeutic experience for children, and that the associated feelings accompany them after the process concludes.

As in previous studies (Accurso & Garland, 2015; DeVet et al., 2003; Hawley & Weisz, 2005) a positive relationship between parents and therapists strengthened a cooperative role of parents in the child's therapy and represented a supportive relationship for parents. In addition, the child's relationship with the therapist mediated the relationship between child and parents,

regulating their interaction in several ways. The triadic link in the therapeutic relationship between child-therapist-parent observed in this study has been formulated previously (Gvion & Bar, 2014) and has significant implications for child psychotherapy process and outcome (Karver et al., 2018).

In light of the present study, the definition of the therapeutic relationship acquires particular facets in relation to child psychotherapy: the inclusion of parents/caregivers in a triadic relationship, the formative role of the relationship and the significance of the real relationship. Therefore, the contributions of children, therapists and parents interrelate in a complex way as the therapeutic relationship develops.

**Strengths and Limitations**

There are a number of strengths to this study. The inclusion of children as participants in this study made it possible to explore a perspective which is often absent in the literature. In addition, examining various perspectives led to complex and rich findings, where participants tended to converge in a positive valuation of the therapeutic relationship (as in Zorzella et al., 2017), but at the same time differed about central aspects of the relationship (Accurso & Garland, 2015; Kazdin et al., 2006; Zandberg et al., 2015). The combination of interviews and drawings worked as complementary sources of information, and drawings allowed children's narratives to expand, and new dimensions to appear. The inclusion of age-appropriate methods enabled children as informers of their experience, providing rich information about child psychotherapy, as demonstrated in other studies (Capella et al., 2015; Carlberg et al., 2009; Carroll, 2002; Luttrell, 2010; Midgley, 2004).

A limitation of this study was that only positive therapeutic relationships were described. This issue is not always what happens in therapy, as sometimes a poor therapeutic relationship is experienced, compromising the therapeutic outcome (Creed & Kendal, 2005). The overall positive views in this study may reflect a bias in the selection of participants, as almost all cases continued therapy until discharge was agreed. Only one case dropped out of therapy, in which a weaker relationship between parent and therapist was observed and the parent decided to prematurely end the therapy, as has been observed in previous studies (Hawley & Weiss, 2005). The timing of assessment soon after the end of therapy may have influenced participants to

recall more positive than negative aspects of the recent therapeutic experience, as they possibly merge the quality of the relationship with the therapeutic outcomes (Horvath et al., 2011).

**Implications for Practice**

The findings of this study suggest that therapists need to pay special attention to enhance children and parents' validation and empowered role in the therapeutic relationship, and overcome possible implicit or explicit reticence. In this study, an improved initial relationship was facilitated through a triad of key elements displayed by therapists: a committed and engaged attitude, a kind and playful stance towards the child and professional capability. Attention towards these broad elements of the therapists' contribution should be underscored in practice and training.

A second implication of this study for practice is that the development of play and child-centred activity are vital elements for the construction of a meaningful therapeutic relationship. This requires therapists' genuineness and true engagement. Joint play goes beyond being a technique for elaboration of psychological contents, or a facilitator for the child's collaboration; it stands out as a relational setting that enables the development of a real relationship. This idea converges with prior critiques towards therapists' training, which focuses more on developing skills and techniques than on genuineness (Blanco et al., 2014), and supports the importance to address this aspect in training and practice.

A third significant element is the construction a positive therapeutic relationship both with children and parents. This issue represents a higher demand for clinicians, as two parallel and connected relationships must develop. It implies the necessity to note and address the emotional impact for therapists of bearing this dual relational demand.

Finally, attending to the ending of therapy, including a consideration of the child's specific needs to gradually move away from the therapeutic relationship, is required for good clinical practice (Novick & Novick, 2006). A satisfactory ending seems crucial, ensuring the child's full comprehension and active participation in this stage of therapy.

**Implications for Research**

A multiple perspective approach towards the therapeutic relationship in child psychotherapy seems important for a more accurate grasp of its nature. In addition, measures at

different moments of therapy are relevant for understanding its development. To move forward in this path, mixed method and longitudinal designs may provide broader and deeper information. The use of drawing as part of such studies, especially when including younger children, may also be important, as well as the exploration of alternative analysis guidelines of the therapeutic relationship, for example those used to examine attachment relationships (Fury et al., 1997). Where possible, studies should include participants with more negative experiences of the therapeutic relationship, as well as therapies where the ending of treatment has been premature (e.g., O'Keeffe et al., 2019).

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## 4.2. Thesis paper 2: Initial therapeutic alliance, clinical and demographic variables: an analysis from the perspectives of children, parents, and therapists

# Initial therapeutic alliance, clinical and demographic variables: an analysis from the perspectives of children, parents, and therapists.

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**Abstract**

**Background:** the initial therapeutic alliance plays a key role in psychotherapy, leading to better treatment adherence and outcomes. Since research has largely focused on adults, more child psychotherapy studies seem necessary, which include specific instruments for this group, clinical and demographic variables, and the inclusion of the perspectives of children, caregivers and therapists. **Objective:** to determine the association between the symptomatology, age, and sex of the child, the years of experience of the therapist, and the initial therapeutic alliance from the point of view of children, therapists, and caregivers. **Methods:** a quantitative, non-experimental, and cross-sectional design of a descriptive, comparative, and correlational nature. **Results:** significant correlations were found between the age of children and their report about the initial alliance, between the child's symptomatology and the therapist's initial alliance report, and between the multiple reports about the initial alliance. **Conclusions:** the integration of multiple perspectives provides a larger understanding of the initial therapeutic alliance. The present study contributes to the comprehension of the therapeutic process by revealing significant differences in the initial therapeutic alliance as reported by children depending on their developmental stage.

**Key words:** therapeutic alliance, child psychotherapy, multiple perspectives, patient-therapist factor.

## Introduction

Psychotherapy has been described as one of the most efficient tools to meet the mental health needs of adults (Lambert & Bergin, 1994) and children (Weisz et al., 1987); fostering changes at a behavioural, identity, relational, and affective level in children (Alamo, 2019; Álvarez, 2017). Studies on the efficacy and effectiveness of psychotherapy highlight the therapeutic alliance as one of the central common factors for outcome and changes in patients (Karver et al., 2006; Krause et al., 2006; Asay & Lambert, 1999). The therapeutic alliance has also been found to be significantly associated with adherence and improvement (Karver et al., 2006), leading to direct changes in some patients (Hawley & Weisz, 2005; Horvath & Luborsky, 1993). Meta-analytic studies have shown an association between the alliance quality and outcomes in child psychotherapy, which vary depending on diagnosis, type of therapy, study design, and treatment setting (Karver et al., 2018).

Initially, Bordin (1979) defined the therapeutic alliance considering three core elements: agreements on the aims of the therapy, collaboration regarding tasks, and the establishment of an emotional or personal bond. These three components have been studied by several authors (Bordin, 1979; Horvath & Luborsky, 1993; Zorzella et al., 2017), who have highlighted the overarching role of the alliance in psychotherapy, in all its forms and theoretical approaches (Kazdin & Durbin, 2012).

Horvath and Luborsky (1993) identified two phases in the alliance development: an initial phase and an advanced phase. The initial phase encompasses the first sessions and makes it possible to attain satisfactory levels of collaboration and trust, which are vital for outcome and the development of the treatment. The second, more advanced phase, is defined as the critical part of therapy. During it, the therapist's interventions challenge the patient's neurotic patterns, generating a reduction in the sympathy and support experienced initially. Regarding the contribution of the initial alliance, it has been linked to better outcomes, increased adherence, and a trust-based bond that makes it possible to discuss more complex topics in the latter stages of the treatment (Cruzat-Mandich et al., 2017; Liber et al., 2010).

Most studies on the therapeutic alliance have been developed with adult patients, however, this variable is also essential in child psychotherapy, leading to better outcomes and symptom reduction (Kazdin & Durbin, 2012; Liber et al., 2010). In addition, some barriers for the alliance construction have been identified, especially in children aged 2-11 years, such as insufficient parental support and economic factors (Campbell & Simmonds, 2011), which could be ascribed to differences between adult and child psychotherapy. Child psychotherapy involves the participation of parents or caregivers; children are brought to therapy by an adult, and they are not always aware of the problems and may not agree with the adult's perspective. Therefore, motivation for change may only exist in the adult and not be shared by the child (Karver et al., 2006; Baylis et al., 2011). Considering this issue, it is necessary to take into account the development of multiple alliances in child psychotherapy, distinguishing potential divergences between the participants' aims and variations over the course of the treatment (Shirk et al., 2011). The therapist enters an existing triadic relationship between the child, the father and the mother, in order to establish another triangle: one composed of the therapist, the child, and the child's parents. Parents represent and evidence the child's external and interpersonal world in daily life, whereas the child directly shows the therapist his/her internal and personal world (Gvion & Bar, 2014). To improve therapeutic outcomes and expand our understanding of the construct, it is relevant to consider the inclusion of multiple perspectives during psychotherapy (Abrishami, 2009; Clark, 2013; DiGiuseppe et al., 1996; Shirk et al., 2011), evaluating the quality of the alliance separately in caregivers, therapists, and children. Recent longitudinal studies that consider these three perspectives in child psychotherapy and trauma, report significantly more positive alliances throughout the process in children and therapists compared with parents or caregivers (Zorzella et al., 2017). Other studies have linked a positive alliance with parents to therapeutic change in the child (Dowell & Ogles, 2010; Hawley & Weisz, 2005; Karver et al., 2006), further stressing the relevance of studying the alliance from the points of view of all the parties involved.

Several factors have been observed to influence the alliance in children, therapists, and parents or caregivers (Shirk et al., 2011). In children, age, sex, and symptomatology can have an effect. Between 6 and 12 years of age, children are expected to attain logical thinking, integrate socially, and develop greater emotional regulation (Midgley et al., 2019). However, when these elements are developing, a causal type of thought may predominate, making it

difficult to understand basic aspects of the alliance such as the tasks and goals of psychotherapy (Bordin, 1979). Given these characteristics of childhood cognitive development, therapy must consider short-term concrete results and rewards (Ronen, 2003). The literature also indicates that children with developmental issues face difficulties when establishing the alliance (Shirk et al., 2011), while those that have stronger social and intellectual competences assess the alliance more positively (Kazdin & Durbin, 2012; Klebanoff et al., 2019).

In addition, it has been observed that therapists are more confident of their ability to establish a positive alliance with children aged 6-11 and report a better alliance with this age group compared to others (Campbell & Simmonds, 2011). As for the patient's sex, this variable has mostly been analysed in adolescents and adults. In adolescents, same-sex pairings with the therapist are associated with a positive alliance. Specifically for female adolescents, research shows that they are more appreciative of interpersonal encounters than males, appearing to find it more attractive to establish a bond with their therapist (Wintersteen et al., 2005; Gilligan, 1982). Studies in adult population have yielded a variety of results: some show that same-sex patient-therapist pairings have a positive impact on the initial therapeutic alliance, with this effect being subsequently lost (Bhati, 2014), while others show no effect (Behn et al., 2018).

Regarding symptomatology, studies show that constructing a positive alliance with children with externalizing symptomatology is more difficult than doing so with children with internalizing symptomatology (DiGiuseppe, et al., 1996; Halfon, et al., 2019). Therapists may need more time to understand the underlying meanings of externalizing symptoms, which may in turn cause patients to feel misunderstood and lacking in immediate support during the treatment (Abrishami, 2009; Shirk & Karver, 2003). In contrast, therapists manage to reach agreements on tasks and aims more easily with patients with internalizing symptoms due to the absence of issues with authority figures (Digiuseppe et al., 1996).

With respect to therapist variables, experience is considered to be clinically relevant, although there is little empirical evidence for the association between this variable and therapeutic alliance development, especially in child psychotherapy (Shirk & Karver, 2003; Wintersteen & Mesinger, 2005). Studies on adolescents and on the alliance between the therapist and the parents/caregivers of children receiving psychotherapy report that a better alliance is achieved with less experienced therapists (Wintersteen & Mesinger, 2005; Accurso & Garland,

2015). Together with the therapist variables that influence the alliance, it should be noted that they tend to have a more negative opinion about the alliance than children and their parents or caregivers (Shirk et al., 2011; Accurso & Garland, 2015).

Regarding parents or caregivers, the alliance that they establish with the therapist has been linked to the maintenance of a good therapeutic process, engagement with the therapy, and treatment adherence (Abrishami, 2009; Clark, 2013; DiGiuseppe et al., 1996; Shirk et al., 2011). With respect to variables associated with the quality of the parental therapeutic alliance, the parents of children with externalizing symptomatology display a better alliance than those of children with internalizing symptomatology, which could be ascribed to the possible difficulties associated with tackling behavioural symptomatology (Hawley & Garland, 2008; Hawley & Weisz, 2005; Hukkelberg & Ogden, 2013). Nevertheless, research on this subject has focused on adolescent patients, and it is not clear whether the same is true for the caregivers of younger children.

Based on the evidence and the importance of the therapeutic alliance in child psychotherapy, this study aims to define the association between the symptomatology, age, and sex of the child, the years of experience of the therapist, and the initial therapeutic alliance from the point of view of the child, the therapist, and the main caregiver. It was hypothesized that a significant association would be found between these variables and that the value of each could be used to predict the initial therapeutic alliance as reported by the three actors. The results of this study are expected to contribute to the field of child psychotherapy and clinical work with children, drawing attention to sociodemographic and clinical variables in the initial construction of the therapeutic alliance.

## Methods

### Design

This study comprised a quantitative, non-experimental, and cross-sectional design, of a descriptive, comparative, and correlational nature. This article describes and characterizes the following variables: initial therapeutic alliance from the perspective of therapists, children, and their caregivers, the number of years of experience of the therapist, and the age, sex, and clinical symptomatology of the child.

## Participants

The cases studied were those of 27 patients who initiated a psychotherapy process at two university psychological care centers in Santiago de Chile. Each case included the child patient (N=27), his/her father, mother, or main caregiver (N=27), and his/her therapist (N=20), with the study comprising a total of 74 participants. The inclusion criteria adopted was the following: children aged 6-10 years, who could read and write. The report of the caregiver who attended the psychotherapy sessions and stayed in contact with the therapist was considered. The exclusion criteria were children with a severe physical and/or psychiatric pathology (schizophrenia spectrum and other psychotic disorders and/or disorders requiring hospitalization), adults who did not directly participate in the intervention, had no contact with the therapist, or were affected by severe physical or psychiatric pathologies.

## Instruments

***Characterization chart.*** Material constructed by the research team to collect information about the patient (name, age, date of birth, sex, educational level/type of school, reason for seeking help, and diagnosis), the caregiver (name, relationship with the patient, sex, and age), the therapist (name, sex, age, years of clinical experience, and theoretical approach), and the therapy (starting date, termination, number of sessions, and discharge criteria).

***Therapeutic Alliance Scale for Children-revised (TASC-r)*** (Shirk & Saiz, 1992). Self-report scale that evaluates the child's and the therapist's perception regarding the patient's alliance through 12 items scored on a Likert scale ranging from 1 to 4. The cut-off scores suggested by Zorzella et al. (2017) were employed, considering alliances over 25 to be high. The original reliability of the scale was $\alpha = 0.84$ (child version) and $\alpha = 0.97$ (therapist version) (Shirk & Saiz, 1992; Shirk et al., 2011; Creed & Kendall, 2005). In the present study, the reliability was $\alpha = 0.70$ for the child version and $\alpha = 0.79$ for the therapist version, with the overall scale reaching $\alpha = 0.81$.

***Therapeutic Alliance Scale for Caregivers and Parents (TASCP)*** (Accurso et al., 2013). Scale created upon the basis of the TASC-r which measures the therapeutic alliance of the caregivers toward the therapist. It consists in 12 items and comprises two parallel versions, one for the caregiver and another for the therapist, with a maximum score of 48 points. In the original study, the instrument exhibited adequate reliability, with values ranging from $\alpha=0.85$ to $\alpha=0.88$ in its

English version. In the present study, the overall scale reached α=0.81, while the caregiver and therapist versions reached α=0.72 and α=0.78 respectively.

The TASC-r and the TASCP were administered in Spanish-language versions adapted for Chile by some of the authors. The instruments were first translated from English into Spanish and then back translated, with a pilot version being generated and evaluated by expert raters. Subsequently, cognitive interviews were conducted, and the final versions adapted for Chile -employed in the study- were produced.

***Strengths and Difficulties Questionnaire (SDQ-Cas).*** Screening tool created to detect possible psychopathology in children aged 4-16 years. Studies conducted in Chile have shown an adequate level of reliability, with α = 0.73 (Caqueo-Uriar et al., 2014), while good sensitivity and specificity values have been found for the Spanish version as well (α =0.96 and α = 0.95 respectively) (Fajardo et al., 2012). In this study α value was 0.765. The questionnaire includes 25 items and 5 subscales: hyperactivity/inattention, behavioural problems, emotional problems, problems with peers, and prosocial behaviour, which can be ordered in two second-order factors, the externalizing and the internalizing factor (Goodman, 2001; Ortuño-Sierra et al., 2016). In this study, the classification of the normal range was based on the overall scale adapted in Chile by Carrasco (2017), which considers: 0-13 points, "normal" with no psychopathology; 14-16 points, "borderline", where the presence or absence of psychopathology cannot be determined; and 17-40 points, "abnormal" with psychopathology. Only the overall score of the SDQ-Cas for caregivers was used, since the subscales have not been shown to be adequately reliable in Chile (Brown, 2012).

**Procedure**

First, an informative meeting was held with the child clinical teams at both centers, where the objectives of the study were explained, and a collaboration agreement was established. The therapists who agreed to participate invited their patients who were starting their psychotherapies to join in the study. Those who decided to participate were contacted by a member of the research team after their first session, who explained to the children and caregivers the purpose of the study, what their participation would involve and the risks and benefits of enrolling. The caregivers who agreed to participate signed an informed consent, while the children signed an informed assent. Afterward, the instruments were administered.

The caregivers and therapists completed a self-report instrument, while a team member assisted the child if necessary. The study was reviewed and approved by the Research Ethics Committee of the Pontificia Universidad Católica de Chile.

### Data analysis

Collected data was analysed with the Statistical Package for the Social Sciences (IBM SPSS 25). Descriptive analyses were conducted, reporting averages, standard deviations, and frequencies, along with t-test analyses, Pearson linear correlations and multiple linear regression analyses.

## Results

### Sample characterization

The participating children's ages ranged from 6 to 10 years (M=7.96; SD=1.34). Most of them were male and initiated psychotherapy due to externalizing symptomatology. Regarding the bond between the caregivers and the children, most were the patient's mother or father (Table 1). The characteristics of therapists are displayed in Table 2.

**Table 1**

*Characterization of children and caregivers*

| | Frequency | % |
|---|---|---|
| **Child's age** | | |
| 6 to 7 years | 12 | 44.4 |
| 8 to 9 years | 11 | 40.7 |
| 10 years | 4 | 14.8 |
| **Child's sex** | | |
| Female | 11 | 40.7 |
| Male | 16 | 59.3 |
| **Initial symptomatology** | | |
| Externalizing | 20 | 74.07 |
| Internalizing | 7 | 25.93 |
| **Relationship with caregiver** | | |
| Mother or father | 24 | 88.9 |
| Grandparent | 2 | 7.4 |
| Aunt | 1 | 3.7 |

**Table 2**

*Characterization of therapists*

| | Frequency | % |
|---|---|---|
| **Therapist's sex** | | |
| Female | 17 | 85 |
| Male | 3 | 15 |
| **Years of experience** | | |
| 1 or fewer | 12 | 60 |
| 2 to 5 | 3 | 15 |
| 6 to 10 | 3 | 15 |
| 11 or more | 2 | 10 |
| **Therapeutic orientation** | | |
| Systemic | 10 | 50 |
| Cognitive constructivist | 4 | 20 |
| Psychoanalytical | 3 | 15 |
| Integrative | 3 | 15 |

## Descriptive symptomatology results by caregiver

According to the scores obtained in the SDQ-Cas from the caregivers' view all the children were within an “abnormal” range, indicative of psychopathology (Table 3).

**Table 3**

*Ranges of clinical symptomatology in children as reported by their caregivers*

| SDQ-Cas | Frequency | % |
|---|---|---|
| **Psychopathology** | | |
| No | 0 | 0 |
| Borderline | 0 | 0 |
| Yes | 27 | 100 |

## Initial therapeutic alliance - descriptive results

Children, therapists, and caregivers tend to report a “high” initial therapeutic alliance according to the criteria set by Zorzella et al. (2017), being lower in therapists with both children and caregivers (Table 4).

**Table 4**

*Initial therapeutic alliance - descriptive statistics*

| | Mean | SD |
|---|---|---|
| **TASC** | | |
| Child version | 40.33 | 5.328 |
| Therapist version | 34.56 | 4.300 |
| **TASCP** | | |
| Caregiver version | 40.78 | 4.108 |
| Therapist version | 36.44 | 4.200 |

## t-test analyses

The first t-test analysis (t=.574, p=.571), with a 95% confidence interval, was conducted to determine whether the children's report of the initial therapeutic alliance differed by sex. Results show no significant differences between the alliance as reported by boys and girls.

The second t-test analysis (t=.744, p=.464), with a 95% confidence interval, was carried out to identify differences in the initial therapeutic alliance from the therapists' perspective depending on the children's sex. Results reveal no significant differences in the alliance as reported by the therapists in connection with the children's sex.

The third t-test analysis (t=4.385, p=.000), with a 95% confidence interval, was conducted to determine whether the initial therapeutic alliance as reported by the children differed from the therapists' reports. Results show significant differences between the children's and the therapists' reports of the alliance, with those of the children being higher.

The last t-test analysis (t=3.833, p=.000) with a 95% confidence interval, was conducted to determine whether the initial therapeutic alliance as reported by the caregivers differed from the therapists' reports. Results indicate that the caregivers report significantly higher scores than the therapists.

## Correlation analyses

A Pearson correlations matrix was generated to determine the association between the following variables: age and sex of the child, years of experience of the therapist, symptomatology of the child, initial therapeutic alliance as reported by the child, therapist's

initial alliance with the child, caregiver's initial alliance with the therapist, and therapist's initial alliance with the caregiver (Table 5).

**Table 5**

*Correlations between initial therapeutic alliance from all three perspectives and child and therapist variables*

| | Child age | Child sex | Therapist experience | Child TASC | Therapist TASC | Caregiver TASCP | Therapist TASCP |
|---|---|---|---|---|---|---|---|
| **Child sex** | .138 | | | | | | |
| **Ther. experience** | .222 | -.005 | | | | | |
| **Child TASC** | .405* | -.211 | -.287 | | | | |
| **Therapist TASC** | .237 | .016 | -.138 | .499* | | | |
| **Caregiver TASCP** | .019 | -.066 | .104 | .149 | .393* | | |
| **Therapist TASCP** | -.297 | -.108 | -.319 | .156 | .401* | .389* | |
| **Total SDQ** | .210 | -.064 | .518* | -.318 | -.441* | -.077 | -.191 |

First, a positive and significant correlation was found between the child's age and the child-reported alliance on the TASC (r=.405, p<.05), with older children reporting a better initial alliance quality than younger ones. Second, a positive and significant correlation was found between the quality of the initial therapeutic alliance as perceived by the child and the therapist (r=.499, p<.05). This indicates that there is a connection between the therapist's and the child's perception of the initial alliance. Third, a positive and significant association was found between the therapist-reported initial alliance with the child and the caregiver-reported alliance with the therapist (r=.393, p<.05). Fourth, a positive and significant correlation was found between the therapist-reported initial alliance with the child and the caregiver (r=.401, p<.05). Fifth, a negative and significant association was found between the therapist-reported initial alliance with the child and the presence of symptomatology in the child (r=-,441, p<,05). And sixth, a positive and significant relationship was detected between the therapist-reported and the caregiver-reported alliance (r=.389, p<.05).

## Linear regression analyses

To define the explanatory value of the variables with respect to each actor's report of the initial therapeutic alliance, several multiple linear regression models were generated. The multiple regression that used the *child-reported initial therapeutic alliance* as its dependent variable (Table 6) indicates that the therapist-reported initial alliance significantly predicts the

quality of the child-reported initial alliance. This suggests that better therapist-reported initial alliance is associated with better patient-reported initial alliance. The $R^2$ of indicates that this model explains 28% of the variance of the dependent variable *child-reported initial therapeutic alliance*, with this percentage being significant (F (2,24) = 6.064, p=.007).

**Table 6**

*Multiple linear regression with child version of the TASC as dependent variable*

| | | B | P |
|---|---|---|---|
| **Intercept** | | 12.473 | .135 |
| **Child age** | | 1.204 | .089 |
| **Therapist TASC** | | .529 | .020 |
| **Adjusted $R^2$** | .280* | | |

The multiple regression that used the *therapist-reported initial therapeutic alliance with the child* as its dependent variable (Table 7), indicates that the child-reported initial therapeutic alliance significantly predicts the quality of the therapist-reported initial alliance. This suggests that better child-reported initial therapeutic alliance is associated with better therapist-reported initial therapeutic alliance. The $R^2$ of this analysis indicates that the model explains 37% of the variance of the dependent variable *therapist-reported initial therapeutic alliance*, with this percentage being significant (F (4,22) = 4.840, p=.006).

**Table 7**

*Multiple linear regression with therapist version of the TASC as dependent variable*

| | | B | P |
|---|---|---|---|
| **Intercept** | | 9.351 | .342 |
| **Child TASC** | | .277 | .050 |
| **Caregiver TASCP** | | .253 | .168 |
| **Therapist TASCP** | | .205 | .255 |
| **Total SDQ** | | -.231 | .112 |
| **Adjusted $R^2$** | .371* | | |

The multiple regression with the dependent variable *caregiver-reported initial therapeutic alliance* (Table 8) indicates that the variables considered have no predictive value.

The $R^2$ of this analysis indicates that the model explains 15% of the variance of the dependent variable *caregiver-reported initial therapeutic alliance*, with this percentage being significant (F (2,24) = 47.882, p=.052)).

**Table 8**

*Multiple linear regression with caregiver version of the TASC as dependent variable*

| | | B | P |
|---|---|---|---|
| **Intercept** | | 21.624 | .008 |
| **Therapist TASCP** | | .270 | .174 |
| **Therapist TASC** | | .269 | .165 |
| **Adjusted $R^2$** | .153 | | |

Finally, the multiple regression with the dependent variable *therapist-reported initial therapeutic alliance with the caregiver* (Table 9) indicates that the variables considered have no predictive value. The $R^2$ of this analysis indicates that the model explains 16% of the variance of the dependent variable *therapist-reported initial therapeutic alliance*, with this percentage being significant (F (2.24) = 51.475, p=.047).

**Table 9**

*Multiple linear regression with therapist version of the TASC as dependent variable*

| | | B | P |
|---|---|---|---|
| **Intercept** | | 15.108 | .080 |
| **Caregiver TASCP** | | .280 | .174 |
| **Therapist TASC** | | .287 | .146 |
| **Adjusted $R^2$** | .160 | | |

## Discussion

The objective of the present study was to examine the degree to which the demographic variables age and sex of the child and the clinical variables symptomatology of the child and years of experience of the therapist explain the initial therapeutic alliance with the children and their parents/caregivers from the multiple perspectives evaluated.

Regarding children's age, older children report a better initial therapeutic alliance. It is relevant to consider the developmental variables of the children who took part in this study: the cognitive development and social integration milestones that school-age children experience enables them to generate relationships of collaboration and co-responsibility with others (Sepúlveda & Capella, 2019). Since the expected goals develop gradually, it is possible to detect differences between children aged 6 and 10 years, with the former displaying more difficulties to understand vital aspects of the therapeutic alliance due to a more concrete, perception-based thinking (Shirk & Brown, 2011; Bordin, 1979), which might explain the lower alliance reported by them compared with their older peers.

It should be noted that, although the child-reported initial alliance differed by age, in the case of the therapists, the children's age was not a significant variable. This difference reveals that the assessment of the initial alliance can change depending on its source (Accurso & Garland, 2015), which stresses the importance of including multiple perspectives without leaving out children's views.

Although the child's sex variable was not found to result in significant differences between perspectives, other studies have determined that the patient's and the therapist's sex is an influential variable, specifically when both parties are male or female (Wintersteen et al., 2005; Bhati, 2014). In the present study, it was not possible to examine same-sex pairings, as the sample comprised mostly female therapists (85%).

With respect to the child's symptomatology variable, 100% of the participating children were within the "presence of psychopathology" range, with this variable having a negative impact on the therapist-reported initial alliance. Also, most of the children were in treatment due to externalizing symptomatology (74.07%), which is consistent with reports of the negative impact of this type of symptomatology on the initial alliance as perceived by the therapist (DiGiuseppe et al., 1996; Halfon et al., 2019) and also coincides with the literature regarding the positive perception of the alliance by parents whose children exhibit externalizing symptomatology (Hawley & Garland, 2008; Hawley & Weisz, 2003; Hukkelberg & Ogden, 2013). In other words, most of the parents who took part in this study have children with externalizing symptomatology and report a positive perception of the alliance. Although

symptomatology was a negative variable for the therapist-reported initial alliance, it was not significant in the case of the children.

Concerning the therapists' years of experience factor, no significant correlation was found with the child- or therapist-reported initial alliance. Nevertheless, a large proportion of the therapists were in the initial stage of their professional career, with up to one year of clinical practice (60%). This issue suggests that future studies must consider this variable and its impact on the therapeutic alliance when generating a sample.

Regarding the initial therapeutic alliance from the perspective of the children and the therapists, both reported values considered to be high (Zorzella et al., 2017), but the children's scores were significantly higher than those of the therapists; furthermore, it was found that the higher the child-reported initial alliance, the higher the therapist-reported initial alliance. As for the therapeutic alliance with parents/caregivers, it was reported to be high by parents and therapists, with the former reporting significantly higher values. These findings are consistent with prior research on the therapeutic alliance with children and parents (Shirk et al., 2011; Accurso & Garland 2015). Even though the therapist-reported alliance was high, therapists tended to be more critical than children and parents regarding the initial therapeutic alliance. In future studies, it would be interesting to determine which elements of the alliance children, parents, and therapists incline to focus on. Previous studies have shown that children and parents focus on the affective aspects of the meeting with the therapist (Altimir et al., 2017), as well as therapists value the bond above everything else (Campbell & Simmonds, 2011). However, their views regarding the elements that predominate in their assessment of the therapeutic meeting have yet to be studied jointly.

With respect to the initial alliance with parents, although the variables studied revealed no significant associations, positive correlations were found between the parent-reported alliance with the therapist and the therapist-reported alliance with the parents and the children. Thus, the therapist's assessments of the initial alliance with the children and their parents/caregivers tend to coincide. This prompts the question of when and why differences appear between the alliance with children and parents, since they are similar during the first meeting. In addition, even though the multiple alliances are interconnected, the study of the alliance established with parents and caregivers must consider their clinical and demographic

variables, including their sex, age, the presence of psychopathology, and attachment styles, among others. These variables could be studied as predictors of the alliance, considering their impact on the therapeutic process and evaluating the influence of coincidences with the therapists' demographic characteristics.

Considering these results, it would be advisable to support younger children's comprehension of the psychotherapy during the first sessions in a way that matches their cognitive and socioemotional development, offering concrete and direct opportunities (Ronen, 2003) to foster the initial alliance. Likewise, it is necessary to strengthen the initial alliance with parents/caregivers, address any possible manifestations of rejection from younger children, and offer clear explanations of the meaning of the process and why it is necessary. With an older child, a low initial alliance could be a warning sign for therapists, who could work on an agreement on the aims and tasks of the therapy and try to strengthen the therapeutic bond, identifying what is hindering the alliance. Also, the findings presented in this study should encourage therapists to be more confident in their ability to establish a therapeutic relationship with all children, regardless of the symptomatology through which their issues are conveyed, since this variable was not found to be significant for children.

The main limitation of this study was its small and homogeneous sample -with respect to the sex and experience of the therapists-, which means that the results should be regarded as exploratory and weighed cautiously. This limitation was largely due to the issues encountered when generating the sample, the most serious being that many therapists, especially the more experienced ones, refused to participate. In this context, researchers should generate a larger and more visible contribution to clinical practice in order to alleviate to some extent the reticence voiced by therapists and make it more attractive for them to share their clinical work.

Another limitation of the study derives from the fact that the alliance was mostly measured after the first therapy session, that is, very early on in the process. Considering that the alliance is a dynamic process that spans the whole therapy (Safran & Muran, 2006) and that understanding it in detail requires taking measurements at multiple points in the process (Horvath, 2006; Roussos et al., 2016), the results presented can be regarded as representative of the first meeting between children, parents, and therapists; however, it is still necessary to study

their subsequent evolution and their predictive value for the continuity of the process and the outcomes achieved.

Lastly, it is possible to discuss research with children between 6 and 10 years of age, who display specific developmental characteristics. In this study, their incorporation yielded relevant findings, since their point of view regarding the initial alliance coincided with that of their therapists, thus enriching the analysis of the phenomenon. This highlights the importance of including children as key informants of their processes in order to counterbalance the adult-centric views of their experiences (Lutrell, 2010). Nevertheless, it was also observed that the self-report instrument used with the children produced rather homogeneous results, which calls into question the sensitivity of such measurements in the age group studied. In this regard, some authors have discussed the relevance of employing developmental-sensitive measurements with children, such as play and drawing, to encourage them to express themselves and gain deeper insights into their experiences (Alamo, 2019; Capella et al., 2015; Calberg et al., 2009).

Even though the present study is hindered by the above limitations, it also sheds new light on the therapeutic alliance in children, which remains scarcely researched compared to adult (Shirk & Karver, 2003). The results obtained prompt the question of which factors explain the initial alliance in child psychotherapy, both with children and their parents/caregivers, stressing the need to continue researching this largely unexplored field. Future studies may use a larger and more diverse sample, especially with respect to the therapists. Furthermore, it is necessary to take repeated measurements to reflect the construction and evolution of the therapeutic alliance and determine the predictive power of the initial therapeutic alliance regarding therapeutic outcomes. To do this, it is also necessary to examine children's experiences using developmental-sensitive instruments. Finally, it is relevant to continue researching the alliance established with parents or caregivers, examining clinical and demographic variables, their evolution, and their association with change in child therapy.

## Conclusions

Incorporating multiple perspectives allowed a more accurate understanding of the therapeutic alliance in child psychotherapy. The children's perspective represented a novel contribution that enriched the views of their parents/caregivers and therapists. Studying the

therapeutic alliance with children contributed to the generation of knowledge adapted to this age group, which has several particularities compared to other developmental phases. The studied developmental period appeared to be a highly sensitive period, as differences in the valuation of the therapeutic alliance were observed within a 4-year age range, being higher in older children than in younger ones.


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## 4.3. Thesis paper 3: The therapeutic relationship and change process in child psychotherapy: A qualitative, longitudinal study of the views of children, parents and therapists.

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# The therapeutic relationship and change process in child psychotherapy: A qualitative, longitudinal study of the views of children, parents and therapists.

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**Abstract**

**Introduction:** Through the perspectives of children, parents and therapists, this study explored the therapeutic relationship as a change facilitator in different moments of psychotherapy. **Methods:** The children, parents and therapists (N=15) who formed part of five therapeutic treatments were studied using a qualitative, longitudinal design. Thirty semi-structured interviews were done; half at the beginning and half after four months of psychotherapy. Children's drawings were incorporated, and data were analysed through grounded theory methods and qualitative analysis guidelines for drawings. **Results:** Participants identified several aspects of the therapeutic relationship as change facilitators. From the first encounters, the therapists' close and adaptable attitude promoted an improved motivation for psychotherapy and enhanced engagement among children and parents. Later in the process, a positive, child-centred and affective therapeutic relationship fostered the child's trust with the therapist as well as a positive relational experience, promoting associated changes in children and the

development of socio-affective tools. Parents and therapists saw their own relationship as a change facilitator, as well as a broader understanding in parents of their children and an improved relationship with them. Parent's and child's changes helped each other. **Discussion:** Specific and common aspects between participants' perspectives provided a richer understanding of the studied phenomena. This study supports the view that a positive therapeutic relationship facilitates early changes in the motivation of children and parents, and provides them a healing, relational experience as it develops. A positive parent-therapist relationship is also key for changes to further progress.

**Key Words:** child psychotherapy, therapeutic relationship, change process, children's drawings, qualitative methods.

## Introduction

Studies on the effectiveness of psychotherapy -measured through the reduction of symptoms- have consistently concluded that child psychotherapy is effective (Fonagy et al., 2015). However, when considering changes that are meaningful according to the experience of patients and therapists, therapeutic change is not just about the improvement of symptoms (Gómez & Roussos, 2012; Krause, 2005). The experience of change of those who participate in psychotherapy has been referred as 'subjective change', which implies a process of transformation of the subjective perspective of how the patients regard themselves and their problems, their environment and their relationships with it (Gonçalves, Matos, & Santos, 2009; Krause et al., 2006). This standpoint supports the growing appreciation for the perspective of clients on outcome, providing balance to the emphasis on quantitative outcome (Elliott, 2008).

The therapeutic relationship has played a central role in theories addressing the therapeutic process and has been signalled as the common factor that best explains change in adults (Horvath, Del Re, Flükiger, & Symonds, 2011) and in children and adolescents (Hawley & Weisz, 2005; Karver, Monahan, De Nadai, & Shirk, 2018). The therapeutic relationship has been defined as the feelings and attitudes that therapists and patients experience for each other and the way they are expressed (Gelso, 2014). The interplay between the technical and relational aspects of therapy has been noted, as they show mutual influence during the process (Gelso, 2019).

In contrast with the abundant research on adult psychotherapy, the therapeutic relationship in child psychotherapy has been less studied (Midgley, Hayes, & Cooper, 2017). This relationship has been usually reviewed through instruments based on Bordin's (1979) therapeutic alliance model (Wilmots, Midgley, Thackeray, Reynolds, & Loades, 2019), which emphasizes the bond, plus collaboration on goals and tasks, and has been examined mainly from the reports of therapists and parents (Noyce & Simpson, 2018).

The therapeutic alliance has proved small but significant positive correlations with outcomes in child psychotherapy (Kazdin, Whitley, & Marciano, 2006; Shirk & Karver, 2011). A positive therapeutic alliance has been associated with symptomatic improvements in children (Hawley & Weisz, 2005; Liber et al., 2010), and with positive outcomes in the treatment of different disorders (Karver et al., 2018). As this alliance grows deeper, further therapeutic changes have been observed (Kazdin & Durbin, 2012). Regarding the therapeutic process, a positive relationship between alliance and treatment adherence has been reported in adults from the initial phase of therapy (Principe, Marci, Glick, & Ablon, 2006). In contrast, mixed results have been reported in child therapy; one study showed that the early alliance with children and adolescents had no predictive value on the premature termination of therapy (Abrishami & Warren, 2013), whereas another study reported that a positive alliance with children and parents was associated with higher adherence and completion of therapy (Hawley & Weisz, 2005).

Considering these previous findings, three possible conclusions concerning child psychotherapy practice stand out, all of which require further investigation. First, establishing the child-therapist relationship may have a slower evolution in comparison to this process in adults (Shirk & Karver, 2003). Considering that collaboration is not as clear as with adult patients, forming the therapeutic alliance with children can be a difficult process because children may be reluctant to engage in psychotherapy; moreover, children may not fully understand why they have been brought to therapy and don't always agree with the adults about the therapeutic goals (Shirk & Karver, 2011). Despite the notion of possible initial difficulties in forming the therapeutic relationship, the evolution of the therapeutic relationship and its role in change processes in different moments in child psychotherapy has been scarcely studied.

Second, there are multiple levels of relationships in child psychotherapy, including those between the child and the therapist and between the parent or caregiver and the therapist (Shirk

& Karver, 2011; Karver et al., 2018). These relationships work in a triadic way, as they dynamically influence each other (Gvion & Bar, 2014) and imply that parents also play a fundamental part in the child's therapeutic change (Karver et al., 2018). It has been reported that the poor motivation of parents to start psychotherapy for their children, their expectations of not being involved in their treatment and their limited ability to think about feelings may be related to dropout rates in psychotherapy (Midgley & Navridi, 2007). Likewise, the parent-therapist relationship is associated with the commitment and the extra-session support of parents, which affects the child therapeutic change (Marker, Comer, Abramova, & Kendall, 2013). The parent-therapist alliance has a positive association with better parental skills and family interactions (Shirk & Karver, 2011). When this positive alliance is combined with high parental commitment with the therapy it also exerts a positive influence on the quality of the therapeutic alliance with the child (Campbell & Simmonds, 2011; Kazdin et al., 2006). The development of strong therapeutic relationships with the children and their families, by providing a stable, supportive, and accepting context, may facilitate the engagement to therapy and decrease the resistance to treatment (Karver et al., 2018). Yet, few studies jointly address the child-therapist and parent-therapist relationship as a triadic setting, to deepen in their mutual influence in the change process.

Thirdly, the views of different participants regarding the therapeutic relationship should also be considered. Some studies have found that children, parents and therapists tend to converge on a positive valuation of the therapeutic relationship (Zorzella, Rependa, & Muller, 2017), while others have observed differences between their reports (Accurso & Garland, 2015; Kazdin et al., 2006; Zandberg, Skriner, & Chu, 2015). Children and parents report higher valuation of the alliance than therapists (Accurso & Garland, 2015; Zandberg, et al., 2015), while the latter are more aware of alliance deterioration (Accurso & Garland, 2015). The positive view of children about the alliance has been more strongly associated to good outcome than their parents' perceptions (Green, 2006). These mixed findings emphasize the need to further explore the convergences and differences between the perspectives of children, parents and therapist, as well as the central aspects drawn from each viewpoint.

The importance of including the views of children, as they deliver valuable information regarding their therapies, has been emphasized in the literature (Carlberg, Thoren, Billstrom, & Odhammar, 2009; Midgley, 2004). Innovative methodologies such as play and drawing have

been used to favour the expression of children in a developmental sensitive way; this approach has enabled researchers to gain new perspectives (Alamo, 2019; Capella et al., 2015; Carlberg et al., 2009). Many children identify initial problems, and although their expectations towards therapy may be unclear or not recalled, their main concern can be not to get bored (Carroll, 2002). Children tend to report positive appreciations of their therapy (Capella et al., 2016) and to refer that what they liked more about therapy was spending time with their therapist (Carlberg et al., 2009). Children report achieving a deeper understanding of their problems, underlining that the therapist provided them with emotional support and listened to them (Capella et al., 2016).

The previous arguments support the therapeutic relationship with children and their parents as a central factor in the therapeutic change process. However, less is known regarding *how* it helps in different phases of psychotherapy from the perspective of children, parents and therapists. This study explores the child-therapist and parent-therapist relationship as a change facilitator at two different moments of the process from the perspective of children, their parents and their therapists. The main convergences and divergences among their perspectives are examined, as well as the key elements of each viewpoint. Considering that this study focuses on 'school age children' that is, children between 6 and 11 years old (Papalia & Martorell, 2015), an age-sensitive methodology such as drawings were employed.

## Methods

### Settings

This study was conducted in an outpatient university mental health service in Santiago de Chile. It involved children referred to psychotherapy in this service, their parents and therapists.

### Design

A qualitative longitudinal study that considered two different moments of the therapeutic process was developed. A multi-perspective approach was employed (Levitt, 2021) to explore the experiences of children, their parents and therapists.

## Participants

This study focused on school-age children who attended weekly psychotherapy, and with at least one of their parents actively involved. Exclusion criteria was the presence of impairing psychiatric disorders in the child or the caregiver, or dropout from psychotherapy. Twenty-seven cases met the initial criteria, from which five cases were selected for this study, which comprised five children, five mothers and five therapists, creating a total of fifteen participants, who took part in psychotherapy for four months. Each participant was interviewed at two different time points, leading to a total of thirty interviews. Sampling strategy was purposive and was based on maximal variation in terms of the sex and age of children, consulting reason and theoretical framework of the therapist. The intentional diversity between participants allowed a wider exploration of differential experiences within the studied group (Flick, 2018).

Three girls and two boys between seven and nine years old (M=8.2 years) participated in this study; they were referred to mental health care due to diverse reasons, including attention-deficit disorder, emotional dysregulation, anxious, depressive and somatic symptoms. They were given the following pseudonyms: Dawn, Eva, Zane, Mia and Vince. Five mothers, between twenty-nine and thirty-four years old (M=32.4 years) actively participated in the therapy of their children. The invitation to participate was extended to both parents, however fathers did not participate in this study as they were not present at the moment of the interviews. This situation reflected their low participation in the therapeutic process or difficulties in accompanying their children to sessions. The four female and one male therapist who participated represented diverse theoretical frameworks (systemic, psychoanalytic, cognitive-constructivist and integrative) but were more homogenous in terms of age (M=26 years) and experience (M=2.8 years). Three therapists were in training, a fourth was initiating her career and a fifth had eleven years of practice. Therapies were open-ended and interventions included individual sessions with the child and their parents, as well as family sessions. Directive and nondirective play, art and narrative techniques were offered. Participant's characteristics are detailed in Table I.

## Procedure

Participants were contacted at the beginning of therapy in the mental health service. Separate parallel interviews were conducted by research team members at the centre after the

first or second therapy session. After four months of therapy (M=16.4 sessions) participants were re-interviewed. Interviews of children included drawings to enhance their narratives and were led by a child psychotherapist, who was not part of the treatment team. Interviews were audio recorded and transcribed using the Mergenthaler Norms (Mergenthaler & Gril, 1996).

Table I. Participants Characteristics.

| **Child** | | | | **Parent** | | **Therapist** | | | |
|---|---|---|---|---|---|---|---|---|---|
| Pseudonym | Sex | Age | Consulting reason | Age | Kinship | Sex | Age | Theoretical framework | Practice (years) |
| Dawn | F | 7 | ADD/emotional dysregulation | 32 | Mother | F | 35 | Cognitive-constructivist | 11 |
| Eva | F | 9 | Anxiety/ depressive symptoms | 29 | Mother | F | 23 | Systemic | 0.5 |
| Zane | M | 7 | Somatization/ emotional dysregulation | 34 | Mother | F | 23 | Integrative | 0.5 |
| Mia | F | 9 | Anxiety/social phobia | 33 | Mother | M | 23 | Psychoanalytic | 0.5 |
| Vince | M | 9 | Depressive symptoms/ Memory issues | 34 | Mother | F | 26 | Systemic | 1.5 |

## Data Collection

### *Semi-structured interviews*

The interview protocol was developed for children; scripts for parents and therapists were adapted from this protocol. The script was oriented by three dimensions: a) expectations, consultation reason and initial motivation towards psychotherapy, b) experience of the therapeutic relationship with children and parents, c) experience of psychotherapeutic change in children and parents. Based on these dimensions, an interview guideline was created, which began with 'ice-breaking' questions, and then a broad question: *"What is it like to come to the therapy? I'd like to know whatever you want to tell me about it"*. Then, specific questions were asked if their content did not emerge in the free narrative, for example: *Do you think psychotherapy will help you? How is your therapist? How do you get along with him/her? Did something change in you, in others? Why do you think it changed?*

### *Drawings*

Children drawings took place in each interview and were in continuous dialogue with the interview topic guide. Interviewers engaged with the children about their drawings and asked non-leading questions about what they drew.

The two drawings included in the first interview were 'My psychologist and me' (Author 1 et al., 2021) and 'How am I at the beginning of therapy/How I want to be at the end of therapy', a variation of the drawing "Before/after therapy" (Capella et al., 2015). For the first drawing, children were asked to draw themselves with their therapist during therapy, and for the second, children were asked to draw themselves how they were at the beginning of therapy and how they would like to be when it ends. Colouring pencils and a sheet of letter sized paper were provided, that in the second drawing had a vertical line in the middle, generating side-by-side illustrations.

In the second interview two drawings were requested in the same terms as in the initial interview and included "My psychologist and me" (Author 1 et al., 2021), and 'How was I before therapy/How am I now' (Capella Gutiérrez, Rodríguez, & Gómez, 2018). For this last drawing, children were asked to draw how they felt and were before starting therapy and in the current moment.

## Data Analysis

Grounded theory (Corbin & Strauss, 2008) was used in the analysis of data. Open coding was based on a concept-indicator model, that consisted in labelling emerging concepts as they related to individual indicators, which were categorized considering theoretical and contextual information (Corbin & Strauss, 2008; Titscher Meyer, Wodak, & Vetter, 2000). Through an iterative process of analysis, emerging concepts were then sorted in a hierarchical organization. How concepts and categories develop and relate was registered through coding memos. Open coding was supported by ATLAS.TIv8 software. Subsequently, axial coding was performed to map relationships among concepts and categories.

To decrease coder bias, safeguard validation and enrich the analysis of data, an intersubjective triangulation strategy was employed, allowing several views to be considered (Altimir Capella, Núñez, Abarzúa, & Krause, 2017). Six coders participated in different phases of the identification of categories, comparing findings, and pursuing agreement (Flick, 2018).

After the initial analyse of drawings as part of the interview with children, these were further explored through qualitative analysis guidelines for therapeutic process-outcome drawings (Alamo, 2019; Núñez et al., 2021), focusing on the content analysis step, which explores the following elements: a) Central theme b) Central figures c) Environment d) Interaction between elements e) Use of colour as an expression tool.

Information provided by the initial data analysis, and the further analysis of drawings was integrated through methodological triangulation (Flick, 2018). The perspectives of children, parents and therapists were treated separately; then they were integrated when convergences were observed and differentiated when not. Findings from both time-points were described and compared, entailing a descriptive and relational process analysis (Corbin & Strauss, 2008).

### Ethical considerations

Ethical approval for this study was granted from the Scientific Ethics Committee in Social Sciences, Arts and Humanities of the Pontificia Universidad Católica de Chile.

## Results

Participants described a positive therapeutic experience and identified several interrelated changes favoured by a positive child-therapist relationship, both at the beginning and after four months of psychotherapy. Parents and therapists also mentioned their relationship as a change facilitator, noting that changes in children and parents facilitated each other. The change process facilitated by the therapeutic relationship was organized in five dimensions:

a) Beginning of therapy: understanding of the problem and disposition towards psychotherapy.
b) The first encounters with the therapist and initial changes.
c) Change facilitators associated with the development of the child-therapist relationship.
d) Change facilitators associated with the parent-therapist relationship.
e) Changes in children, in parents and in their relationship after four months of therapy.

The relationship between these dimensions and the core changes are outlined in Figure 1.

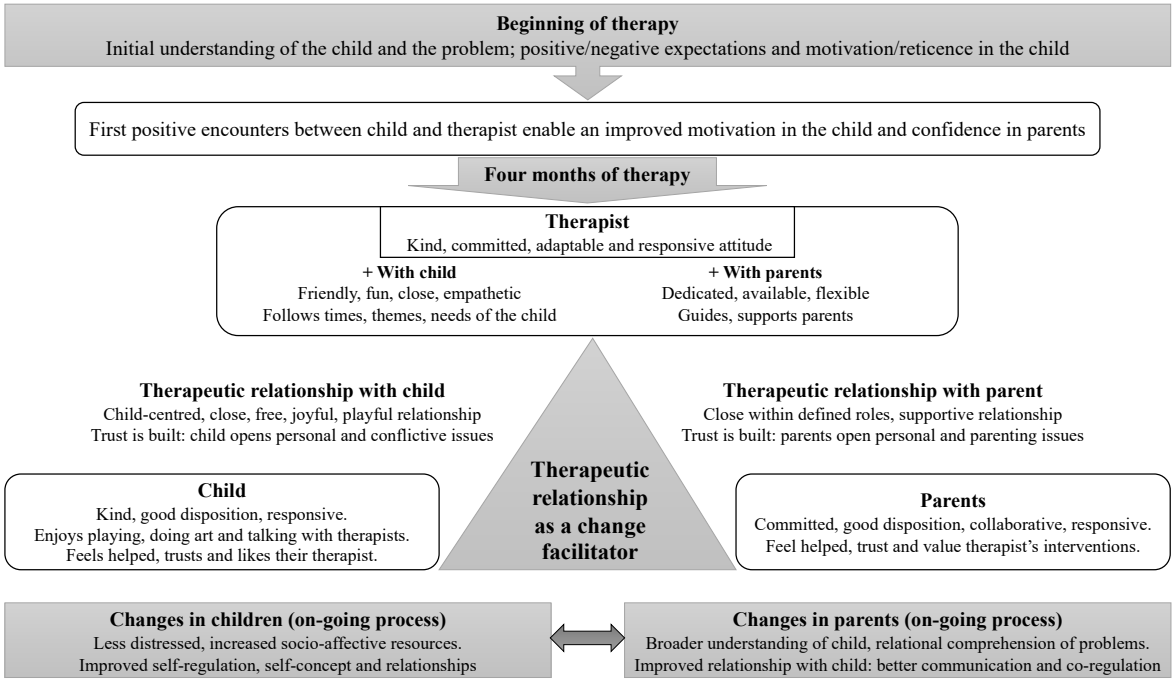


Figure 1: Therapeutic relationship as a change facilitator

### a) Beginning of therapy: *"I look black and grey inside".*

The parents spontaneously decided to start psychotherapy or followed the referral made by another professional. The initial consulting reason identified by participants was the emotional distress of the child. Children emphasized feeling sad or upset about their problems, and some added having difficulties and feeling lonely in peer relationships. These emotions appeared in the drawings of themselves at the beginning of therapy, in which troubled faces were observed. Scarce or no colour was utilized, and some children obscured their figure or added environmental elements to represent their emotional distress. These aspects can be seen in the drawing of Vince (Figure 2), about which he said: "I drew myself with a grey background because of the sadness and loneliness I felt (...). I look black and grey inside because of all the suffering I had at the other school".

It was observed in the children's drawings that their self-concept and difficulties were mingled at the beginning of the therapy; children came to the first session feeling bad about themselves and self-conscious in their relationships with others.

Figure 2: ‘How was I before therapy’ (Vince’s first drawing)

Some children and parents added a relational understanding of their problems, feeling responsible and distressed for generating discomfort in the other, as Eva held:

> “I’ve been too sad, and I cry for nothing. My mom stresses because she doesn’t know what’s wrong with me (…) she stresses out very quickly” (Eva).

From the parents’ point of view things worked in the other direction, as one mother stated:

> “she started with these episodes, first, because I started studying and, second, because I have panic attacks (...) so, I think that seeing me so low also affected her” (Mia’s mother).

Parents added feeling overwhelmed by their child’s problems, seeking for help from the therapist and for a better understanding of them.

Generally, participants had positive initial expectations of the therapeutic process, yet some children expressed negative expectations regarding the therapist or the effectiveness and purpose of therapy, leading to reticence and low motivation. Dawn expressed in this regard:

> “I didn’t want to come (...) because I didn’t know… I thought she [therapist] was going to be grouchy” (Dawn).

In these cases, parents and therapists related the child’s lack of motivation to tiredness and a negative mood due to the evening schedule of the session more than to the reasons raised by the children, evidencing discrepancies between their views.

**b) The first positive encounter with the therapist and initial changes: *"she came really reluctantly, and at the end she didn't want to leave".***

The initial attitude of children with the therapist reflected their initial motivation; it was described as positive by some participants and as rejecting by others, as one mother explained:

> "When we entered the interview with him, she was serious, very apathetic, like upset because she didn't feel like coming" (Mia's mother).

Despite this variability in the children's attitudes, children and parents underlined that the therapist was friendly, nice and kind to the child, which they positively valued.

After the first sessions, an improved disposition in the child and greater collaboration with the therapist was referred to by participants. According to their perspectives, this change derived from the good initial connection between child and therapist, as one therapist described:

> "the session had this development because she came very reluctantly, and at the end she didn't want to leave because we were talking, we were laughing. (...) it was a lovely session and now she's super motivated to come back to the next one" (Mia's therapist).

Parents and therapists also pointed out that the child's initial mood improved after the first sessions, feeling happier and less troubled. Parents mentioned feeling calmer and more confident after observing how the therapist managed to establish a positive relationship with their child.

Children emphasized feeling good and happy in these first encounters with the therapist; parents observed that their child felt comfortable and free, and some therapists mentioned that the child had fun and a good time. This positive relationship was represented in the children's drawings; when asked to draw the therapy situation at the first interview, the central figures had happy faces and positive feelings were expressed. In these drawings, the interaction between figures focused on the action of the therapist, who asked questions or spoke. The consulting room setting was emphasized through the furniture, materials, walls and door. It is possible to observe these elements in the drawings of Eva (Figure 3) and Zane (Figure 4).

Boundaries and concrete elements of the consulting room in the drawings of children seem to organize and sustain the interaction in this first moment of the therapeutic relationship.

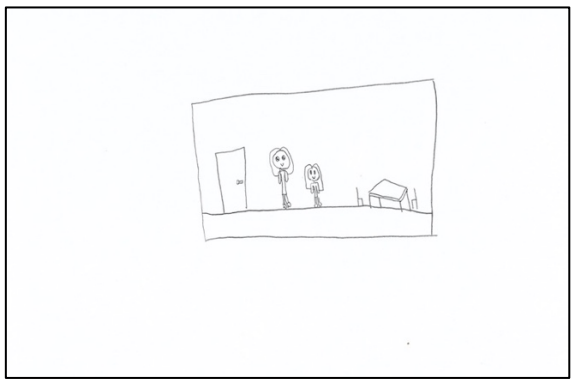

Figure 3: ‘My psychologist and me’ (Eva’s first drawing)

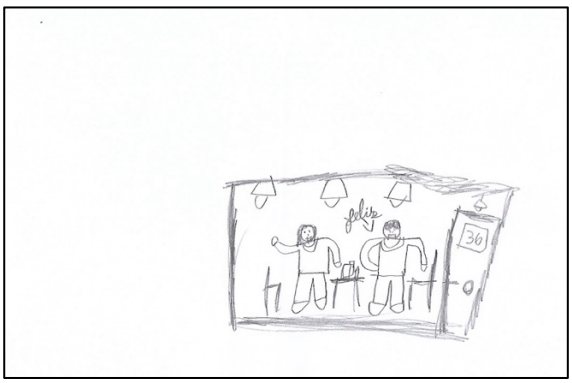

Figure 4: ‘My psychologist and me’ (Zane’s first drawing)

**c) Change facilitators associated with the development of the child-therapist relationship.**

After four months of therapy, participants expressed that the therapeutic relationship was a key change facilitator. The attitudes and disposition of child and therapist enabled a positive evolution of the therapeutic relationship, particularly in terms of trust and openness in the child. It was noted that the therapist’s interventions and attitudes merged from the point of view of children and parents, while therapists made a distinction between them.

***Attitudes and disposition of child and therapist that facilitated a positive development of the therapeutic relationship: “she’s funny and nice”.***

The nice, kind and friendly attitude of the therapist towards the child was again highlighted by children and parents as facilitators of the therapeutic relationship. Parents added that the therapist was caring, close and warm, and children said that the therapist was fun and cheerful. Children liked the way their therapist was and felt good with them, as Vince pointed out:

> “She's funny and nice. (I: How do you feel with her?) I feel good, I feel like reassured (...) (I: What do you like most about her?) That she lets me draw a lot” (Vince).

Participants also emphasized the therapist’s flexibility to adapt to the needs of children and give them freedom of expression, meaning that children felt comfortable in psychotherapy. Therapists mentioned focusing on the child’s interests, playing and doing things together, as

facilitators of the therapeutic relationship. The activities offered by the therapist were appealing for the children; they positively valued play and art, and some of them appreciated talking with their therapist. For therapists the use of play and art went beyond being relational facilitators; they were conceived as change facilitators as well, by supporting an empowered role in the child, allowing the therapist's access to the inner feeling and conflicts of the child and to focus on them.

Children were described in this relationship as kind, friendly, responsive and with a good disposition towards the therapist, which was considered therapeutic relationship facilitator.

***The positive evolution of the therapeutic relationship: "she opened little by little".***

At this point in the process, all children mentioned feeling good and happy with their therapist. When comparing the children's drawings of the therapeutic relationship at the beginning and after four months of therapy, changes were observed. At the second time point the central figures were happy as in the first drawings, but their interaction was more active and playful; there was a greater use of colour associated with the expression of positive affection, the emphasize of the consulting room disappeared. These changes can be seen in the drawings of Zane; in his first drawing he had emphasized the consulting room (Figure 4), but in the second one he just represented himself and his therapist "very happy chatting" (Figure 5). This change was also observed in the drawing of Dawn (Figure 6), who in her initial drawing detailed the consulting room environment and in the second moment emphasized the playful interaction with her therapist, noting that they felt good while having fun.

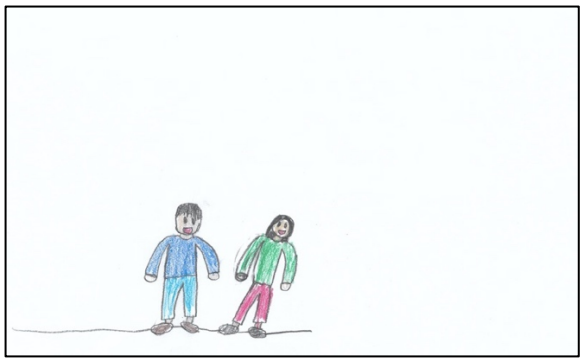

Figure 5: 'My psychologist and me' (Zane's second drawing)

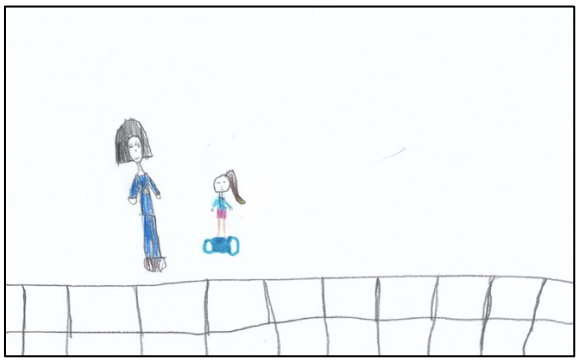

Figure 6: 'My psychologist and me' (Dawn's second drawing)

In the children's second drawings, the focus was on the two people in the room and not on the material elements of the consulting setting, implying that the therapeutic relationship evolved towards a freer encounter, more symmetric in terms of roles and actions and centred on a positive and playful interaction. This aspect concurs with the report of parents of a close, friendship-like relationship of child and therapist.

For participants, a central aspect that arose from this relationship was trust. Trust was seen by parents and therapists as an expression of positive affection between child and therapist, and this affection would be eased by having fun together. One therapist described the girl's process:

> "We got to know each other, and our interaction improved. She started to tell a little of her story, to talk more about her family (...) as the sessions progressed, she also brought things, showed me things, told me things (...) then she was happy (...) being able to laugh in the session, constantly; she advanced towards a more trustful space" (Mia's therapist).

The increased emotional connection between patient and therapist was also associated by participants with a progressive growth of the child's collaboration and involvement in the process. In this regard, one therapist noted:

> "there was a cooperative atmosphere that strengthened (...) until I finally saw her smile, and that, for me, was the best. I felt like she wanted to come. She opened little by little, we went from 'I don't know' to more words and actions that concerned her" (Eva's therapist).

Some parents and therapists emphasized that this trust and affection was deep and special, and generated a confidence that the child would not have with others, as one mother described:

> "She adores her (...) like she gave herself to her and talks, she lets herself go with her, it's something that she doesn't do. With me she doesn't talk, she's a girl who doesn't talk about her stuff, and with [therapist's name] she opened (...)" (Eva's mother).

Opening relevant personal topics with the therapist was identified by therapists and parents as a facilitator of change because it allowed addressing these issues.

Children and therapists noted that therapists felt good and happy with the child, enjoying their company and the possibility of helping them. At the same time, therapists felt fond of the

child but sad for the difficulties they faced. This emotional involvement generated mixed feelings in some young therapists, as expressed by one:

> "I want to adopt her (laughs), like I... involved a lot of my feelings, and that's a stumbling stone on the affective side, on my part. I mean, I understand that I'm young, I don't have much experience (...), but personally, I really like this little girl (...) it's been a very good experience, very difficult too (...) but it gives me great hope to see the small and great steps we have achieved along the way" (Eva's therapist).

As noted in the previous quote, the emotional involvement of the therapist also implied a high level of commitment towards the child's process, and this commitment was viewed as a relationship facilitator by participants.

**d) Change process facilitators associated with the parent-therapist relationship.**

Parents and therapists emphasized the direct work of the therapist with parents, the collaboration of parents and a positive therapeutic relationship between them as significant facilitators of change for the child and the parents. Children referred that their parents and the therapist got along well, but they did not say much about this relationship as a change facilitator.

***Attitudes and actions of parents and therapist: "She took time to listen to us".***

Individual and family sessions with their child's therapist were positively valued by parents, who highlighted the therapists' help to better understand their child's psychological issues as well as the specific strategies to improve the parent-child relationship. Therapists and parents noted that parents were receptive to these interventions, which facilitated their changes.

Some therapists also highlighted handling the personal issues of parents that arose within the therapeutic process. This point strengthened the relationship between them through an improved disposition of the parent towards the therapist. One therapist referred to this change:

> "after she [mother] opened up her abuse experience, and I was able to contain her, to my surprise, she changed (...) she went from being rough to a bit warmer" (Eva's therapist).

Therefore, the therapist's work with parents was noted as a change facilitator at two levels: in their parental role and in strengthening the parent-therapist relationship.

Parents pointed out the commitment and interest of the therapist in their experiences as parents as a facilitator for positive therapy outcomes, as well as the therapists' kind, available

and responsive attitude with them. They perceived that the therapist tried to incorporate them in the process, adjusting to the needs of both child and parents, as one mother described the therapist:

> "I feel she is committed with the case. She is very kind, affectionate, very empathetic with him, that also helped him. She talked to us [parents] as well; she took the time to listen to us (...) made an effort so both of us could attend parent sessions" (Vince's mother).

Parents' commitment, concern, collaboration, and willingness to change was also highlighted by parents and therapists as change facilitators for the child and the family.

***Therapeutic relationship with parents: "If there is someone who doesn't get along in the working team, no, the work itself doesn't function"***

The previously described features led to the construction of a positive therapeutic relationship between parents and therapists. This relationship was described by parents as close but professional, reliable, and supportive, as one mother detailed:

> "It's like close, but within a practitioner-patient relationship (...) like respecting those boundaries. But good, there is like a good reception. I feel her welcoming attitude and I feel like the trust to tell her 'this happened, this other thing happened'" (Zane's mother).

Parents and therapists stated that a good relationship between them was a significant facilitator of the therapeutic process, as it promoted the receptivity to the therapist's interventions.

Parents viewed the psychotherapy as a *teamwork* between the therapist, the child and them. A mother reflected about how a good therapeutic relationship affected the girl's therapy:

> "In a good way, since we are all working with her and if there is someone who doesn't get along in the working team, the work itself doesn't function" (Eva's mother).

A positive parent-therapist relationship, their commitment with the child's process and their joint work were described as facilitators of changes in children and parents.

**e) Changes in children, in parents and in their relationship after four months of therapy: *"my therapist helped me to solve my problems and not feel so lonely".***

Children mentioned feeling better, happier and more relieved about the initial emotional distress that had brought them to therapy. These changes were observed in the drawings of

themselves, which were more colourful, dynamic and had other people in them, in comparison with the drawings at the beginning of therapy, as may be noted in Vince's drawing (Figure 7), who said: "[Before] Me, sad and forgotten in forgetfulness (…) I'm lonely (…) [I: And now?] I'm happy because I can play with my sister and I'm not so worried (…) (I: Why do you think it changes?) Because my therapist helped me to solve my problems and not feel so lonely".

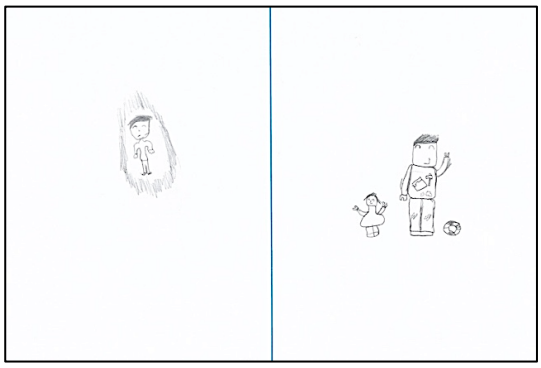

Figure 7: 'How I was before therapy/ I am now' (Vince's second drawing)

Changes observed in children's drawings pointed to changes in their self-concept, which became more positive and less burdened by difficulties than before psychotherapy. Parents and therapists also mentioned that children were more self-confident at this point. It is noteworthy that for children and parents the changes in children were facilitated by the therapist's help.

Participants underlined a higher level of emotional regulation and development of socio-emotional skills in the child, related to a greater comprehension of internal states. These changes facilitated interpersonal changes in children, expressed in improved relationships, greater interest in others and enhanced social skills.

Parents and therapists positively valued these changes, as they enabled a more suitable response on their behalf. Parents also perceived that changes in the child and themselves appeared together, in terms of a greater mutual regulation, as one mother said:

> "He reached a point where he threw a tantrum, cried, calmed down, cried again and then apologized (...). Not now, we talk, he explains what's happening to him, what's wrong or what bothered him (...) it's a huge change (…). I feel calmer, more confident on how to approach the issues with him (...) and it's because he's also calmer" (Zane's mother).

An expanded comprehension in parents of their child's problem, enabled a better disposition towards the child and improved the parent-child relationship. Therapists highlighted parents' enhanced listening and reflective ability, as well as their greater support to the child.

Meaningful changes in children and parents were described at this extent of therapy, but for some parents and therapists, deeper changes in the children were not felt to have been fully achieved and would require continuing therapy, as one mother stated:

> "The core of the problem is still there, but the little rays that used to come out, which also affected him, have improved. The therapy has helped him, but he has been in treatment for a short time, and we have to continue to improve the core of the problem" (Vince's mother).

Some therapist emphasized unfulfilled changes in parents as well and considered that the change process in parents was slower than in the child. One therapist reflected:

> "I feel that progress has been made in Dawn's behavioural regulation and that the mother manages to make more emotional attributions of Dawn's behaviour (…) but there is still this complaint in the mother that Dawn is 'difficult', that she has behavioural problems (…) I think that is where the challenge still lies" (Dawn's therapist).

Although not all the changes were fully reached after four months of therapy, for participants the changes achieved would already have a positive impact on the child's future.

## Discussion

In this study, a positive therapeutic relationship was seen as a facilitator of change in early and more advanced phases of psychotherapy. From the initial encounters, the therapeutic relationship favoured changes in three ways: first, by improving children's disposition towards therapy by handling their initial reticence. This study reinforces the importance of the first interactions between young patients and therapists (Fernández, Pérez, & Krause, 2016; Shirk, & Karver, 2003) and the therapist's ability to handle interpersonally challenging encounters with patients (Anderson Ogles, Patterson, Lambert, & Vermeersch, 2009). Second, through supporting intrapersonal changes in children, as they felt better after a positive interaction with the therapist, thus, the relationship became therapeutic by itself. And third, by favouring the parents' confidence towards the therapist due to his or her ability to overcome the initial challenges set by the child.

The initial reticence observed in some children in this study towards psychotherapy has been reported in similar terms (Author 1 et al., 2021; Shirk & Karver, 2011). However, this study explored further the reasons for this reluctance in children. While parents and therapists provided practical explanations related to the children's tiredness, children referred to negative expectations regarding the utility of psychotherapy and the therapist personal features.

Both the child-therapist and parent-therapist relationship evolved positively in all treatments in this study, but in different terms. The therapeutic relationship with the child gradually strengthened, representing a more affective and symmetric relational experience from the perspective of children and parents than the parent-therapist relationship, similar to the concept of the real relationship (Gelso, 2019). The evolution of the therapeutic relationship implied a shift from the external structure provided by the therapeutic setting to an affective structure based on the child-therapist's interaction, and this change seems to indicate a positive development of the therapeutic relationship.

The parent-therapist relationship preserved a clearer asymmetry of roles during the processes studied than the therapeutic relationship with children, due to the collaborative disposition in parents, and their recognition of the professional function of the therapist (Altimir et al., 2017). The parent-therapist relationship came closer to the therapeutic alliance construct observed in adult psychotherapy, representing more of a 'teamwork relationship'.

In a more advanced phase, the therapeutic relationship with children and parents was also considered as a change facilitator by children, parents and therapists, but at a deeper level than at the beginning of psychotherapy. In addition, more specific emphasis was observed between their viewpoints regarding this time point. Children felt good and happy in the therapeutic relationship, which functioned as an affective motivator for them to engage in the process and to build a meaningful relationship with the therapist. This positive experience with the therapist seemed to be very important considering that children reported feeling troubled in other relationships; it provided a valuable and healing relational experience for children. Children felt they changed thanks to the help of their therapist. Regarding parents, they highlighted that children felt free and accepted by the therapist. Both parents and therapist emphasized that this positive therapeutic relationship enabled the construction of trust in the child, and underscored that a positive relationship between them was significant to support the

child's process and to favour the parent's receptivity and changes, an element that children did not emphasize. Parent's collaboration was underlined by therapists, and parents highlighted the therapist's commitment and their own with the child's process as change facilitators. Therapists focused more on their adaptable, child-centred attitude and interventions as change facilitators. It is noteworthy that when the subjective experience of children and parents is considered, a higher importance was given to the affective dimension of the therapeutic relationship as a change facilitator over the focus on technical aspects observed in the views of therapists.

In this regard, therapists focused more on the experience of children and parents than on their own. When they addressed their experience, it tended to appear in mixed terms: satisfaction for helping and self-criticism and insecurity for their high emotional involvement with the child's process. Insecurity was more evident in less experienced therapists, as previously reported (Erekson et al., 2017). However, parents and children in this study positively valued the therapist's high level of commitment; they appreciated it over and beyond the therapist's age or experience, and it favoured a positive therapeutic relationship and the collaboration of parents and children in therapy. A higher alliance with young therapist was previously reported, but the underlying reasons were not explored (Accurso & Garland, 2015).

When children and parents' motivation towards therapy improved after the first positive encounters with the therapist, it seemed to support a higher adherence towards therapy, as indicated in previous studies (Hawley & Weiss, 2005). As these relationships evolved, they opened a space to address personal and interpersonal issues of children and parents, that in the end improved the parent-child relationship. Accordingly, changes in children and parents also have a positive reciprocal effect. This three-way interconnection has been previously described in terms of the triadic understanding of the therapeutic relationship (Gvion & Bar, 2014) and the relation between changes in children and parents (Alamo, 2019). As noted in this study, when parents establish a positive therapeutic relationship, they become not only open to the therapist intervention and to change, but also a vector of the child's change.

### Implications for practice

The socio-affective motor in children towards psychotherapy seems particularly relevant to child psychotherapy. To generate this positive experience for children, child therapists may need to display a close, flexible and playful attitude, and focus on the child's interests and forms

of expression such as play or art. Child therapists may feel insecure or guilty when having fun with their patients (Núñez et al., 2021). However, this form of interaction between child and therapist favours the development of the real relationship (Gelso, 2019), which seems central for a positive therapeutic relationship in child psychotherapy (Núñez et al., 2021).

Another implication for practice is that children's initial expectations towards the therapist and the meaning of psychotherapy need to be considered by therapists and parents, to be able to favour children's disposition towards psychotherapy. When a negative initial disposition towards the therapist is observed, a therapist who is open to adapt to the child's reticence and have fun, is key to improve children's motivation to therapy.

In addition, a positive parent-therapist relationship is central for change to take place and requires special attention. Working with parents may be challenging for child psychotherapists, especially when they display low motivation towards the child's process (Midgley & Navridi, 2007). However, when the parents seek therapy for their child, as was the case in this study, they have a more collaborative initial disposition. Yet, this motivation is not sufficient and requires the development of trust in the parent-therapist relationship to enable a higher disposition for change in parents. The therapist's ability to favour a positive relationship with the child, their direct support to parents and their commitment with the case are key for parents to advance in this path.

A final reflection concerns new child therapists' practice. Parents and children appreciated the high commitment displayed by new therapists towards their case. However, this level of involvement also generated self-criticism in the less experienced therapists. New therapists should recognise the positive influence of their high involvement on the therapeutic relationship and change process, and training should incorporate this element as a central aspect of the therapists' initial experiences.

**Strengths and Limitations**

A strength of this study was the inclusion of multiple perspectives in the exploration of a complex phenomenon. As pointed out in the framework of critical-constructivist grounded theory (Levitt, 2021), the consideration of multiple perspectives provides an equilibrium with respect to power asymmetries. In this study, a higher balance between perspectives was observed in two dimensions: first the inclusion of children's perspective balanced an adult-

centred approach to children's experiences, based on the opinion of parents and therapists, and second, the inclusion of children and parents balanced the professional-centred valuation of the elements that facilitate the child change process. Further studies including multiple perspectives in child and adolescent psychotherapy seem relevant to advance in this direction.

The drawings employed in this study supported a deeper exploration of how children viewed themselves, the therapeutic relationship and their changes. This age-sensitive methodology reinforced the participation of children as key informers of their psychotherapy, and this study strengthens the notion that children can address their experience through words and drawings, as reported previously (Alamo, 2019; Capella et al., 2015; Núñez et al., 2021).

A third strength of this study was the collection of data in two different moments of psychotherapy, which allowed a broader understanding of the evolving nature of the therapeutic relationship (Horvath, 2006; Roussos, Gómez Penedo, & Muiños, 2016). The therapeutic relationship entailed different facilitating functions for change according to the moment of psychotherapy. These results emphasize that the therapeutic relationship in child psychotherapy requires time to develop. In addition, the different trajectories observed between child-therapist and parents-therapist relationships seem relevant for practice and may be further explored.

However, in this same regard this study presents the limitation that only the initial and middle phases of the therapy were studied, and not the later or ending phase. Future studies of the therapeutic relationship until psychotherapy ends may provide a better understanding of children and parents needs for a positive ending of this relationship (Karush, 2014; Núñez et al., 2021). Also, the participants in this study were mostly pleased with how therapy was progressing; this feature is not representative of all children and parents attending therapy services. Exploring the experience of families who drop out of therapy or who have negative experiences of the therapeutic relationship seems necessary to better support these processes.

Another limitation of this study was that the results tend to over represent inexperienced therapists' views of the therapeutic relationship. It may be possible that more experienced therapists would have put less emphasis on engaging children through being friendly and would have stressed some of the confrontational aspects of therapy, which new therapists may find harder to implement.

A final limitation was the impossibility of exploring the perspective of fathers or caregivers other than mothers. The lack of participation of fathers may reflect a tendency where mothers assume a more active role in bringing the child to therapy sessions. Regardless, in the understanding that child psychotherapy seems to naturally impact the whole family system, it is important to include the perspectives of other caregivers besides mothers in future studies.

## Conclusions

The simultaneous analysis of the perspectives of children, parents and therapists done in this study enabled a relational comprehension of the change process in child psychotherapy. The child-therapist relationship was viewed as a positive affective experience by participants. Although this relationship did not always start with a collaborative stance in children, the first positive encounters with the therapist facilitated an improved disposition in children. The parent-therapist relationship started from a different point, as parents pursued for psychotherapy and were more collaborative from the beginning. As both relationships strengthened, trust in the therapist emerged in children and parents and favoured deeper changes. Children became more emotionally regulated and socially open, and parents expanded their understanding of the child's problems and how to deal with them. As they both changed, the child-parent relationship improved. At this point of psychotherapy, changes were viewed as important but insufficient in some children and parents. To achieve deeper levels of change, participants considered that the process should continue.

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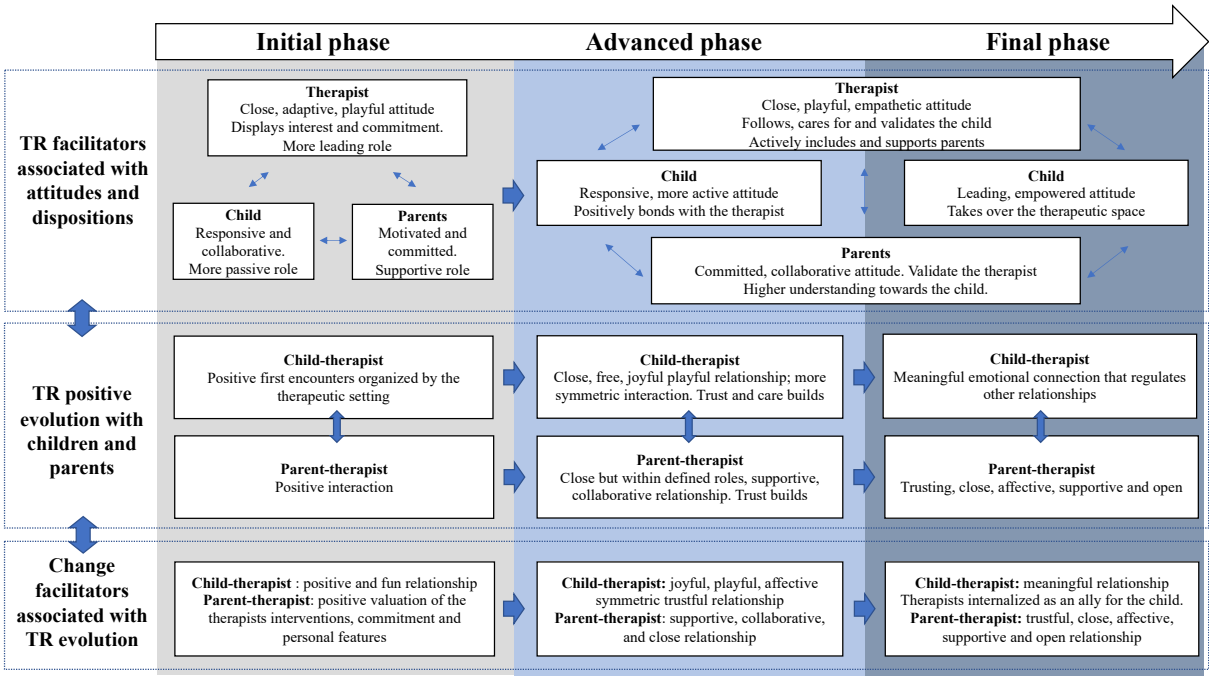
# 5. DISCUSSION AND CONCLUSIONS

The integrated findings of the studies that comprised the present doctoral thesis enabled the formulation of a comprehensive model of the change facilitating elements of the therapeutic relationship, which was the general aim of this doctoral dissertation. This model entails the core aspects of the therapeutic relationship and the child's, therapist's, and parent's roles in change processes (Figure 1).

**Figure 1.**

*Therapeutic change facilitating elements associated with the therapeutic relationship (TR)*




Two central courses of change are described. The first course presents a temporal vector from the beginning to the final phase of psychotherapy, where the evolution of the child's, therapist's and parent's contributions, the child-therapist and parent-therapist relationship and the facilitators that stem from the evolution of these relationships are outlined. Then, a second course of change describes successive shaping dimensions; starting from the child's, therapist's, and parent's particular facilitating roles, followed by the core interactional features that

facilitated a positive therapeutic relationship with children and parents and presenting, finally, the central change facilitating aspects of these relationships, according to the phase of psychotherapy.

It is interesting to note from this model that the roles of children, therapists and parents changed through the course of psychotherapy. In the beginning, the parents assumed a chief role in terms of the motivation towards the child's psychotherapy, while the therapists displayed a central lead in generating a positive therapeutic relationship with the child. Children seemed more passive, or even rejective, in their motivation concerning therapy and their relational disposition towards the therapist. As initial positive interactions were experienced by children, their motivations and relational dispositions significantly improved. This change is relevant in the frame of child psychotherapy, considering that core elements for psychotherapy to work, such as motivation towards psychotherapy and a positive disposition to interact with the therapist, which are usually present when the "client" is who voluntarily seeks therapy, - may require external support in the case of children. This quality underlines the role of parents and the therapist in the beginning of the therapeutic process, as they convey these fundamental elements to the child.

As the therapeutic relationship with children and parents positively evolved, children displayed a more active, participative and affectionate attitude towards the therapist, who stepped back and followed the child's needs and contents and sustained a close, playful attitude throughout the process. At the same time, the therapist promoted the active participation of parents in their child's therapeutic process and supported parents in improving their relationship with the child. Parents appeared as responsive and committed with the therapist's interventions, as they felt supported and positive changes emerged in their child and their relationship. Finally, children assumed a leading, empowered attitude with their therapist, that transferred to the relationship with themselves and others.

A second relevant change was noted in the evolution of the therapeutic relationship, especially with children. Once the child's possible initial reticence was overcome, a role defined child-therapist relationship emerged in the initial phase of psychotherapy, characterized by a positive interaction and the child's compliance towards the therapist's interventions. This positive initial interaction helped to generate initial changes in children and the evolution of a

stronger therapeutic relationship. Children were responsive to the special relational offer displayed by the therapist, characterized by a playful and child-centred stance, and joyful and symmetric encounters; moreover, the genuine engagement of therapists in joint activities favoured the development of the child's trust and affection in the relationship. Lastly, a deeper bond developed between the child and therapist, and children internalized the therapist as a significant figure, that formed part of their relational background. The relational experience of the child with the therapist interacted with their other interpersonal contexts. In parallel, parents and therapist developed their own relationship, which became much more collaborative. As a positive and supportive interaction advanced within them, trust and affection built, but within a more symmetric-role related relationship.

Finally, specific elements of these evolving therapeutic relationships worked as change facilitators in different moments of psychotherapy. In the beginning, a positive and fun child-therapist improved the child's disposition and mood. In a more advanced phase, having fun and feeling free in the therapeutic relationship favoured the construction of trust and care within child and therapist, improved the child's self-concept, self-confidence and favoured the strengthening of socio-affective tools in the child. In a final phase of more extensive treatments, a meaningful therapeutic relationship favoured deeper identity, relational and affective changes in the child.

Parent's changes were also facilitated by evolving aspects of their relationship with the therapist. In the beginning, the confidence and collaboration of parents in the child's process was shaped by their positive evaluation of the therapist's characteristics and interventions, as they observed their child's positive response. In a more advanced phase, the supportive, collaborative, close and trustful relationship with their child's therapist favoured parent's compliance and disposition to change. At this point, it is interesting to note that these changes in parents and children mutually favoured each other as well as their relationship. In the final phase of more extensive therapies, the aspects of the parent-therapist relationship that facilitated change were somewhat the same as in the earlier phase; however, the therapist non-judgmental stance towards parents enabled them to open even more and further changes were favoured.

It is important to note that this model represents a positive evolution of the therapeutic relationship, which stems from the fact that the participants in the studies reported favourable

therapeutic processes. The further discussion of this model is structured according to the specific aims of this thesis and integrates the clinical relevance of the results. Finally, the strengths, limitations, further research paths and conclusion are formulated.

## 5.1. The contributions of therapists, parents and children in the construction of the therapeutic relationship in child psychotherapy

The first specific aim of this doctoral thesis was to *describe the components of the therapeutic relationship with children and parents from the perspective of children, parents and therapists*. These components materialized in the characteristics, attitudes and the roles displayed by the participants of psychotherapy.

### *5.1.1. Therapist's contributions*

The contribution of therapists for the initial formation of a positive therapeutic relationship was crucial. Therapists assumed a leading and active initial role in generating an inviting relational environment for the child. This active role in therapists has been previously described in psychotherapy with adults and children (Altimir et al., 2017). However, the specific facilitating attitudes of child therapists were explored in this thesis. The therapist's genuine interest, affectionate and kind attitude towards children and their parents, plus a playful and child-centred adaptable stance, especially when children appeared as reticent to attend psychotherapy, constituted therapists-offered particular conditions for child psychotherapy to work. Likewise, the therapist's flexibility to adapt to the child's needs, the focus on the child's interests, and involvement in joint play and art activities were significant facilitators of the therapeutic relationship. As Roger's (1951) therapists-offered conditions in adult settings, these conditions were crucial in the context of child psychotherapy; however, as discussed in paper 1, they do not represent the whole relational dimension as they centre solely on the therapist's contribution (Gelso, 2019). The child's responsive attitude and the parent's motivation were also required for these therapist's offered conditions to be therapeutic relationship facilitators.

As therapy advanced, the therapist's personal attributes, such as a friendly, fun and nice attitude, and a high level of commitment and availability, were very valued by children and

parents, and were not role-expected. This positive appreciation of the further commitment in therapists has been described previously, as therapists that do more than what was expected from their role and supported patients to feel they are important on a personal level, and not only in a "work" level (Altimir et al., 2017). These personal traits in therapists contributed to a positive interaction with children and parents, but also favoured their engagement in the process.

At this point, it seems necessary to recall that the therapists that participated in study 2 were relatively young practitioners, and the studied cases were within their first conducted psychotherapies. As their initial experiences, a high level of commitment with the case was observed; this aspect was highly valued by children and parents beyond therapists young age or lack of experience, as it has reported in previous studies (Accurso et al., 2015). However, in this thesis, the counterpart experience of young therapists was further explored, and a tendency emerged to self-criticize their high involvement as they fear it may be unprofessional or not therapeutic. This phenomenon entails a fundamental clinical implication for the training of child psychotherapists, as insecurity is more evident in less experienced therapists (Erekson et al., 2017). In seems important to share with young therapists that the high commitment with their initial cases is a strength more than a weakness, both from the perspectives of children and parents; it represents a significant and supportive reinterpretation of their initial practice.

Regarding the parent-therapist relationship, parents highly valued the therapists committed, supportive, receptive and non-judgemental attitude. Similar findings have been reported in adult psychotherapy (Krause et al., 2011) and seem to relate to a positive adult-adult interaction. This element has very relevant clinical implications when working with parents in child psychotherapy. Even when parents are those who seek help, they may begin their child's psychotherapy with negative feelings regarding their parenting skills of competence or feeling guilty for their child's issues. These feelings may locate parents in a negative or defensive position towards the therapist, and the child. A non-judgemental and empathetic stance in the child's therapist towards parents seems key for them to open and get involved in the whole change process, that includes them as well.

In parallel, the therapist's professional ability to deliver information regarding their child and provide helpful, precise orientation was underscored by parents. The features of the therapist underlined by parents are very similar to Gelso's (2019) description of the therapist's

contribution to the working alliance in his tripartite model and supports the idea that the parent-therapist relationship recalls the therapeutic alliance concept as described in adult therapy.

### *5.1.2. Children's contributions*

The child's collaborative attitude was an essential element for the development of the therapeutic relationship in child psychotherapy. As in adult psychotherapy, patient's collaboration in child psychotherapy emerged as an important element for the therapeutic process. However, collaboration was not expressed in such a conscious manner as in voluntary adult settings. Thus, collaboration was expressed in terms of 'participation', as has been previously described (Shirk & Karver, 2011), but also it was noted as 'responsiveness' and 'receptiveness' in the child towards the therapist. This description expands how therapeutic collaboration may be expressed in children, as it not always emerges as an active stance.

It is important to note that even before the child's collaborative attitude, an initial passive or reticent attitude was described in several children; this aspect agrees with earlier descriptions of children initiating psychotherapy (Baylis et al., 2011; Shirk & Karver, 2011). However, through the studies conducted in this doctoral thesis, the child's initial passive or reticent disposition was explored. Initial passivity in children was related to different levels of distress in the child regarding psychotherapy. In some cases, it was originated by feeling self-conscious and embarrassed at being with an unknown person (the therapist), moreover alone and without their parents. Children tended to hold back these emotions from the therapist (who they have just met) and appeared as 'passive'. These cases tended to coincide with children that presented internalizing symptomatology. Children with more externalizing symptoms tended to be more openly reticent to participate in therapy, but this reticence also related to their negative expectations regarding the usefulness of psychotherapy or the personal characters of the therapist. These negative expectations emerged as a more apathetic or challenging attitude in the child towards the therapist; a 'difficult' child.

Understanding the underlying reasons for children reluctant or distant stance at the beginning of psychotherapy is crucial for child psychotherapy practice. Child psychotherapists may interpret these attitudes as part of the child's personal conflicts, or parents may disapprove of their child's attitude and interpret it as them being willingly unkind towards the therapist. It

is important for child psychotherapists to keep in mind that the therapeutic relationship and psychotherapy itself is a challenging context for many children, so that to fully engage in the therapeutic process children require time, information, and a comprehensive stance from the adults that accompany their process. As discussed in paper 3, when an initial negative disposition towards the therapist is observed, a therapist who is willing and open to adapt to the child's reticence and have fun is a vital element for improving children's motivation to therapy.

Regarding the child's age, younger children reported a lower initial therapeutic alliance than older ones. As discussed in paper 2, it is relevant to consider the developmental variables of school-age children, as even within an age range of five years, significant developmental differences emerged. Cognitive development and social integration milestones, which enable school-age children to generate relationships of collaboration and co-responsibility with others, develop gradually (Sepúlveda & Capella, 2019). Therefore, differences between children within this age range may be expected; the younger children exhibit more difficulties to comprehend key aspects of the therapeutic alliance due to more concrete thinking (Shirk & Brown, 2011), which might explain the lower alliance reported by them compared with their older peers. This result entails relevant implications for child psychotherapy practice. Childhood is not a 'homogenous' age and psychotherapy conducted with younger school-age children requires a better initial preparation to support their possible difficulties in feeling comfortable with a newly known adult, actively including the parents/caregivers in the first sessions if needed. Also, children require to clearly understand why they are initiating psychotherapy, integrating their views in the construction of this explanation even when they are very young. A similar conclusion regarding the importance of children's understanding of therapy was drawn by Midgley & Target (2005) and is supported by this thesis. Child psychotherapists should address parents in this regard and openly talk with children in this direction.

Finally, in a more advanced and final phase of psychotherapy, children were described with diverse positive attitudes, such as being kind, friendly, responsive and with a good disposition towards the therapist, which was considered a therapeutic relationship facilitator. Age and symptomatology type and intensity in children were less important factors at these later phases of psychotherapy. It may be that as the therapeutic relationship positively evolves, the child's 'difficulties' move back to a second level, and more positive features are underscored within the child-therapist relationship. This focus on the child's positive relational offer was

very important for children to experience a more positive version of themselves in the therapeutic relationship, aiding an improved self-concept as this relationship evolved.

### *5.1.3. Parent's contributions*

The initial motivation of parents to seek help for their child and themselves in the management of the child's issues implied their collaborative and compliant initial attitude towards the therapist. Some parent's felt responsible for their child's problems, and others did not understand why their child was presenting emotional conflicts. From both positions, parents looked for help as they felt overwhelmed by these issues and in need of answers. This particular motivation in parents has been less explored in the research of parental alliance and seems very relevant, since a high parental motivation favoured the maintenance of the therapeutic process and parent's participation. Parents also supported the child's process by explaining its importance and by encouraging their child to participate when they displayed initial reticent attitudes towards psychotherapy.

However, some parents also revealed initial reticence towards very young therapists. This phenomenon has been observed previously in adult psychotherapy (Krause et al., 2011); the therapist's level of expertise seems relevant for adult patients in the development of the alliance. As parent's felt insecure in the management of their child's issues and seek for guidance, a young therapist appeared as a 'unexperienced' guide and triggered negative valuation in parents. However, it is interesting to note that this feature was not relevant for children, as therapists were viewed as adults. The parent's reticence changed as the process advanced, and this change was favoured by a positive valuation of the therapist. This change is discussed in the following section.

## 5.2. The evolution of the therapeutic relationship with children and parents in child psychotherapy

The second specific aim of this doctoral dissertation was to *describe the evolution of the therapeutic relationships in different moments of psychotherapy, according to the perspective of children, parents and therapists*. This aim was addressed by the three papers presented in this

dissertation, as each examined the therapeutic relationship with children and parents in different moments of child psychotherapy. Both the child-therapist and the parent-therapist relationship evolved positively in this study, but in different terms. Therefore, the described trajectory details the evolution of positive therapeutic relationships. The particularities and changes in these relationships are discussed in the different phases of psychotherapy.

### *5.2.1. The evolution of the child-therapist relationship*

The evolution of the therapeutic relationship from an initial to a more advanced phase of psychotherapy was carefully studied in this thesis. The therapeutic relationship with the child strengthened progressively. The progress of this relationship implied several changes, shifting from a possible initial reticence in the child, to a positive child-therapist relationship based on the external structure of the therapeutic setting. It then advanced to a more affective, freer and symmetric interaction in terms of roles and actions, based on the child- therapist playful and joyful interaction. In extensive therapies, it moved to a significant relationship that was expressed by the internalization of the therapist in the child's relational background.

Some of the mentioned therapeutic relationship configurations have been previously described in similar terms, such as the technical and affective dimensions of the therapeutic relationship in Altimir et al. (2017). However, this doctoral thesis further explored the evolving configurations of the therapeutic relationship. As noted previously, children's initial reticence towards therapy may be expected. This initial challenge places the therapist in a relational dimension that precedes any conscious collaborative work, as described in the therapeutic alliance concept. In this initial context, child therapists are demanded to generate a positive emotional interaction with children, to reassure their willingness to participate in psychotherapy; to succeed in this path requires a high amount of flexibility and focus from the therapist on the child's interests. In this regard, it is interesting to note that child psychotherapy may start from a "pre-rupture" state of the alliance, generally expressed as a more avoidance stance in children. Child psychotherapists' first relational task may be to repair this onset fracture in the child's disposition to participate in psychotherapy. If resolved, a positive child-therapist relationship was experienced, and the child's disposition, motivation and mood improved, giving place to a positive, collaborative, role-related relationship. In this account, it has been noted that a positive

alliance between patient and therapist from the outset of treatment, which facilitates collaboration and the deployment of effective techniques, is different from the process of building an alliance or repairing it, which has the potential to create a corrective experience in which the alliance constitutes a healing factor (Zilcha-Mano, 2017), which leads the patient to learn that interpersonal conflicts can be tolerated (Christian et al., 2012).

In the second relevant configurational change of the therapeutic relationship, which implied that a more affective and symmetric encounter developed, play and playful joint activities engaging both the child and the therapist represented the core of their positive therapeutic relationship. The relevance of play for children that participate in psychotherapy has been reported previously (Areas et al., 2020). This thesis deepened the analysis of this play experience for children and therapists. The joint involvement of child and therapist playing together promoted positive interpersonal feelings in children and therapists, and when focusing on the child's developmental preferences (i.e., play and art), therapists empowered children through a child-centred encounter.

As discussed in paper 1, the role of play in child psychotherapy goes beyond the technical dimension encompassed in each therapist's theoretical background, drawing attention to children's affective and relational experience of play in psychotherapy. Play and child-centred activities enable the development of a meaningful therapeutic relationship. But not any play; it requires play that fully involves the therapist in terms of genuineness and realism, both key elements of the real relationship described as one of the components of the therapeutic relationship (Gelso, 2019). In this regard, the real relationship components, and in particular the therapist's genuineness, appeared as vital elements of the therapeutic relationship in child psychotherapy. This idea has significant implications for practice, as in the child therapists training there has been a focus on developing skills and techniques (Blanco et al., 2014), which used without the genuine engagement of therapists may lose their therapeutic value. Child psychotherapists must place careful care in being genuine when relating with the child, as technical deployment is not enough for the therapeutic relationship to evolve towards deeper levels and to enable further changes.

As the therapeutic relationship grew in terms of the emotional connection between child and therapist, trust emerged. Trust was not present at the beginning of the relationship and was

considered essential for therapeutic change. The importance of trust-based therapeutic relationships for change in child and adolescent psychotherapy has been previously underlined (Areas et al., 2020; Capella et al., 2018). This doctoral dissertation contributed to the knowledge of how trust is built in child psychotherapy, as it emerged as an expression of the child-therapist positive affection, and this affection was facilitated by having genuine fun together and a validating attitude in the therapist. The clinical implication of building trust in psychotherapy is widely known, but the importance of child and therapist having fun may be less clear. Having 'real' fun, 'real' laughers in child psychotherapy are important interactional moments that shape the child's belief and trust in the therapists and also favours the construction of a real relationship. This finding recalls Carlberg's (1997) 'turning points' in child psychotherapy, as they underline the notion the changes may be described in terms of 'intersubjectivity'; the emotional meeting between two mutually influencing subjects prepares the way for change to take place.

Moreover, this type of relational encounters was key for a stronger therapeutic relationship to develop. As discussed in paper 3, the evolution of the therapeutic relationship in terms of a positive, genuine affective encounter was key for children to collaborate and engage in psychotherapy, working as a socio-affective motor. Children liked their therapist and felt good and comfortable with them. This consideration implies for child psychotherapy practice that beyond the child therapists' close, flexible and playful attitude, and the focus on the child's interests, child therapists must care for their genuineness in the therapeutic relationship. This means having real fun, real laughs and real expressions when interacting with the child. In study 1, some child therapists recalled feeling insecure or guilty when having fun with their patients; however, this form of interaction is crucial for achieving a stronger therapeutic relationship.

In more extensive psychotherapy processes, therapists were remembered and named outside psychotherapy by children; they were even conveyed when the child needed to regulate their parent's conduct. This aspect reflected the internalization of the therapist in the child's interpersonal repertory, where the therapist represented a positive interpersonal experience and an ally for the child. The advocacy role of the therapist was discussed in paper 1 and was previously observed by Caroll (2002) in family contexts that required a higher regulation of caregivers. Moreover, the internalization of the therapist recalls elements of Attachment Theory; a core contention of this theory is that the therapist can undertake the role of an attachment

figure within the relationship, and when this relationship favours affective bonding, it can become part of the child's internalized relational resources (Holmes, 2015). It is interesting to discuss the therapist's internalization in terms of mentalization, as children evoked their therapists in extra therapeutic interpersonal situations. This issue may suggest that the child is "having the therapist mind in mind", and the therapists "mind" favours the child to ponder difficult social interactions with friends and family in a self-caring way, as they have been well treated and cared for by their therapists within a secure relationship.

Finally, a significant phase in the evolution of the therapeutic relationship was studied: the goodbye phase. Children tended to feel happy about finishing treatment but sad when they stopped seeing their therapist. This result has been previously described, as patients often find it difficult to end the therapeutic relationship, involving loss and a mourning process for child and adult patients (Altimir et al., 2017; Karush, 2014). It is fundamental to consider the ending of psychotherapy as a very important stage of child psychotherapy, and the way this ending occurs may determine the overall therapeutic experience for children. Child psychotherapy practice must focus the termination process on the child's specific needs to gradually move away from the therapeutic relationship (Novick & Novick, 2006) and should carefully listen to a child that is not ready to terminate the process. A satisfactory ending should ensure the child's full comprehension, active participation and opinion.

### *5.2.2. The evolution of the parents-therapist relationship*

The parent-therapist relationship started from a different point than the child-therapist relationship, as parents pursued psychotherapy for their children and were more collaborative from the beginning. In this sense, this relationship behaved as the therapeutic alliance construct observed in adult psychotherapy, characterized more as a 'teamwork relationship'. However, as noted previously, some parents presented a degree of initial scepticism towards the therapist's capacity to help, especially when there are young inexperienced therapists or when parents had prior negative experiences with a psychotherapist. This initial distrust in parents was overcome through two central actions by the therapist; the first was the high commitment displayed with the case, and the second was the capacity of the therapist to make meaningful and accurate interventions with the parents. Parents contributed to this change through a positive disposition.

Once this initial reticence in parents was surpassed, a higher validation of the therapist and the parent's compliance in the intervention grew.

As parents were committed and responsive to the therapist's support, guidance, close and dedicated attitude concerning the child and them, the parents-therapist relationship evolved in terms of trust, validation and affection, but within defined roles. Parents viewed psychotherapy as *teamwork* between the therapist, the child and them. As parent's were not the central patient, the parent-therapist relationship seemed not to evolve much further, as it did happen in the child-therapist relationship. However, in more extensive therapies, a deeper level of involvement and openness in parents emerged, facilitated by the further development of affection and trust in the parent-therapist relationship. This deeper relationship enabled further changes in parents and was facilitated by the therapist non-judgmental and committed stance towards them, as previously mentioned.

Parents appreciated not being alone in their concern for their child's wellbeing. They also felt directly helped by the therapist in some of their personal issues. Handling the parent's personal issues that appeared within the child's therapeutic process strengthened the parent-therapist relationship through an improved disposition of the parent towards the therapist. At this point, it is interesting to note that even when stronger affection developed in the parent-therapist relationship, it seemed not to be as deep in comparison with what developed directly with adult patients (Levitt et al., 2006) and child patients (Zorzella et al., 2017).

## 5.3. The therapeutic relationship as a change facilitator

The third specific aim of this doctoral thesis was to *identify which aspects of the therapeutic relationship in child psychotherapy are associated as facilitators or obstacles with therapeutic change, according to the perspective of children, parents and therapists, considering different moments of psychotherapy*. Almost all aspects of the therapeutic relationship were viewed as facilitators; therefore, the following sections will briefly discuss these elements in the initial and more advanced phases of therapy.

### *5.3.1. The therapeutic relationship as a change facilitator in the initial phase of child psychotherapy*

The initial attitudes described, including the feelings and interactions of children, parents and therapists facilitated the construction of a positive therapeutic relationship that shaped a higher motivation and an improved disposition in children and parents to participate. As discussed in paper 3, this improved motivation in children and parents supported a higher adherence towards therapy, as indicated in previous studies (Hawley & Weiss, 2005). The results presented in this thesis reinforce the relevance of the first interactions between young patients and therapists (Fernández et al., 2016; Shirk, & Karver, 2003), and the therapist's ability to manage interpersonally defiant encounters with patients (Anderson et al., 2009). The core elements of the therapeutic relationship that facilitated this change process, were the previously described therapist-offered features plus the positive first interactions between child and therapists. Attention towards these broad elements should be underscored in child psychotherapy practice.

A second change process was facilitated through the initial positive interactions between child and therapist. Affective changes were referred in children, as they felt more animated, happier, less troubled after the first comfortable, free and fun encounters with the therapist. This change placed the child-therapist relationship as therapeutic by itself, as it alleviates the child's initial discomfort when attending psychotherapy.

Finally, changes in parents were also observed as facilitated by the child-therapist early relationship. Parents appreciated the therapist's ability to manage the child's initial reticence, dedication and guidance, improving their confidence towards their child therapist. This improved confidence promoted the parent's validation and commitment towards the therapist's interventions, which were key elements for psychotherapy to continue and for the parental support in the process. It is important to mention that the positive first encounters between child and therapist facilitated the construction of stronger therapeutic relationships with children and parents.

### *5.3.2. The therapeutic relationship as a change facilitator in more advanced phases of child psychotherapy*

As the therapeutic relationship evolved in affective terms, trust between child and therapist and higher involvement of the child in the process emerged. The child participated more actively and opened more conflictive personal content in psychotherapy. Addressing these matters with the therapists was considered a relevant change facilitator.

Further levels of change facilitated by experiencing and internalizing a meaningful and positive therapeutic relationship were the identity and interpersonal changes in the child. As discussed in paper 1, children felt important and enjoyed the relationship with their therapist. This point is particularly relevant when considering that many children who attend psychotherapy have lived stressful moments in other interpersonal contexts. Children's self-concepts became more positive and less burdened by difficulties than before psychotherapy; they improved their personal confidence and interpersonal skills, and for children and parents, these changes were facilitated by the therapist's help. These changes in children are reflected in their relationships with family and friends. It is interesting to consider that as a meaningful therapeutic relationship developed in more extensive psychotherapies, it impacted other meaningful relationships for the child, working as a chain of influence that may benefit the child's interpersonal context.

In the case of the parent-therapist relationship, some changes were facilitated by their therapeutic relationship. A positive parents-therapists relationship was a significant facilitator of the therapeutic process, as it promoted the support and receptivity of parents to the therapist's interventions, and this receptiveness facilitated changes in their parental role. Previous studies (Accurso & Garland, 2015; DeVet et al., 2003; Hawley & Weisz, 2005) have argued that a positive relationship between parents and therapists strengthens the parent's cooperative role in the child's therapy and represents a supportive relationship for parents.

Furthermore, parents expanded their understanding of the child's problems and how to deal with them, as reported by Alamo (2019). This change made parents feel calmer and more reassured in their parenting skills. This aspect has been discussed in previous studies (Sorensen, 2005) and underscores the importance of empathetically supporting parents in their parenting role for their child's and their own wellbeing.

Even when the studied psychotherapies were not mentalized-based treatments, an increased parental reflective function was observed. This finding supports the idea that mentalization is a common factor in different psychotherapy models (Fonagy & Allison, 2014; Midgley & Vrouva, 2012), including diverse forms of child psychotherapy. Moreover, an expanded comprehension in parents of their child's problem enabled a better disposition towards the child and improved the parent-child relationship.

As discussed in paper 3, a positive parent-therapist relationship was central for change to take place and requires special attention; parents became not only open to the therapist intervention and to change but also a vector of the child's change. However, working with parents may be challenging for child psychotherapists, especially when they display low motivation towards the child's process (Midgley & Navridi, 2007). Parent's motivation should also be directly addressed and co-constructed when necessary, as it is a necessary element for the child's process to success. Yet, in the cases that this initial motivation was successfully constructed or was spontaneously existent in parents, it was not sufficient for deeper changes to occur. The parent-therapist relationship requires trust to develop and to achieve a higher disposition for change in parents. The therapist's ability to favour a positive relationship with the child, their direct support to parents and their commitment to the case are key for parents to advance in this path and should be actively pursued in child psychotherapy practice.

Consequently, the construction of a positive therapeutic relationship with children and parents is essential for change processes in child psychotherapy. This dual demand represents an important challenge for child therapists, and it entails the need to address through constant supervision the therapist's emotional experience in this particular relational context. The child therapist's possible counter-transferential feelings are duplicated when working with children and parents, and therefore they need to be equally listened and analysed to support the process.

### 5.4. Convergences and divergences between the multiple perspectives

The last specific aim of this doctoral thesis was to *analyse the main convergences and divergences between children, parents and therapists about the components, evolution and facilitators and obstacles of therapeutic change associated with the therapeutic relationship*.

It is important to mention that the simultaneous analysis of the perspectives of children, parents and therapists supported a relational and integrated comprehension of the change processes facilitated by the therapeutic relationship in child psychotherapy. Children, parents, and therapists tended to converge in an overall positive valuation of the therapeutic relationship, as reported in previous studies (Zorzella et al., 2017). But at the same time, they differed about central aspects of the relationship, which also has been formerly stated (Accurso & Garland, 2015; Kazdin et al., 2006; Zandberg et al., 2015), stressing the importance of including multiple perspectives in child psychotherapy research. Many micro emphases of each view were observed; however, only some specific differences within the perspectives were notorious. These core differences and their rationale were explored in this thesis.

Regarding the quantitative valuation of the initial child-therapist and parent-therapist alliance, it is relevant to note that children, parents and therapists rated the initial alliance within positive values (Zorzella et al., 2017); however, the evaluation was significantly higher from the perspective of children and parents than from the viewpoint of therapists. This difference underscores that the assessment of the initial alliance can change depending on its source (Accurso & Garland, 2015). Moreover, the higher the child-reported the initial alliance, the higher the therapist-reported the initial alliance. These findings align with previous studies, where therapists tended to be more critical than children and parents regarding the initial therapeutic alliance (Shirk et al., 2011; Accurso & Garland 2015). At this point, it is interesting to note that the alliance scale used (TASC-R and TASCP) focuses on the child's or parent's alliance towards the therapist in the child, parent or therapist versions. This aspect implies that in the therapists' versions of the instruments, therapists rate the alliance they perceive in the child towards them. So, the lower ratings in therapists may be influenced, for instance, by the therapist's expectations of what makes a 'higher' alliance versus the child's or parent's expectations of the alliance, or the therapists understanding of the progressiveness in the construction of the therapeutic alliance.

The therapists' more critical view of the initial alliance was evidenced as the intensity of the child's symptomatology was a negative variable for the therapist-reported initial alliance but was not significant in the case of the children. It may be interesting to recall that children in this study presented more externalizing symptoms and may have expressed their initial reticence in a more confrontational style, negatively impacting the therapists' view of the initial alliance,

as reported by Halfon et al. (2019). However, the alliance instruments were used after these first encounters, where children felt happier with their therapist, and may reflect this positive experience. Therapists may be more sceptical about the depth of this rapid change in the child.

The initial negative disposition observed in some children was explained in different terms: parents and therapists argued that it related to the child's tiredness, while children referred to negative expectations regarding the utility of psychotherapy and the therapist personal features. This finding supports the inclusion of children's views even when they do not initiate the consultation and stresses the adult tendency to interpret children's behaviour without considering the child's motivations.

Another important difference within these perspectives was that children exhibited significantly higher valuations of the initial alliance when they were older, but therapists did not report age-related differences. This finding stress that child therapists should be aware of the difficulties of younger school-age children in establishing the alliance, as previously discussed.

Regarding the more advanced phases of psychotherapy, more specific emphasis was observed between the viewpoints of children, parents and therapists. Children underlined feeling good and happy in the therapeutic relationship and felt they changed thanks to the help of their therapist. Parents highlighted that the child felt free and accepted by the therapist, and parents and therapist emphasised the construction of trust in the child as a change facilitator.

Concerning the parent-therapist relationship, parents' and therapists' perspectives converged and emphasised that a positive relationship between them facilitated the child's therapeutic process, the parent's receptivity and changes. The commitment and collaboration of parents were also highlighted by parents and therapists. However, children did not refer to this relationship beyond considering it 'good'. In this same direction, children tended to obviate their parent's role in the process. At this point, the inclusion of parent's and therapist's perspectives was a valuable complement to what children identify as relevant for their process.

Finally, it is notable that when the subjective experiences of children, parents and therapists of the therapeutic relationship were explored, children and parents gave higher importance to the affective dimension as a change facilitator over the focus on technical aspects observed in the views of therapists, who also concentrated more on the experience of children and parents than on their own. Therefore, each perspective complemented and balanced the

understanding of crucial elements of the therapeutic relationship and the change processes in child psychotherapy.

## 5.5. Principal strengths and limitations

The core strengths and limitations of each paper were developed in the three papers comprised in this doctoral thesis. The principal strengths and limitations are summarized as follows. A first limitation of the conducted studies was that only positive therapeutic relationships were described. This feature is not representative of all children and parents attending therapy services.

A second limitation regards the characteristics of participants in study 2, particularly the therapists, who were rather young and inexperienced. As stated in paper 3, more experienced therapists may have stressed some of the more hard and confrontational aspects of therapy and focussed less on engaging children through being friendly. It is important to note that the inclusion of younger therapists in this study related to the fact that many more experienced therapists declined to participate in it. As discussed in paper 2, researchers should generate a more visible contribution to clinical practice in order to alleviate to some extent the reticence voiced by therapists and make it more attractive for them to share their clinical work.

On the other hand, numerous strengthening aspects were identified in this doctoral thesis. In the first place, the multiple perspective approach towards the therapeutic relationship as a facilitator of change in child psychotherapy was essential for a more accurate grasp of its nature. Also, as discussed in paper 3, the consideration of multiple perspectives provided an equilibrium with respect to power asymmetries (Levitt, 2021; Lutrell, 2010). In this doctoral thesis, a higher balance was achieved between children's perspectives and adult-centred approaches to children's experiences, and between children's and parent's valuation and the therapist's valuation of the core elements of change processes.

Furthermore, the inclusion of children's views through interviews and drawings significantly enriched the findings. Drawings in particular enhanced children's narratives, and new elements appeared, supporting the use of age-appropriate methods in child psychotherapy research. The drawings used in this doctoral thesis and prior investigations proved to be a significant contribution for child psychotherapy research. A developmentally sensitive approach

is fundamental for future research, including children's experiences through their predilect expressive means.

This doctoral thesis sheds new light on the understanding of the therapeutic relationship in child psychotherapy and underscores the need to continue doing research on this largely unexplored field. Future studies may use a larger and more diverse sample, especially with respect to the therapists. The different trajectories observed in the child-therapist and parents-therapist relationship may be further explored to advance in understanding the particularities of each one, as well as more challenging or negative experiences in child psychotherapy should be considered to further contribute to understand and better manage this topic. The expectations of the therapeutic alliance and how it should develop also should be further studied, as it seemed to impact the different valuations within children, parents and therapists. In this direction, it is relevant to continue researching the therapeutic relationship established with parents or caregivers, as well as the influence of other clinical and demographic variables, the interconnection between the parent-child-therapist relationships, their impact in the process and their association with change.

## 5.6. Conclusions

The simultaneous analysis of the views of children, parents and therapists done in this thesis enabled a relational comprehension of change processes and a broader understanding of the role of the therapeutic relationship in child psychotherapy. The children's perspective represented a novel contribution that enriched the views of their parents and therapists. Studying the therapeutic relationship from the experiences of the participants of child psychotherapy contributed to generate knowledge that represents this age group.

The child-therapist relationship was viewed as a positive affective experience by participants that facilitated changes in children and parents from the first encounters. The parent-therapist relationship and changes clearly supported this process. As the therapeutic relationship evolved beyond the role-related dimension towards a more affective and genuine interaction, it favoured greater changes. In this direction, the definition of the therapeutic relationship in child psychotherapy should considerer the inclusion of parents and should place higher relevance on the real relationship.

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# 7. APPENDIXES

## 7.1. Appendix 1: Agreements with mental health centres

Red de Salud
UC • CHRISTUS

Dando cumplimiento al Artículo 11 de la Ley 20120, se autoriza el Proyecto de Investigación **"RELACIONES TERAPEUTICAS Y PROCESOS DE CAMBIO EN PSICOTERAPIA CON NIÑOS/AS: INTEGRANDO LAS EXPERIENCIAS SUBJETIVAS DE NIÑOS/AS, PADRES Y TERAPEUTAS"** para ser realizado en la Unidad de Salud Mental en el Centro Médico San Joaquín.

Nombro a Marianne Cottin, como delegada para la firma de los consentimientos informados de esta investigación.

INVESTIGADOR: Lucía Núñez H. – Facultad de Ciencias Sociales

NÚMERO PROYECTO : 180614006
FECHA APROBACIÓN : 11-07-2018
FECHA EXPIRACIÓN : 10-07-2019

**Se solicita informar a esta Dirección cuando este proyecto finalice o enviar documentos de renovación.**

**DRA. BLANCA PEÑALOZA H.**
**Director Médico**
**Centro Médico San Joaquín**

Santiago, 2018

PONTIFICIA
UNIVERSIDAD
CATÓLICA
DE CHILE

Santiago, 01 de Junio 2018

Sr. Uwe Kramp
Director
Centro de Psicología Aplicada de Universidad de Chile (CAPs)
Presente

En calidad de investigadora responsable me dirijo a usted para invitar a psicólogos/as tratantes y usuarios del CAPs a participar en mi estudio "Relaciones terapéuticas y procesos de cambio en psicoterapia con niños/as: integrando las experiencias subjetivas de niños/as, padres y terapeutas". Se trata de un proyecto de tesis doctoral del Programa de Doctorado en Psicoterapia conjunto de la Pontificia Universidad Católica de Chile y de la Universidad de Chile. Se desarrolla con el apoyo de la Beca de Doctorado Nacional otorgado por CONICYT, y presenta un potencial impacto en el campo de la psicoterapia infantil, aportando conocimiento y orientaciones para la práctica terapéutica eficaz con niños/as, al profundizar en el rol de las relaciones terapéuticas en los procesos de cambio terapéutico. De este modo, el objetivo general de la investigación es desarrollar un modelo comprensivo del rol de las relaciones terapéuticas en psicoterapia con niños en los procesos de cambio desde la perspectiva de los niños/as, sus padres y terapeutas.

Se acompañan a esta carta el CV resumido de la investigadora responsable y el resumen ejecutivo del proyecto. En éste se detallan las principales etapas del estudio y los momentos en que se propone involucrar a los participantes del Centro. El proyecto considera la participación de psicólogos/as, niños/as y padres o cuidadores, que desarrollen procesos psicoterapéuticos en el Centro. La participación en el estudio implica la realización de las siguientes acciones: entrevistas en profundidad respecto de la relación terapéutica y procesos de cambio con los niños/as, sus padres o cuidadores y sus terapeutas en diferentes momentos de la psicoterapia (inicio, 6 meses, 12 meses, 18 meses o al término). Las entrevistas de los niños serían apoyadas con la realización de dibujos de la relación terapéutica y el proceso de cambio. Además se aplicarán a los niños/as, terapeutas y padres o cuidadores en los diferentes momentos mediciones de cambio a partir del instrumento Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999; Brown, 2012) y de alianza terapéutica a partir del Therapeutic Alliance Scale for Children-Revised (TASC-R; Creed & Kendall, 2005) y el Therapeutic Alliance Scale for Caregivers and Parents (TASCP; Accurso, Hawley, & Garland, 2013).

Para garantizar la correcta conducción del proyecto, cumpliendo los requerimientos éticos de la investigación con personas, a todos los actores invitados a participar se les solicitará su consentimiento informado y asentimiento informado a los niños/as, antes de involucrarlos en el estudio.

Frente a cualquier duda que le suscite la participación en este proyecto, Ud. podrá contactarse conmigo como investigador responsable Sra. Lucía Núñez Hidalgo, al e-mail: ltnunez@uc.cl, dirección Av. Vicuña Mackenna 4860, Macul, teléfono: 22 3545883, y/o con el Comité Ético Científico en Ciencias Sociales, Artes y Humanidades de la Pontificia Universidad Católica de Chile, cuya presidenta es la Sra. María Elena Gronemeyer, e-mail de contacto: mgroneme@uc.cl, teléfono: 223542020.

Agradezco de antemano la acogida y valioso apoyo que pueda brindar a este proyecto.

Saludos cordiales,

Lucía Núñez Hidalgo

Investigador Responsable

PONTIFICIA
UNIVERSIDAD
CATÓLICA
DE CHILE

**AUTORIZACIÓN**

Yo Uwe Kramp, Director del Centro de Psicología Aplicada de la Universidad de Chile (CAPs), autorizo y apoyo la participación de este Centro en el proyecto "Relaciones terapéuticas y procesos de cambio en psicoterapia con niños/as: integrando las experiencias subjetivas de niños/as, padres y terapeutas). El propósito y naturaleza de la investigación me han sido explicados por la investigadora responsable, Sra. Lucía Núñez Hidalgo.

La investigación constituirá un aporte al campo del conocimiento y orientaciones para la práctica psicoterapéutica eficaz con niños/as y sus familias, al profundizar en el rol de las relaciones terapéuticas en los procesos de cambio terapéutico en la infancia.

El apoyo aprobado por el comité que dirijo, exige que esta investigación se despliegue bajo las condiciones que el protocolo de desarrollo de investigación del CAPs establece para la realización de investigación financiada por fondos internos o externos a la Universidad de Chile. Dicho protocolo se encuentra en proceso de construcción y contempla los siguientes aspectos: a) sólo se podrá contactar a los pacientes del Centro que hayan aceptado participar de alguna investigación en el consentimiento de ingreso a CAPs; b) todos los reportes de investigación publicados con resultados obtenidos en el CAPs, deberán indicar el patrocinio del Centro de Psicología Aplicada de la Facultad de Ciencias Sociales de la Universidad de Chile (CAPs); y c) el uso de las dependencias de CAPs tendrá un costo asociado que esperamos pueda ser compensado por la Investigadora Responsable del proyecto patrocinado, aportando a la formación de nuestros terapeutas a través de charlas, conferencias, talleres u otras instancias de formación académica.

Para efectos de dar curso a esta autorización, la investigadora responsable cuenta con la certificación previa de un Comité Ético Científico que corresponde de acuerdo a la normativa legal vigente.

Me han quedado claras las implicancias de la participación de nuestro establecimiento en el proyecto y se me ha informado de la posibilidad de contactar ante cualquier duda al investigador responsable del estudio Sra. Lucía Núñez Hidalgo, al e-mail: ltnunez@uc.cl, dirección Av. Vicuña Mackenna 4860, Macul, teléfono: 223545883; y/o con el Comité Ético Científico en Ciencias Sociales, Artes y Humanidades de la Pontificia Universidad Católica de Chile, cuya presidenta es la Sra. María Elena Gronemeyer, e-mail de contacto: mgroneme@uc.cl, teléfono: 223542020.

Nombre del Director: ____**Prof. Dr. Uwe Kramp Denegri**_____

Firma del Director: _____

Fecha: __**25/10/2018**_____

(Este documento se firma en duplicado, quedando una copia para el Director del Centro y otra copia para la investigadora responsable)

## 7.2. Appendix 2: Informed assent and informed consents

### *7.2.1. Informed Assent and Informed Consents Study 1 (paper 1)*

Pontificia Universidad Católica de Chile
Escuela de Psicología

P. Universidad Católica de Chile – Comité de Ética – Esc. de Psicología

**CARTA DE ASENTIMIENTO INFORMADO (niñas/os)**

**Has sido invitado a participar en un estudio sobre "Experiencias con la psicoterapia", a cargo de la investigadora Mariane Krause, docente de la Pontificia Universidad Católica de Chile.**

**El objetivo de esta carta es ayudarte a tomar la decisión de participar en esta investigación.**

**¿Cuál es el propósito de esta investigación?**
El propósito del presente estudio es conocer la experiencia que tuviste en tu terapia con psicólogo/a.

**¿En qué consiste tu participación y cuánto durará?**
Te pediremos que participes en una entrevista donde conversaremos y dibujaremos sobre tu experiencia en la terapia con psicólogo/a (lo que experimentaste, lo que sentiste, lo que viviste), de una hora de duración aproximadamente. Luego, entrevistaremos a uno de tus padres y al psicólogo/a que te atendió, y ninguno de los tres podrá conocer la información que entreguen los otros participantes.

**¿Qué riesgos corres al participar?**
Ninguno.

**¿Qué beneficios puede tener tu participación?**
Aunque no tendrás un beneficio directo al participar de este estudio, los resultados que tengamos en la investigación podrán ayudar a desarrollar el conocimiento científico y a entregar un mejor apoyo a otros niños y adolescentes que necesiten terapia psicológica. Además, participar de esta entrevista te ayudará a pensar sobre la experiencia que tuviste en tu terapia, en un espacio confidencial.

**¿Qué pasa con la información y datos que tú entregues?**
La conversación y los dibujos que tendremos sobre tu experiencia en la terapia serán grabados en audio y guardados, y ambos serán usados únicamente para el análisis de la investigación. Toda la información que nos entregues será estrictamente **confidencial**, lo que significa que ni tu nombre ni tu voz ni ningún dato de identificación tuyo aparecerán jamás en las publicaciones o presentaciones que se deriven de este estudio u otros estudios vinculados. Ni tus padres ni tu terapeuta tendrán ninguna de las informaciones que tú nos entregues en la entrevista. Además, toda la información que obtengamos será debidamente resguardada en la Escuela de Psicología de la Pontificia Universidad Católica de Chile, en las oficinas de la investigadora responsable, por el tiempo que se estime necesario para el desarrollo de ésta y futuras investigaciones, además de docencia especializada. Al firmar este documento, autorizas al equipo de investigación para acceder a la información diagnóstica registrada por tus profesionales tratantes en tu ficha clínica, la cual será tratada con los mismos compromisos de de confidencialidad que te hemos indicado. También solicitaremos a tus padres y/o apoderado su autorización para que participes de este estudio.

Comité Ético Científico UC Ciencias Sociales Artes y Humanidades

**¿Es obligación participar? ¿Puedo arrepentirme después de participar?**
Tu participación en esta actividad es voluntaria. Tienes el derecho a abandonar el estudio sin dar ningún tipo de explicación y sin que ello signifique ninguna consecuencia negativa para ti.

**¿A quién puedo contactar para saber más de este estudio o si me surgen dudas?**
Si tú o tus padres tienen cualquier pregunta acerca de esta investigación, pueden contactar a la investigadora responsable Mariane Krause. Su teléfono es el 23547176 y su e-mail es mkrause@uc.cl. Si tú o tus padres tienen alguna consulta o preocupación respecto a tus derechos como participante de este estudio, pueden contactar a Christian Berger, Secretario Ejecutivo del Comité de Ética de la Escuela de Psicología de la Pontificia Universidad Católica de Chile, e-mail comite.etica.psicologia@uc.cl, fono 2354-5883.

HE LEÍDO (O ME HAN LEÍDO) ESTA DECLARACIÓN DE ASENTIMIENTO INFORMADO, HE PODIDO HACER LAS PREGUNTAS QUE ME HAN SURGIDO SOBRE ESTE PROYECTO DE INVESTIGACIÓN Y ME HAN RESPONDIDO COMO YO NECESITABA, Y ACEPTO PARTICIPAR EN ESTE PROYECTO.

_____ _____
Firma del (de la) Participante Fecha

_____
Nombre del (de la) Participante

_____ _____
Firma de la Investigadora Fecha

(Firmas en duplicado: una copia para el/la participante y otra para la investigadora)

Pontificia Universidad Católica de Chile
Escuela de Psicología

P. UNIVERSIDAD CATOLICA DE CHILE COMITE DE ETICA ESC. DE PSICOLOGIA

**CARTA DE CONSENTIMIENTO INFORMADO (Padres niñas/os)**

**Usted ha sido invitado a participar en el estudio sobre "Experiencias con la psicoterapia", a cargo de la investigadora Mariane Krause, docente de la Pontificia Universidad Católica de Chile.**

**El objetivo de esta carta es ayudarlo a tomar la decisión de autorizar la participación de su hijo/a y de usted en esta investigación.**

**¿Cuál es el propósito de esta investigación?**
El propósito del presente estudio es conocer la experiencia que su hija/o tuvo en su terapia psicológica y también como ustedes percibieron dicho proceso.

**¿En qué consiste su participación y cuánto durará?**

Al inicio y al final de la terapia de su hijo le solicitaremos a usted que complete un cuestionario acerca de características de él/ella. Después de haber terminado la terapia, le pediremos a su hija/o y a usted que participen, por separado, en una entrevista sobre sus experiencias en la terapia psicológica. La entrevista a su hijo/a incluirá una actividad de dibujo. Cada una de estas entrevistas tendrá una hora de duración aproximadamente. Luego, entrevistaremos también al psicólogo que trabajó con su hija/o. Ninguno de los tres podrá conocer la información que entreguen los otros participantes.

**¿Qué riesgos corre usted o su hija/o al participar?**
Ninguno.

**¿Qué beneficios puede tener su participación?**
Aunque ni usted ni su hija/o tendrán un beneficio directo al participar de este estudio, los resultados que tengamos en la investigación favorecerán el desarrollo del conocimiento científico y el diseño de estrategias para favorecer la psicoterapia con niños y adolescentes. Además, participar de esta entrevista ayudará a usted y a su hija/o a pensar sobre la experiencia que tuvo en la terapia psicológica, en un espacio confidencial.

**¿Qué pasa con la información y datos que entreguen?**
Las entrevistas serán grabadas en audio, el que será usado únicamente para el análisis de la investigación. Toda la información que nos entreguen será estrictamente **confidencial**, por lo que ningún dato de identificación suyo o de su hija/o aparecerá jamás en las publicaciones o presentaciones que se deriven de este estudio u otros estudios vinculados. El terapeuta de su hija/o no tendrá acceso a ninguna de las informaciones que nos entreguen en la entrevista. Además, toda la información que obtengamos será debidamente resguardada en la Escuela de Psicología de la Pontificia Universidad Católica de Chile, a cargo de la investigadora responsable, el tiempo que se estime necesario para el desarrollo de ésta y futuras investigaciones, además de docencia especializada. Por la firma del presente documento, Ud. autoriza a su hijo/a a participar de este estudio, y autoriza al equipo de investigación para acceder a la información diagnóstica registrada por los profesionales tratantes de su hijo en su ficha clínica, la cual será tratada con los mismos estándares de confidencialidad señalados previamente.

Comité Ético Científico UC Ciencias Sociales Artes y Humanidades

**¿Es obligación participar? ¿Puedo arrepentirme después de participar?**
Su participación en esta actividad, así como la de su hija/o, es voluntaria. Ambos tienen el derecho a abandonar el estudio sin dar ningún tipo de explicación y sin que ello signifique ningún perjuicio para usted ni para su hija/o.

**¿A quién puedo contactar para saber más de este estudio o si le surgen dudas?**
Si tiene cualquier pregunta acerca de esta investigación, puede contactar a la investigadora responsable Mariane Krause. Su teléfono es el 23547176 y su e-mail es mkrause@uc.cl. Si tiene alguna consulta o preocupación sobre sus derechos o los de su hija/o como participante de este estudio, puede contactar a Christian Berger, Secretario Ejecutivo del Comité de Ética de la Escuela de Psicología de la Pontificia Universidad Católica de Chile, e-mail comite.etica.psicologia@uc.cl, fono 2354-5883.

HE LEÍDO ESTA DECLARACIÓN DE CONSENTIMIENTO INFORMADO, HE PODIDO HACER LAS PREGUNTAS QUE ME HAN SURGIDO SOBRE ESTE PROYECTO DE INVESTIGACIÓN Y ME HAN RESPONDIDO COMO NECESITABA, Y ACEPTO PARTICIPAR EN ESTE PROYECTO.

_____ _____
Firma del (de la) Participante Fecha

_____
Nombre del (de la) Participante

_____ _____
Firma de la Investigadora Fecha

(Firmas en duplicado: una copia para el/la participante y otra para el/la investigadora)

Pontificia Universidad Católica de Chile
Escuela de Psicología

P. UNIVERSIDAD CATOLICA DE CHILE
COMITE DE ETICA
ESC. DE PSICOLOGIA

**CARTA DE CONSENTIMIENTO INFORMADO (terapeuta)**

**Usted ha sido invitado a participar en el estudio sobre "experiencias con la psicoterapia", a cargo de la investigadora Mariane Krause, docente de la Pontificia Universidad Católica de Chile.**

**El objetivo de esta carta es ayudarlo a tomar la decisión de participar en la presente investigación.**

**¿Cuál es el propósito de esta investigación?**
El propósito del presente estudio es conocer su experiencia como psicoterapeuta respecto al tratamiento psicológico llevado a cabo con sus pacientes, hace un tiempo atrás.

**¿En qué consiste su participación y cuánto durará?**

A sus pacientes se les solicitará participar en una entrevista sobre su experiencia en el proceso de psicoterapia, de una hora de duración aproximadamente (lo mismo con los padres de sus pacientes, en el caso que éstos sean niños y/o adolescentes). En el caso de los niños, la entrevista incluirá una actividad de dibujo. Luego, usted también será entrevistado y ninguno de los participantes tendrá acceso a la información que otorgue el otro participante.

**¿Qué riesgos corre al participar?**
Ninguno.

**¿Qué beneficios puede tener su participación?**
Aún cuando no obtendrá beneficios directos participando en este estudio, los resultados obtenidos en esta investigación favorecerán el desarrollo del conocimiento científico y el diseño de estrategias para favorecer la psicoterapia. Además, el participar de esta entrevista promueve una oportunidad para reflexionar sobre su experiencia como psicoterapeuta, en un espacio confidencial.

**¿Qué pasa con la información y datos que usted entregue?**
La entrevista será grabada en audio, el que será usado únicamente para el análisis de la investigación. La información sobre su experiencia como psicoterapeuta será tratada **confidencialmente**, no será publicada en forma alguna que permita su identificación y será utilizada solamente con fines de investigación y de docencia especializada, para éste u otros estudios vinculados. Sus pacientes (ni los padres de éstos, en caso de ser menores de edad) tendrán información alguna de lo que usted narre en su entrevista, tampoco usted tendrá acceso a la información que ellos brinden en sus entrevistas. Asimismo, toda la información será debidamente almacenada y resguardada en la Escuela de Psicología de la Pontificia Universidad Católica de Chile, a cargo de la investigadora responsable, el tiempo que se estime necesario para el desarrollo de ésta y futuras investigaciones, además de docencia especializada.

**¿Es obligación participar? ¿Puede arrepentirse después de participar?**
Se le ha pedido participar en esta actividad en forma voluntaria. Tiene el derecho a abandonar el estudio sin necesidad de dar ningún tipo de explicación y sin que ello signifique ningún perjuicio para usted.

Comité Ético Científico
UC
Ciencias Sociales
Artes y Humanidades

**¿A quién puede contactar para saber más de este estudio o si le surgen dudas?**
Si tiene cualquier pregunta acerca de esta investigación, puede contactar a la investigadora responsable Mariane Krause. Su teléfono es el 23547176 y su e-mail es mkrause@uc.cl. Si tiene alguna consulta o preocupación respecto a sus derechos como participante de este estudio, puede contactar a Christian Berger, Secretario Ejecutivo del Comité de Ética de la Escuela de Psicología de la Pontificia Universidad Católica de Chile, e-mail comite.etica.psicologia@uc.cl, fono 2354-5883.

HE TENIDO LA OPORTUNIDAD DE LEER ESTA DECLARACIÓN DE CONSENTIMIENTO INFORMADO, HACER PREGUNTAS ACERCA DEL PROYECTO DE INVESTIGACIÓN, Y ACEPTO PARTICIPAR EN ESTE PROYECTO.

_____ _____
Firma del (de la) Participante Fecha

_____
Nombre del (de la) Participante

_____ _____
Firma de la Investigadora Fecha

(Firmas en duplicado: una copia para el/la participante y otra para la investigadora)

### *7.2.2. Informed Assent and Informed Consents Study 2 (paper 2 and 3)*

PONTIFICIA UNIVERSIDAD CATOLICA DE CHILE

**CARTA ASENTIMIENTO INFORMADO PARA NIÑOS Y NIÑAS**

Te invitamos a participar del estudio: "Relaciones terapéuticas y procesos de cambio en psicoterapia con niños/as: integrando las experiencias subjetivas de niños/as, padres y terapeutas", a cargo de Lucía Núñez, alumna del Doctorado en Psicoterapia de la Pontificia Universidad Católica de Chile.

**Esta carta es para ayudarte a tomar la decisión de si quieres participar en esta investigación.**

**También preguntaremos a tus padres/cuidadores si autorizan que participes en el estudio.**

**¿De qué se trata y cuánto dura tu participación?** Conocer tu experiencia en la terapia con psicólogo/a. Cuando empiece tu terapia te pediremos que contestes algunas preguntas y hagas unos dibujos, sobre tu experiencia en la terapia. Todo esto dura cerca de media hora. Además, es posible que te pidamos que nos des una breve entrevista, que duraría otra media hora. Esto mismo lo repetiremos cada 3 meses y cuando tu terapia termine.

**¿Qué beneficios puede tener tu participación?** Los resultados ayudarán a saber más sobre cómo ayudar mejor a los niños y niñas que van al psicólogo/a. Además te ayudará a pensar en un espacio confidencial, sobre tu experiencia en la terapia con el/la psicólogo/a.

**¿Qué riesgos corres al participar?** Ninguno.

**¿Qué pasa con la información y los datos que des?** Toda la información que compartas será **estrictamente confidencial**, es decir que tu nombre, tu voz y cualquier otro dato que te identifique nunca será mencionado en las presentaciones de este estudio o otros estudios vinculados. La información será identificada con números, y no se podrán reconocer nombres ni otros datos que muestren quien eres. En el caso de hacerte una entrevista, la grabaremos en audio, que se usa sólo para esta investigación. Ni tus padres/cuidadores, ni tu psicólogo/a tendrán acceso a la información entregada por ti en las entrevistas. Además, toda la información será guardada en un mueble bajo llave en la Escuela de Psicología de Pontificia Universidad Católica de Chile, y cuidada por la investigadora responsable.

**¿Es obligación participar? ¿Puedes arrepentirse después de participación?** NO estás obligado de ninguna manera a participar en este estudio. Si decides participar, puedes dejar de hacerlo en cualquier momento sin dar ninguna explicación y sin ninguna consecuencia negativa para ti.

**¿Cómo se usará la información que entregues?** Los resultados se pueden usar para publicar artículos en revistas científicas, presentaciones en congresos y clases especializadas.

**¿A quién puedes contactar para saber más de este estudio o si te surgen dudas?** Si tienes cualquier pregunta, podrán contactar a la investigadora Lucía Núñez a su teléfono el

Comité Ético Científico UC Ciencias Sociales Artes y Humanidades

PONTIFICIA UNIVERSIDAD CATÓLICA DE CHILE

223545883 y a su email ltnunez@uc.cl. Además podrán contactar a la profesora responsable Mariane Krause, al email mkrause@uc.cl o al teléfono 223545883. Si tienes alguna consulta o preocupación respecto a tus derechos como participante de este estudio, pueden contactar al Comité Ético Científico de Ciencias Sociales, Artes y Humanidades. Presidenta: María Elena Gronemeyer. Contacto: eticadeinvestigacion@uc.cl.

**Además, queremos preguntarte si autorizas al equipo de investigación a ver información diagnóstica registrada por el psicólogo/a en la ficha clínica, la cual será tratada con el mismo cuidado antes mencionado:**

Autorizo: _____ No autorizo: _____

**He leído, o me han leído, esta declaración de asentimiento informado, he podido hacer las preguntas que he tenido acerca de este proyecto de investigación y me han respondido como yo necesitaba, y acepto participar en este proyecto.**

| Firma del/la Participante | Nombre del/la Participante | Fecha |
|---|---|---|
| Firma de la Investigadora | Nombre de la Investigadora | Fecha |

Además, me han mostrado los dibujos que podrían ser parte de presentaciones audiovisuales o publicaciones escritas. Me han explicado y he entendido que la utilización de mis dibujos será confidencial y que si quiero puedo negarme a autorizar la utilización de éstos, sin tener que dar explicaciones y sin consecuencias para mí.

**Sabiendo todo esto, autorizo además la utilización de mis dibujos en presentaciones audiovisuales o publicaciones escritas.**

| Firma del/la Participante | Firma de la Investigadora | Fecha |
|---|---|---|

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**¡Muchas gracias por tu tiempo!**

(Firmas en duplicado: una copia para el participante y otra para el investigador)

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## CARTA CONSENTIMIENTO INFORMADO PADRES/CUIDADORES NIÑO/A

Usted ha sido invitado a participar en el estudio titulado: "Relaciones terapéuticas y procesos de cambio en psicoterapia con niños/as: integrando las experiencias subjetivas de niños/as, padres y terapeutas", a cargo de la investigadora Lucía Núñez, alumna del Doctorado en Psicoterapia de la Pontificia Universidad Católica de Chile y la Universidad de Chile. Este estudio cuenta con apoyo derivado de la Beca de Doctorado Nacional de CONICYT.

**El objeto de esta carta es ayudarlo a tomar la decisión de participar en la presente investigación.**

**¿De qué se trata la investigación científica a la que se lo invita a participar?** Esta investigación busca comprender como la relación que su hijo/a y usted tiene con el psicólogo/a a cargo del tratamiento influye en los procesos de cambio producto de la psicoterapia.

**¿Cuál es el propósito concretamente de su participación en esta investigación?** Conocer su experiencia y la de su hijo/a en el proceso de psicoterapia, especialmente en torno a la relación con el psicólogo/a a cargo y la percepción de cambios asociados a la intervención psicológica.

**¿En qué consiste su participación?** En el transcurso de la terapia de su hijo/a, le solicitaremos a su hijo/a y a usted que completen dos breves cuestionarios en torno a ella. A su hijo/a le pediremos también que realice dos dibujos para facilitar su expresión. Además, podríamos solicitarles a ambos por separado una entrevista sobre su experiencia en la terapia psicológica. Al psicólogo/a de su hijo/a y le pediremos responda dos breves cuestionarios, y lo entrevistaremos si corresponde al caso. Ninguno de los tres podrá conocer la información que entreguen los otros participantes.

**¿Cuánto durará su participación?** Los cuestionarios durarán aproximadamente 10 minutos, y en el caso de hacerle una entrevista, duraría media hora más, realizándose en paralelo la de su hijo/a. Este proceso se realizará al inicio de la psicoterapia y se repite cada tres meses, hasta que termine la psicoterapia.

**¿Qué beneficios puede obtener de su participación?** Aunque usted ni su hijo/a obtendrán un beneficio directo al participar del estudio, los resultados obtenidos a partir de ésta favorecerán el desarrollo del conocimiento científico y el diseño de prácticas psicoterapéuticas eficaces en el tratamiento de niños y niñas y sus familias. Además, participar de esta investigación le ayudará a usted y a su hijo/a a pensar en un espacio confidencial sobre la experiencia que tuvieron en la terapia psicológica.

**¿Qué riesgos corre al participar?** Ninguno.

**¿Cómo te protege la información y datos que usted entregue?** Toda información que entreguen será **estrictamente confidencial**, por lo que cualquier dato de identificación suyo o de su hijo/a nunca será mencionado en las publicaciones o presentaciones que deriven de este estudio o otros estudios vinculados. Para ello, la información obtenida será almacenada e identificada con números, por lo cual no se podrán reconocer de ninguna manera datos que permitieran identificar a los participantes. En caso de realizarse, las entrevistas serán grabadas en audio, el que será usado únicamente para el análisis de la investigación. El/la psicólogo/a de su hijo/a no tendrá acceso a ninguna información entregada en las entrevistas. Además, toda la información obtenida será debidamente resguardada en la Escuela de Psicología de Pontificia Universidad Católica de Chile a cargo de la investigadora responsable, el tiempo que estime necesario para el desarrollo de ésta y futuras investigaciones, además de [illegible] especializada. Por la firma de este documento autoriza a su hijo/a a participar del estudio.

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**¿Es obligación participar? ¿Puede arrepentirse una vez iniciada su participación?** Usted NO está obligado de ninguna manera a participar en este estudio. Si accede a participar, puede dejar de hacerlo en cualquier momento sin repercusión negativa alguna para usted o su hijo/a, aunque el Director del Centro haya autorizado la realización de esta investigación.

**¿Qué uso se va a dar a la información que yo entregue?** Los usos potenciales de los resultados de esta investigación se orientan a publicaciones científicas, presentaciones en congresos y docencia especializada. Ello incluye los productos realizados por su representado (dibujo o narrativa) en la presente investigación.

**¿A quién puede contactar para saber más de este estudio o si le surgen dudas?** Si tiene cualquier pregunta acerca de esta investigación, puede contactar a la investigadora responsable Lucía Núñez. Su teléfono es el 223545883 y su email es ltnunez@uc.cl. Además usted podrá contactar a la profesora tutora de esta tesis doctoral como académica responsable de la investigación Mariane Krause, al email mkrause@uc.cl o al teléfono 223545883. Si usted tiene alguna consulta o preocupación respecto a sus derechos como participante de este estudio, puede contactar al Comité Ético Científico de Ciencias Sociales, Artes y Humanidades. Presidenta: María Elena Gronemeyer. Contacto: eticadeinvestigacion@uc.cl.

**He tenido la oportunidad de leer esta declaración de consentimiento informado, hacer preguntas acerca del proyecto de investigación, y acepto participar en este proyecto.**

| _____ | _____ | _____ |
|---|---|---|
| Firma del/la Participante | Nombre de/la Participante | Fecha |
| _____ | | _____ |
| Firma de la Investigadora | | Fecha |

**De forma adicional, se me consulta si autorizo al equipo de investigación para acceder a información diagnóstica registrada por el psicólogo/a de mi hijo/a en la ficha clínica, la cual será tratada con mismos estándares de confidencialidad antes mencionados:**

Autorizo: _____ No autorizo: _____

**Además, autorizo voluntariamente la utilización de el/los dibujos de mi representado/a, para su uso en la presentación de los resultados que se deriven de ésta investigación.**

| _____ | _____ | _____ |
|---|---|---|
| Firma del/la Participante | Firma de la Investigadora | Fecha |

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(Firmas en duplicado: una copia para el participante y otra para el investigador)

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## CARTA CONSENTIMIENTO INFORMADO TERAPEUTAS

Usted ha sido invitado a participar en el estudio titulado: "Relaciones terapéuticas y procesos de cambio en psicoterapia con niños/as: integrando las experiencias subjetivas de niños/as, padres y terapeutas", a cargo de la investigadora Lucía Núñez, alumna del Doctorado en Psicoterapia de la Pontificia Universidad Católica de Chile y la Universidad de Chile. Este estudio cuenta con apoyo derivado de la Beca de Doctorado Nacional de CONICYT.

**El objeto de esta carta es ayudarlo a tomar la decisión de participar en la presente investigación.**

**¿De qué se trata la investigación científica a la que se lo invita a participar?** Esta investigación busca comprender como la relación terapéutica que usted tiene con el niño/a y sus padres/cuidadores influye en los procesos de cambio producto de la psicoterapia.

**¿Cuál es el propósito concretamente de su participación en esta investigación?** Conocer su experiencia en el proceso de psicoterapia, especialmente en torno a la relación con el niño/a y sus padres/cuidadores y la percepción de cambios asociados a la intervención psicológica.

**¿En qué consiste su participación?** En el transcurso de la terapia, le solicitaremos que complete dos breves cuestionarios en torno a la alianza terapéutica con el niño/a y con sus padres/cuidadores. También al niño/a y sus padres/cuidadores les pediremos respondan dos cuestionarios. Además, podríamos solicitarle una entrevista sobre su experiencia en esta terapia, con énfasis en la relación y el cambio terapéutico, entrevistando también al niño/a y a sus padres/cuidadores. Ninguno de los tres podrá conocer la información que entreguen los otros participantes.

**¿Cuánto durará su participación?** Los cuestionarios duran alrededor de 10 minutos. En caso de ser entrevistado, ésta se desarrolla en aproximadamente 30 minutos. Este proceso se realizará al inicio de la psicoterapia, se repite cada tres meses y al término de la intervención psicológica.

**¿Qué beneficios puede obtener de su participación?** Aunque usted no obtendrá un beneficio directo al participar del estudio, los resultados derivados a partir de ésta favorecerán el desarrollo del conocimiento científico y el diseño de prácticas psicoterapéuticas eficaces en el tratamiento de niños y niñas y sus familias. Además, participar de esta investigación le ayudará a usted a pensar en un espacio confidencial sobre la experiencia que tuvo en esta terapia psicológica.

**¿Qué riesgos corre al participar?** Ninguno.

**¿Cómo se protege la información y datos que usted entregue?** Toda información que entreguen será **estrictamente confidencial**, por lo que cualquier dato de identificación nunca será mencionado en las publicaciones o presentaciones que deriven de este estudio o otros estudios vinculados. Para ello la información obtenida será almacenada e identificada con números, por lo cual no se podrán reconocer de ninguna manera los nombres ni otros datos que permitieran identificar a los participantes. Las posturas entrevistas realizadas serán grabadas en audio, el que será usado únicamente para el análisis de la investigación. El niño/a y sus padres/cuidadores no tendrán acceso a ninguna información entregada en las entrevistas. Además, toda la información obtenida será debidamente resguardada en la Escuela de Psicología de Pontificia Universidad Católica de Chile a cargo de la investigadora responsable, el tiempo

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que estime necesario para el desarrollo de ésta y futuras investigaciones, además de docencia especializada.

**¿Es obligación participar? ¿Puede arrepentirse una vez iniciada su participación?** Usted NO está obligado/a de ninguna manera a participar en este estudio. Si accede a participar, puede dejar de hacerlo en cualquier momento sin repercusión negativa alguna para usted, aunque el Director del Centro haya autorizado la realización de esta investigación.

**¿Qué uso se va a dar a la información que yo entregue?** Los usos potenciales de los resultados, de esta investigación se orientan a publicaciones científicas, presentaciones en congresos y docencia especializada.

**¿A quién puede contactar para saber más de este estudio o si le surgen dudas?** Si tiene cualquier pregunta acerca de esta investigación, puede contactar a la investigadora responsable Lucía Núñez, al teléfono 223545883 y al email ltnunez@uc.cl. Además usted podrá contactar a la profesora tutora de esta tesis doctoral como académica responsable de la investigación, Mariane Krause, al email mkrause@uc.cl o al teléfono 223545883. Si usted tiene alguna consulta o preocupación respecto a sus derechos como participante de este estudio, puede contactar al Comité Ético Científico de Ciencias Sociales, Artes y Humanidades. Presidenta: María Elena Gronemeyer. Contacto: eticadeinvestigacion@uc.cl.

**He tenido la oportunidad de leer esta declaración de consentimiento informado, hacer preguntas acerca del proyecto de investigación, y acepto participar en este proyecto.**

| _____ | _____ | _____ |
|---|---|---|
| Firma del/la Participante | Nombre de/la Participante | Fecha |

| _____ | _____ |
|---|---|
| Firma de la Investigadora | Fecha |

**De forma adicional, se le consulta si autoriza al equipo de investigación para acceder a la información diagnóstica registrada por usted en la ficha clínica, la cual será tratada con los mismos estándares de confidencialidad antes mencionados:**

Autoriza: _____ autoriza: _____

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(Firmas en duplicado: una copia para el participante y otra para el investigador)

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## 7.3. Appendix 3: Adaptation of therapeutic alliance instruments: TASC-r and TASCP

**ESCALA DE ALIANZA TERAPÉUTICA PARA NIÑOS/AS ADAPTADA** (Shirk & Saiz, 1992)

**VERSIÓN PARA NIÑOS/AS (TASC-C)**

Voy a leerte algunas frases sobre cuando vienes a ver a tu psicólogo/a. Quisiera que me cuentes cuánto te pasa a ti lo que dice cada frase. Cuéntame si la frase te pasa nada, poco, bastante o mucho. Probemos con un ejemplo: *jugamos juegos con mi psicólogo/a*: ¿eso te pasa nada, poco, bastante o mucho? Aquí sigue el resto. Recuerda, no hay respuestas correctas o incorrectas, ni le comentaremos nada a tu psicólogo/a. La idea es que sólo me cuentes tu opinión.

1. Me gusta estar con mi psicólogo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

2. Encuentro difícil trabajar con mi psicólogo/a en resolver problemas de mi vida.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

3. Siento que mi psicólogo/a está de mi lado y trata de ayudarme.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

4. Trabajo con mi psicólogo/a en resolver mis problemas.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

5. Cuando estoy con mi psicólogo/a, quiero que las sesiones terminen rápidamente.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

6. Espero juntarme con mi psicólogo/a en las sesiones.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

7. Siento que mi psicólogo/a gasta demasiado tiempo trabajando en mis problemas.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

8. Preferiría hacer otras cosas que reunirme con mi psicólogo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

9. Uso el tiempo con mi psicólogo/a para mejorar cosas en mi vida.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

10. Me agrada/cae bien mi psicólogo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

11. Preferiría no trabajar en mis problemas con mi psicólogo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

12. Creo que mi psicólogo/a y yo trabajamos bien juntos en enfrentar mis problemas.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

Fecha: _____ Firma Niño/a: _____

**¡Muchas gracias por tus respuestas!**

**ESCALA DE ALIANZA TERAPÉUTICA PARA NIÑOS/AS ADAPTADA** (Shirk & Saiz, 1992)

**VERSIÓN PARA TERAPEUTAS (TASC-T)**

Por favor use la siguiente escala para evaluar cómo cada afirmación aplica a la presentación general del momento actual del/la niño/a en las sesiones de psicoterapia. Las respuestas pueden ser: "1: nada", "2: poco", 3: bastante" o "4: mucho". Después de leer cada afirmación, escoja su respuesta y marque con un círculo la opción que mejor represente su experiencia.

1. A el/la niño/a le gusta estar con usted, su psicólogo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

2. Al niño/a le resulta difícil trabajar con usted en resolver problemas de su vida.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

3. **El/la niño/a lo considera un/a aliado/a.**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

4. El/la niño/a trabaja con usted en resolver sus problemas.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

5. **El/la niño/a parece ansioso/a de que la sesión termine rápido.**

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

6. El/la niño/a espera con anhelo las sesiones de terapia.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

7. El/la niño/a siente que usted gasta demasiado tiempo enfocado en sus problemas/conflictos.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

8. El/la niño/a está resistente a venir a terapia.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

9. El/la niño/a utiliza el tiempo con usted para hacer cambios en su vida.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

10. El/la niño/a expresa afecto positivo hacia usted, su psicólogo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

11. El/la niño/a preferiría no trabajar en los problemas/conflictos en terapia.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

12. El/la niño/a es capaz de trabajar bien con usted el abordaje de sus problemas/conflictos.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

Fecha: _____ Firma Psicólogo/a: _____

**¡Muchas gracias por sus respuestas!**

**ESCALA DE ALIANZA TERAPÉUTICA PARA CUIDADORES Y PADRES ADAPTADA**
(TASCP; Accurso, Hawley, & Garland, 2013)

**VERSIÓN PARA PADRES/CUIDADORES**

Las siguientes afirmaciones son sobre su relación actual con el/la psicólogo/a de su hijo(a). Los/as niños/as pueden ser llevados al psicólogo/a por sus padres, sólo por su madre, sólo por su padre o por otros familiares o figura cuidadora. Por ello, antes de comenzar, por favor indique con una X quien responde a este cuestionario:

Madre: Padre: Ambos padres: Otro(s): (indique relación con el/la niño/a):

En caso de ser sólo una persona indique con una X si su opinión representa a ambos padres: SI __ NO __
Si su respuesta es NO, señala brevemente por qué:

Después de leer cada afirmación, marque con un círculo la opción que mejor represente su propia experiencia. Las respuestas pueden ser: "1: nada/no", "2: poco", 3: bastante" o "4: mucho/si". Recuerde que no hay respuestas buenas ni malas, correctas o incorrectas, sino que sólo lo que usted opina a partir de su experiencia.

1. Me agrada/gusta pasar tiempo con el/la psicólogo/a de mi hijo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

2. Encuentro difícil trabajar con el/la psicólogo/a de mi hijo/a en resolver problemas de mi/nuestras vida(s) como madre/padre/padres/cuidadores.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

3. Siento que el/la psicólogo/a de mi hijo/a está de mi lado e intenta ayudarme.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

4. Trabajo con el/la psicólogo/a de mi hijo/a en resolver mis/nuestros problemas como madre/padre/padres/cuidadores.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

5. Cuando estoy con el/la psicólogo/a de mi hijo/a, quiero que las sesiones terminen rápido.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

6. Espero las sesiones que tengo con el/la psicólogo/a de mi hijo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

7. Siento que el/la psicólogo/a de mi hijo/a dedica excesivo tiempo trabajando en mis/nuestros problemas como madre/padre/padres/cuidadores.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

8. Preferiría hacer otras cosas que tener que reunirme con el/la psicólogo/a de mi hijo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

9. Ocupo el tiempo con el/la psicólogo/a de mi hijo/a para hacer cambios en mi/nuestras vida(s) como madre/padre/padres/cuidadores.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

10. Me agrada/gusta el/la psicólogo/a de mi hijo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

11. Preferiría no trabajar en mis/nuestros problemas de madre/padre/padres/cuidadores con el/la psicólogo/a de mi hijo/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

12. Creo que trabajamos bien juntos con el/la psicólogo/a de mi hijo/a en afrontar mis/nuestros problemas como madre/padre/padres/cuidadores.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

Fecha: _____ Firma: _____

**¡Muchas gracias por sus respuestas!**

**ESCALA DE ALIANZA TERAPÉUTICA PARA CUIDADORES Y PADRES ADAPTADA**
(TASCP; Accurso, Hawley, & Garland, 2013)

**VERSIÓN PARA TERAPEUTAS**

Las siguientes 12 afirmaciones buscan conocer su relación actual con el adulto responsable de la terapia de su paciente. Este puede(n) ser los padres, sólo la madre, sólo el padre, otro familiar o figura cuidadora.

Antes de comenzar, por favor indique con una X si responde pensando en la relación con la/el/los:

Madre:___ Padre: ___ Ambos padres: ___ Otro:___ (indique la relación con el/la niño/a): _____

En caso de ser una sola persona, señale brevemente por qué: _____

Por favor puntúe a los padres, la madre, el padre o figura cuidador/a del niño/a en la siguiente escala de la forma más precisa posible. Las respuestas pueden ser: "1: nada/no", "2: poco", 3: bastante" o "4: mucho/si". Después de leer cada afirmación, marque con un círculo la opción que mejor represente su opinión.

1. A los/la/el padres/madre/padre/cuidador les agrada/gusta pasar tiempo con usted, el/la terapeuta.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

2. A los/la/el padres/madre/padre/cuidador les resulta difícil trabajar con usted en resolver problemas de su vida familiar.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

3. Los/la/el padres/madre/padre/cuidador lo/la consideran a usted como un/a aliado/a.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

4. Los/la/el padres/madre/padre/cuidador trabajan con usted en resolver sus problemas familiares.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

5. Los/la/el padres/madre/padre/cuidador parecen ansiosos en que su sesión termine pronto.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

6. Los/la/el padres/madre/padre/cuidador esperan las sesiones de terapia con usted.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

7. Los/la/el padres/madre/padre/cuidador sienten que usted dedica excesivo tiempo enfocado en sus problemas como padres/madre/padre/cuidador.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

8. Los/la/el padres/madre/padre/cuidador están resistentes a venir a terapia.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

9. Los/la/el padres/madre/padre/cuidador usan el tiempo con usted para hacer cambios en su vida familiar.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

10. Los/la/el padres/madre/padre/cuidador expresan emociones positivas hacia usted, el/la terapeuta.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

11. Los/la/el padres/madre/padre/cuidador preferirían no trabajar en sus problemas como padres/madre/padre/cuidador en la terapia.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

12. Los/la/el padres/madre/padre/cuidador son capaces de trabajar bien con usted en abordar sus problemas familiares.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Nada | Poco | Bastante | Mucho |

Fecha: _____ Firma: _____

**¡Muchas gracias por sus respuestas!**

## 7.4. Appendix 4: Semi-structured interviews protocols

### *7.4.1. Semi-Structured interview protocol study 1 (paper 1)*

**FONDECYT SEGUIMIENTO**
**GUIÓN DE ENTREVISTA A PACIENTE NIÑO/A**

**Instrucciones para el Entrevistador**
El objetivo de esta entrevista es conocer la percepción subjetiva de los participantes acerca de la experiencia de haber participado en terapia, o bien de que su familiar haya participado de una terapia. Es por ello que se busca que el entrevistado se explaye lo más posible en la descripción detallada de su experiencia, incluyendo la emergencia de reflexiones, recuerdos y sentimientos asociados. Por este motivo es que se espera que la entrevista sea una experiencia fluida.

En términos generales, esta entrevista pretende abarcar las siguientes grandes temáticas:

1. **Experiencia y definición de éxito y fracaso de la terapia**. Interesa conocer cómo evalúa retrospectivamente el paciente la experiencia de haber estado en terapia. Específicamente, qué aspectos considera que fueron positivos para su proceso, cómo y por qué, y cuáles percibe como negativos u obstaculizadores para este proceso. Es importante también conocer su definición personal de un buen o mal resultado en psicoterapia. Por último, es relevante conocer cómo se dio término al proceso terapéutico y cómo fue experimentado este término por parte del paciente.

2. **Atribuciones de causalidad**. Es importante indagar acerca de lo que el paciente considera que influyó en dichos éxitos y fracasos, cuáles fueron los factores o aspectos que llevaron a estos resultados percibidos y de qué manera. También es importante indagar acerca de qué cosas hicieron el paciente, el terapeuta o ambos juntos, así como también el familiar o adulto responsable, que influyeron en dicha percepción del éxito de la terapia. Esto incluye las intervenciones "típicas", así como también eventos atípicos, cosas que le llamaron la atención y que le parecieron relevantes. En esto es fundamental preguntar por momentos significativos de la terapia.

3. **Teoría subjetiva de salud y enfermedad**. Esto corresponde a la teoría o explicación que el sujeto tiene de su padecer, cómo lo entiende, a qué lo atribuye y asocia, y cómo entiende su propio proceso de mejora. Esto incluye explorar si la teoría de enfermedad sufrió alguna transformación producto de la terapia y cuál fue esta transformación, en qué consistió, y en relación a qué aspectos.

4. **La experiencia de la relación terapéutica**. Es importante explorar cómo el paciente percibe su relación y la relación del adulto o familiar responsable con el terapeuta, a lo largo del proceso. Interesa indagar en los cambios y oscilaciones experimentados o percibidos en los distintos intercambios con el terapeuta, los sentimientos hacia éste, así como la influencia de dichos sentimientos en el proceso de la terapia y de cambio (o no cambio) del paciente.

Teniendo en cuenta estas grandes temáticas, se sugiere que el entrevistador guíe la entrevista de manera fluida, y, en base a lo que el paciente vaya narrando, ir flexiblemente profundizando en dichas

temáticas. Si es necesario, el entrevistador puede tomar nota de los contenidos que parezcan importantes y retomarlos en el curso de la entrevista.

**Entrevista**

**Consigna:**

Mi nombre es _____ y pertenezco al equipo de investigación del proyecto _____ (Fondecyt, Milenio).

Esta entrevista es para conversar sobre la terapia psicológica que tuviste con el psicólogo/a _____ y conocer cómo fue tu experiencia y cuál es tu opinión sobre lo que te gustó y no te gustó de la terapia.

**Confidencialidad:**

Este estudio tiene la intención de ayudar a mejorar los tratamientos psicológicos a partir de la experiencia y opinión de quienes han ido al psicólogo/a.

Todo lo que hablemos aquí es confidencial, o sea, no se lo contaremos a tu psicólogo/a ni a tus papás. Pero si tú quieres, puedes contarles de lo que hablamos. Lo que tú nos cuentes servirá para saber cómo ayudar a otros niños que vengan al psicólogo/a.

Para no tomar nota, me gustaría grabar la entrevista.

| **Pregunta de apertura de la entrevista** |
|---|

Dependiendo de las características del niño/a, podemos realizar un "rompe hielo", con aspectos generales, como por ejemplo: Ahora me gustaría que me contaras un poco de ti y de tu vida, para saber cómo eres tú; por ejemplo, cuéntame qué edad tienes, en qué curso estás, qué te gusta hacer, qué música escuchas, etc.

**"Cuéntame sobre cómo fue para ti venir al psicólogo/a _____. Quiero conocer lo que tú quieras contarme de esto. Lo que se te venga a la mente, lo que se te ocurra".**

**QUEDARSE LO MÁS POSIBLE EN ESTA FASE**: Dejar que el sujeto construya la narración, con la menor cantidad de intervenciones posibles. Evitar interrumpir u orientar el curso del pensamiento del entrevistado, sólo intervenir cuando sea necesario pedir aclaraciones, profundizar (pedir ejemplos concretos) o reflejar para confirmar que se está entendiendo lo que el paciente dice. El orden del guión puede alterarse de acuerdo a lo que vaya emergiendo en el discurso del paciente, lo importante es que se aborden los diferentes tópicos.

**DIBUJOS:** Con los niños/as se solicitará la realización de dibujos durante la entrevista. Por eso recuerde llevar lápices mina, de color, hojas, etc.

El uso del dibujo es para favorecer la narrativa, no como técnica de evaluación, por lo cual se sugiere conversar con el niño a medida que va realizando el dibujo.

**Dibujo 1:** Se espera que este dibujo genere diálogo acerca de los temas relativos al proceso terapéutico y la relación terapéutica. Su realización, sin embargo, es OPCIONAL, por lo que se sugiere utilizarlo SÓLO en caso de que la narrativa relativa a estos temas no surja espontáneamente.

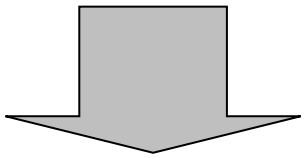
**Consigna:** "Me gustaría pedirte que hagas un dibujo que se llama '**yo y mi psicólogo/a en la consulta/terapia**".

**Dibujo 2:** Se sugiere utilizar este dibujo en **TODOS** los casos, salvo que el niño/a no quiera realizarlo. A través de él, se espera generar un diálogo acerca de los temas relativos al inicio de la terapia, sus resultados (cambios percibidos y/o vivenciados) y el término de la terapia.
**Consigna**: "Me gustaría pedirte que hagas un dibujo que se llama **antes/después**, y que tiene que ver con cómo estabas y te sentías antes de la terapia, y después, cuando ésta terminó. Vamos a hacer primero una línea acá al medio (poner la hoja en posición horizontal y hacer una línea divisoria en la mitad); entonces acá, al lado izquierdo, le vamos a poner 'Antes de venir al psicólogo/a' (o al centro, a terapia o cómo el niño lo llame) y al lado derecho le vamos a poner 'Después de venir al psicólogo/a' (o al centro, a terapia o cómo el niño lo llame). El dibujo que te voy a pedir entonces tiene dos partes (o dos dibujos), uno en que puedas dibujarte cómo estabas y cómo te sentías antes de empezar a venir con el psicólogo/a, y cómo te sientes después de haber venido, o sea, ahora".

Si el niño/a no ha verbalizado o generado un relato en relación a los dibujos mientras los realiza, al finalizarlos pedirle que cuente acerca de ellos ("¿Qué me puedes contar acerca de este dibujo?").

| **Profundización** |
|---|

Una vez que el paciente haya desarrollado su narración, el entrevistador debe profundizar y abarcar las siguientes áreas relevantes, pidiendo ejemplos específicos de lo que está contando, lo más concretos posibles, incluso si recuerda en qué sesión ocurrió, o qué se estaba trabajando en esa sesión que recuerda.
A continuación se listan las áreas de exploración como guía y preguntas a modo de ejemplos que pueden ser usadas flexiblemente. No es necesario hacer todas las preguntas que aparecen en cada área, éstas son sólo una guía o referencia (con negrita se destacan las preguntas más relevantes para cada área temática).



| | |
|---|---|
| **Diagnóstico y noción de enfermedad** | ¿Cómo fue que llegaste a terapia?<br>**¿Sabías por qué venías?** ¿Qué pasaba? ¿Había algo que estaba siendo difícil?<br>**¿Quién te trajo? ¿Sabes por qué te trajo?** ¿Quién te dijo que vinieras?<br>¿Que decía tu mamá/papá/figura significativa de por qué venías?<br>**¿Qué te dijo el psicólogo/a de por qué venías?**<br>¿Cómo te sentiste al venir?<br>¿Cómo estabas al principio? |
| **Cuéntame un ejemplo o situación de esto.** | |
| **Expectativas (Proceso)** | Antes de llegar, ¿sabías a qué venías?<br>**¿Tenías ganas de venir al psicólogo/a?**<br>**¿Pensabas que te iba a ayudar? ¿En qué o para qué?** |

| | |
|---|---|
| | **¿Cómo te imaginabas que iba a ser esto?**<br>¿Hay algo que te sorprendió?<br>¿Habías ido antes al psicólogo/a? ¿Cómo fue? |
| **Cuéntame un ejemplo o situación de esto.** | |
| **Aspectos de proceso (Intervenciones y momentos significativos)** | **¿Te gustaba venir?**<br>**¿Qué hacían con tu psicólogo/a?,** ¿eso fue cambiando?<br>¿De qué te acuerdas?<br>¿Qué te gustaba?<br>¿Qué no te gustaba tanto?<br>**¿Hay algún momento especial que recuerdes?**<br>¿Cuál era tu parte favorita?<br>¿Hay algo que te gustaría que hubiera sido distinto?<br>¿Se cumplió lo que imaginabas que iba a ser?<br>**¿Qué es lo que más te ayudó?**<br>¿Cómo era al principio, (al medio), al final? ¿Hubo cambios?<br>¿Qué cosas hiciste tú en la terapia que crees hayan servido?<br>¿Qué cosas hicieron tu mamá/papá/figura significativa que crees hayan servido?<br><br>Contexto: ¿Quién te traía?, ¿le gustaba traerte?, ¿te gustaba venir con esa persona? |
| **Cuéntame un ejemplo o situación de esto.** | |
| **Relación Terapéutica (Proceso)** | ¿Qué pensabas de tu psicólogo/a? ¿Cómo era? Descríbemelo/a<br>**¿Cómo te sentías con tu psicólogo/a?** ¿Cómo te sentías con él/ella al principio y después? ¿Hubo cambios?<br>**¿Cómo te llevabas con él/ella?**<br>¿Cómo eras tú con él/ella?<br>**¿Cómo se llevaba tu mamá/papá/figura significativa con él/ella?**<br>¿Cómo era tu mamá/papá/figura significativa con él/ella?<br>¿Qué es lo que más te gustaba del psicólogo/a?<br>¿Y lo que menos te gustaba?<br>¿Qué cosas hacías con el psicólogo/a que te hacían sentir bien/ mal?<br>**¿El psicólogo/a conversaba a veces con tu mamá/papá/figura significativa? ¿Iba a veces a tu colegio? ¿Qué pensabas y/o sentías en relación a eso?** |
| **Cuéntame un ejemplo o situación de esto.** | |
| **Resultados** | **¿Crees que fue bueno venir al psicólogo/a? ¿Por qué? ¿Encuentras que te sirvió o te ayudó venir? ¿En qué o para qué?**<br>¿Hay algo distinto?, ¿pasó algo? **¿Cambió algo (en ti, en otros)? ¿Qué cambió?**<br>¿Por qué?, ¿qué habrá influido en eso?<br>¿Otras personas notaron eso?, **¿alguien te dijo o notó que habías cambiado algo? ¿En qué?** ¿Crees que alguien se dio cuenta si te sirvió venir?<br>**Si le preguntáramos a tu mamá/papá/figura significativa, ¿qué dirían ellos que cambió?**<br>¿En qué crees que no te ayudó venir?<br>¿Hubo cosas que no cambiaron? ¿Hubo cambios que no te gustaron? |

| | |
|---|---|
| | **¿Te hubiera gustado que te ayudara para algo más**? ¿Qué cosas podrían haber sido mejores?<br>**¿Sientes que ayudó a otras personas venir? (por ejemplo, a tu mamá/papá/figura significativa/otros miembros de tu familia). ¿Cómo y en qué los ayudó?**<br><br>Contexto:<br>¿Otras personas sabían que venías al psicólogo/a? ¿Cómo te sentías con eso?<br>¿Hay alguien más que haya ayudado en tu terapia o hecho esto más difícil? **¿Qué cosas hizo tu familia/ tus papás/ tu colegio/ tu profesor/a que hayan ayudado/ dificultado el proceso?**<br>¿Hubo algunas otras cosas (del centro, sala, sala espera, secretaria, etc.) que te hayan ayudado/ dificultado el proceso?<br>¿Cómo te sentiste con la grabación/ espejo en la terapia (contexto de investigación)?<br>¿Tomabas remedios/pastillas? ¿Sientes que te sirvieron? |
| **Cuéntame un ejemplo o situación de esto.** | |
| **Término del proceso** | **¿Tú sabías cuándo se iba a terminar la terapia?**<br>¿Qué hicieron la última sesión?<br>**¿Qué pensaste y sentiste cuando terminaste/dejaste de venir?**<br>¿Te gustó o no te gustó venir?<br>**¿Crees que tendrías que haber venido más (o menos)?** ¿Por qué?<br>**¿Crees que haber venido te va a servir para cuando seas más grande?**<br>¿En qué o para qué?<br><br>Para el **cierre de la entrevista, no olvidar preguntar:**<br>**Desde tu experiencia, ¿qué consejo le darías a otros niños que empiezan a venir al psicólogo/a?**<br>**¿Qué consejo le darías a los psicólogos de cómo ayudar a los niños que vienen a terapia/ aquí?**<br>**¿Qué consejo le darías a las familias/papás/adultos que traen a los niños/as al psicólogo?**<br>**¿Volverías a ir al psicólogo/a si lo necesitaras (a este/ otro)?** |

Para finalizar, se le agradece al entrevistado su colaboración y se enfatiza la importancia de haber compartido su experiencia para efectos de mejorar nuestros conocimientos acerca de la terapia.

Y se le pregunta si hay algo más que quisiera agregar.

(Entregar pequeña retribución)

**FONDECYT SEGUIMIENTO**
**GUION DE ENTREVISTA A FAMILIAR O ADULTO RESPONSABLE**

**Instrucciones para el Entrevistador**
El objetivo de esta entrevista es conocer la percepción subjetiva de los participantes acerca de la experiencia de haber participado en terapia, o bien de que su familiar haya participado de una terapia. Es por ello que se busca que el entrevistado se explaye lo más posible en la descripción detallada de su experiencia, incluyendo la emergencia de reflexiones, recuerdos y sentimientos asociados. Por este motivo es que se espera que la entrevista sea una experiencia fluida.
En términos generales, esta entrevista pretende abarcar las siguientes grandes temáticas:

1. **Experiencia y definición de éxito y fracaso de la terapia**. Interesa conocer cómo evalúa retrospectivamente el familiar o adulto responsable del paciente la experiencia de haber estado en terapia. Específicamente, qué aspectos considera que fueron positivos para el proceso, cómo y por qué, y cuáles percibe como negativos u obstaculizadores para este proceso. Es importante también conocer su definición personal de un buen o mal resultado en psicoterapia. Por último, es relevante conocer cómo se dio término al proceso terapéutico y cómo fue experimentado este término por parte del paciente.

2. **Atribuciones de causalidad**. Es importante indagar acerca de lo que el familiar o adulto responsable del paciente considera que influyó en dichos éxitos y fracasos, cuáles fueron los factores o aspectos que llevaron a estos resultados percibidos y de qué manera. También es importante indagar acerca de qué cosas hicieron el paciente, el terapeuta o ambos juntos, así como también el familiar o adulto responsable, que influyeron en dicha percepción del éxito de la terapia. Esto incluye las intervenciones “típicas” así como también eventos atípicos, cosas que le llamaron la atención y que le parecieron relevantes. En esto es fundamental preguntar por momentos significativos de la terapia.

3. **Teoría subjetiva de salud y enfermedad**. Esto corresponde a la teoría o explicación que el sujeto tiene del padecer del paciente, cómo lo entiende, a qué lo atribuye y asocia, y cómo entiende su proceso de mejora. Esto incluye explorar si la teoría de enfermedad sufrió alguna transformación producto de la terapia y cuál fue esta transformación, en qué consistió, y en relación a qué aspectos.

4. **La experiencia de la relación terapéutica**. Es importante explorar cómo el adulto o familiar responsable percibe su relación y la relación del paciente con el terapeuta, a lo largo del proceso. Interesa indagar en los cambios y oscilaciones experimentados o percibidos en los distintos intercambios con el terapeuta, los sentimientos hacia éste, así como la influencia de dichos sentimientos en el proceso de la terapia y de cambio (o no cambio) del paciente.

Teniendo en cuenta estas grandes temáticas, se sugiere que el entrevistador guíe la entrevista de manera fluida, y, en base a lo que el adulto o familiar responsable del paciente vaya narrando, ir flexiblemente profundizando en dichas temáticas. Si es necesario, el entrevistador puede tomar nota de los contenidos que parezcan importantes y retomarlos en el curso de la entrevista.
**Entrevista**

**Consigna:**

Mi nombre es _____ y pertenezco al equipo de investigación del proyecto _____ (Fondecyt, Milenio).

Esta entrevista es para conversar sobre la terapia psicológica que tuvo su hijo/a con el psicólogo/a _____ y conocer cómo fue esta experiencia y cuál es su opinión al respecto.

**Confidencialidad:**

Este estudio tiene la intención de ayudar a mejorar los tratamientos psicológicos a partir de la experiencia y opinión de quienes han ido al psicólogo/a.

Todo lo que hablemos aquí es confidencial, es decir, no se compartirá con el psicólogo/a ni con su hijo/a. Pero si usted quiere, puede contarle lo que hablamos. Lo que usted nos cuente servirá para saber cómo ayudar a otras familias que vengan al psicólogo/a con sus hijos/as.

Para no tomar nota, me gustaría grabar la entrevista.

**Pregunta de apertura de la entrevista**

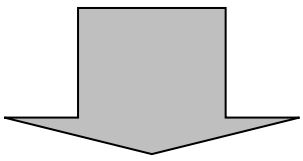
"Cuénteme sobre cómo fue para usted y para su hijo/a venir al psicólogo/a _____. Quiero conocer su opinión acerca de la experiencia respecto a la terapia de su hijo/a. Todo lo que usted quiera contarme en relación a esto, lo que se le venga a la mente".

**QUEDARSE LO MÁS POSIBLE EN ESTA FASE**: Dejar que el sujeto construya la narración, con la menor cantidad de intervenciones posibles. Evitar interrumpir u orientar el curso del pensamiento del entrevistado, sólo intervenir cuando sea necesario pedir aclaraciones, profundizar (pedir ejemplos concretos) o reflejar para confirmar que se está entendiendo lo que él dice. El orden del guión puede alterarse de acuerdo a lo que vaya emergiendo en el discurso del entrevistado, lo importante es que se aborden los diferentes tópicos.

**Profundización**

Una vez que el familiar o adulto responsable haya desarrollado su narración, el entrevistador debe profundizar y abarcar las siguientes áreas relevantes, pidiendo ejemplos específicos, lo más concretos posibles, incluso si recuerda en qué sesión ocurrió lo que está narrando.

A continuación se listan las áreas de exploración como guía y preguntas a modo de ejemplos que pueden ser usadas flexiblemente. No es necesario hacer todas las preguntas que aparecen en cada área, son solo una guía o referencia (con negrita se destacan las preguntas más relevantes para cada área temática).



*Agregar criterio de orden de acuerdo al discurso del familiar*

| | |
|---|---|
| **Diagnóstico y noción de enfermedad** | **¿Por qué su hijo/a fue a terapia, qué pasaba*?***<br>**¿Por qué cree que le pasaba eso?** (ideas asociadas a las causas de su problema) (indagar en factores personales, familiares, biológicos y/o sociales)<br>¿Qué pensaba usted respecto a consultar al psicólogo/a? ¿Cómo se sintió?<br>¿De quién fue la idea de consultar al psicólogo, y por qué?<br>¿Ud. le informó o lo conversó con su hijo/a antes de asistir?<br>**¿Qué le dijo el psicólogo/a respecto a lo que le pasaba a su hijo/a?** ¿Qué pensó/sintió usted al respecto? ¿Le hizo sentido?<br>¿Cambió la percepción inicial acerca de lo que le estaba pasando a su hijo/a en el transcurso de la terapia? ¿Cómo? ¿En qué sentido? |
| **Cuénteme un ejemplo o situación de esto.** | |
| **Expectativas (Proceso)** | **¿Ud. quería llevar a su hijo/a al psicólogo/a? ¿Ud. quería participar en el proceso?**<br>**¿Pensaba que el psicólogo/a podía ayudar a su hijo/a? ¿Cómo o en qué?**<br>**¿Qué esperaba Ud. que pasara con la terapia?**<br>¿Se cumplió lo que Ud. esperaba o fue distinto?<br>¿Sucedieron cosas en la terapia que no esperaba que pasaran y que le llamaron la atención?<br>¿Su actitud frente a la terapia siempre fue igual o fue cambiando?<br>¿Habían ido antes al psicólogo/a, Ud. y/o su hijo/a? ¿Cómo fue esa experiencia? (experiencia psicológica previa) |
| **Cuénteme un ejemplo o situación de esto.** | |
| **Aspectos de proceso (Intervenciones y momentos significativos)** | **<u>En relación a su hijo/a:</u>**<br>**¿Le gustaba ir a terapia?** ¿Fue siempre así?<br>¿Había algo que no le gustaba tanto?<br>¿Sabía Ud. lo que hacían en la terapia?<br><br>**¿Qué es lo que más contaba su hijo/a de la terapia? ¿Hay algo en especial que su hijo/a le haya mencionado?**<br>¿Cree que su hijo/a colaboró con la terapia? ¿Cómo?<br><br>**<u>En relación a Ud.:</u>**<br>**¿Ud. u otro familiar participó en la terapia de su hijo/a? ¿Quiénes? ¿Cómo participaron?**<br>**¿Y qué le parecía a Ud. eso?**<br>¿Hay alguna sesión o momento especial de la terapia que Ud. recuerde?<br><br>¿Piensa Ud. que aportó /colaboró con la terapia de su hijo/a? ¿Cómo?<br>¿Hay algo que le hubiera gustado que fuera distinto?<br><br>Contexto: ¿Quién acompañaba a su hijo/a a las sesiones? |
| **Cuénteme un ejemplo o situación de esto.** | |
| **Relación Terapéutica (Proceso)** | **<u>En relación a su hijo/a:</u>**<br>**¿Cómo era la relación con su psicóloga/o? ¿Cómo se llevaban*?*** |

| | |
|---|---|
| | ¿Hubo cambios en la relación? ¿Cuáles?<br>¿Cómo era su hijo/a con el psicólogo/a? ¿Qué opinaba de él/ella?<br>¿Cree que el tipo relación entre ellos ayudó/dificultó el proceso de terapia? ¿Cómo?<br><br>Si tuviera que elegir una palabra o frase para describir la relación de su hijo/a con el psicólogo/a, ¿cuál sería?<br>¿Ud. supo o percibió alguna situación incómoda o problemática entre su hijo/a y el/la terapeuta? ¿Cómo fueron? ¿De qué manera las manejaron? ¿Cómo se sintió su hijo/a con esta situación?<br><br>**<u>En relación a Ud.:</u>**<br>¿Cómo se llevaba con el psicólogo/a de su hijo/a?<br>**¿Cómo era la relación con él/ella?**<br>¿Qué pensaba Ud. del psicólogo/a?<br><br>**¿Hubo situaciones de desencuentro o incomodidad entre Ud. y el/la terapeuta?** ¿Hubo cosas que no le gustaron? ¿Cómo fueron? ¿De qué manera las manejaron? ¿Cómo se sintió en esas situaciones? |
| **Cuénteme un ejemplo o situación de esto.** | |
| **Resultados** | **En relación a su hijo/a, ¿cree que fue bueno venir a terapia? ¿Por qué? ¿Encuentra que le sirvió o le ayudó venir? ¿En qué o para qué?**<br>¿En qué siente que no le sirvió o no lo ayudó?<br><br>**¿Cambió su hijo/a en algo? ¿En qué?** ¿Qué habrá influido en eso? (retomar razones o problemas que motivaron la consulta)<br>**¿Cómo se fueron dando estos cambios?**<br>**¿Cómo logró Ud. darse cuenta o percibir estos cambios?**<br>**Si le preguntáramos a su hijo/a, ¿qué diría él/ella que cambió?**<br><br>¿Hubo cambios/resultados que no esperaba o que le sorprendieron?<br>**¿Hubo cosas que no cambiaron (y que Ud. esperaba que sí cambiaran)?**<br>**¿Hubo cambios que no le gustaron**?<br>**¿Le hubiera gustado que la terapia le ayudara en algo más?** ¿Qué cosas podrían haber sido mejores?<br>**¿Alguien le dijo o notó que su hijo/a había cambiado en algo? ¿En qué? ¿Quiénes lo notaron? ¿Cómo se dieron cuenta o percibieron estos cambios?**<br>**¿Siente que la terapia ayudó a otras personas? A Ud., otros familiares, otras figuras significativas. ¿Cómo y en qué los ayudó?**<br><br>Contexto:<br>¿Qué pensaban otras personas acerca de la terapia de su hijo/a? (familiares, amigos, profesores)<br><br>**¿Qué cosas hicieron ustedes como papás o familia que hayan ayudado/ dificultado el proceso o que hayan influido en los resultados de la terapia?** |

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| | ¿Qué cosas hicieron otros (el colegio, el profesor/a del niño/a, sus amigos) que hayan ayudado/ dificultado el proceso o que hayan influido en los resultados de la terapia?<br><br>¿Hubo algunas otras cosas (del centro, sala, sala espera, secretaria, etc.) que hayan ayudado/ dificultado el proceso o que hayan influido en los resultados de la terapia?<br>¿Su hijo/a le comentó cómo se sintió con la grabación/ espejo en la terapia (contexto de investigación)?<br>Además de la terapia, ¿había otros tratamientos (medicamentos u otros)? ¿Siente que sirvieron o ayudaron? |
| **Cuéntame un ejemplo o situación de esto.** | |
| **Término del proceso** | **¿Cómo fue el término de la terapia? ¿Quién propuso la finalización?**<br>¿Cómo fue para su hijo/a dejar de venir al psicólogo/a? ¿Él/ella sabía por qué dejó de asistir? ¿Le comentó algo al respecto? ¿Quería seguir asistiendo?<br>**¿Cree que haber venido le va a servir a su hijo/a para más adelante o a futuro?**<br>¿Cree que la terapia terminó en el momento adecuado? **¿Piensa que su hijo/a hubiera necesitado más (o menos) tiempo?** ¿Por qué?<br>**¿Qué le llevó a mantener / abandonar el tratamiento de su hijo/a?**<br>**Y a Ud. como mamá/papá, ¿en qué cree que la terapia le puede servir a futuro?**<br>¿Cómo cree que recordarán Ud. y su hijo/a esta experiencia más adelante?<br>Para el **cierre de la entrevista, no olvidar preguntar:**<br>**¿Qué consejo le daría a otros papás o familias que empiezan a llevar a sus hijos/as al psicólogo/a?**<br>**¿Qué consejo le daría a los psicólogos de cómo ayudar a los padres/niños/ adolescentes que vienen a terapia/ aquí?**<br>**¿Volvería a llevar a su hijo/a al psicólogo/a si lo necesitaras (a este/ otro)?** |

Para finalizar, se le agradece al entrevistado su colaboración y se enfatiza la importancia de haber compartido su experiencia para efectos de mejorar nuestros conocimientos acerca de la terapia.

Y se le pregunta si hay algo más que quisiera agregar.

**FONDECYT SEGUIMIENTO**

**GUIÓN DE ENTREVISTA A TERAPEUTA DE PACIENTE NIÑO/A, ADOLESCENTE**

**Instrucciones para el Entrevistador**

El objetivo de esta entrevista es conocer la percepción subjetiva de los terapeutas acerca de la experiencia de la terapia. Es por ello que se busca que el entrevistado se explaye lo más posible en la descripción detallada de su experiencia, incluyendo la emergencia de reflexiones, recuerdos y sentimientos asociados. Además, busca favorecer la reflexión del entrevistado sobre su quehacer en terapia y el modo en cómo se relaciona con la percepción de éxito o fracaso terapéutico. Por este motivo, se espera que la entrevista sea una experiencia fluida.

En términos generales, esta entrevista pretende abarcar las siguientes grandes temáticas:

1. **Experiencia y definición de éxito y fracaso de la terapia**. Interesa conocer cómo el terapeuta evalúa retrospectivamente la experiencia de una terapia en particular. Específicamente, qué aspectos considera que fueron positivos para el proceso, cómo y por qué, y cuáles percibe como negativos u obstaculizadores para este proceso. Es importante también conocer su definición personal de un buen o mal resultado en psicoterapia. Por último, es relevante conocer cómo se dio término al proceso terapéutico y cómo fue experimentado este término por parte del terapeuta.

2. **Atribuciones de causalidad**. Es importante indagar acerca de lo que el terapeuta considera que influyó en dichos éxitos y fracasos, cuáles fueron los factores o aspectos que llevaron a estos resultados percibidos y de qué manera. También es importante indagar acerca de qué cosas hicieron el terapeuta, el paciente o ambos, así como también el familiar o adulto responsable, que influyeron en dicha percepción del éxito de la terapia. Esto incluye las intervenciones “típicas” así como también eventos atípicos, cosas que llamaron la atención y que le parecieron relevantes. En esta temática es fundamental preguntar por momentos significativos de la terapia.

3. **Teoría subjetiva de salud y enfermedad**. Esto corresponde a la teoría o explicación que el terapeuta tiene de la enfermedad o del problema del paciente (cómo entiende el padecer del paciente, a qué lo atribuye y asocia), y cómo entiende el proceso de mejora. Esto incluye explorar si la teoría subjetiva de enfermedad sufrió alguna transformación producto de la terapia y cuál fue esta transformación, en que consistió y en relación a qué aspectos.

4. **La experiencia de la relación terapéutica**. Es importante explorar cómo el terapeuta percibe su relación con el paciente y con el familiar o adulto responsable a lo largo del proceso. Interesa indagar en los cambios y oscilaciones experimentados en los distintos intercambios con el paciente y el familiar o adulto responsable, los sentimientos hacia estos, así como la influencia de dichos sentimientos en el proceso de la terapia y de cambio (o no cambio) del paciente.

Teniendo en cuenta estas grandes temáticas, se sugiere que el entrevistador guíe la entrevista de manera fluida, y, en base a lo que el terapeuta vaya narrando, ir flexiblemente profundizando en dichas temáticas. Si es necesario, el entrevistador puede tomar nota de los contenidos que parezcan importantes y retomarlos en el curso de la entrevista.

Si el terapeuta lo considera necesario (por ejemplo, si no recuerda detalles importantes del proceso), puede consultar sus notas personales o la ficha clínica del paciente. Es importante que el entrevistador indague en el significado que el terapeuta da a esta acción.

**Entrevista**

**Consigna:**

Mi nombre es _____ y pertenezco al equipo de investigación del proyecto _____ (Fondecyt, Milenio).

La conversación que tendremos es parte de un estudio que mirará retrospectivamente la experiencia de estar en psicoterapia, desde la perspectiva de pacientes, terapeutas y familiares.

Por esta razón, nos interesa conversar sobre la psicoterapia que llevó a cabo con el paciente _____ y conocer cómo fue esta experiencia y cuál es su opinión sobre los aspectos positivos y negativos de este proceso.

**Confidencialidad:**

Todo lo que hablemos y quede registrado es de carácter confidencial y será utilizado para fines de investigación y publicación, resguardando siempre el anonimato tanto en la presentación como manejo de los datos.

Además, es importante que sepa que lo que Ud. mencione sobre la psicoterapia y su paciente no se comentarán con él o ella, su familia ni con ningún profesional de esta institución. Tampoco quedará registro de ello en la ficha del paciente.

Disponemos de entre una hora y una hora y media para esta entrevista. Para no tomar nota, me gustaría grabar la entrevista.

| **Pregunta de apertura de la entrevista** |
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"Me gustaría preguntarle sobre la terapia que desarrolló con el paciente _____. ¿Cómo fue esa experiencia de terapia para ti/usted?"

**QUEDARSE LO MÁS POSIBLE EN ESTA FASE**: Dejar que el sujeto construya la narración, con la menor cantidad de intervenciones posibles. Evitar interrumpir u orientar el curso del pensamiento del entrevistado, sólo intervenir cuando sea necesario pedir aclaraciones, profundizar (pedir ejemplos concretos) o reflejar para confirmar que se está entendiendo lo que el terapeuta dice. El orden del guión puede alterarse de acuerdo a lo que vaya emergiendo en el discurso del entrevistado, lo importante es que se aborden los diferentes tópicos.

| **Profundización** |
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Una vez que el terapeuta haya desarrollado su narración, el entrevistador debe profundizar y abarcar las siguientes áreas relevantes, pidiendo ejemplos específicos de lo que está contando, lo más concretos posibles, incluso si recuerda en qué sesión ocurrió, o lo que se trabajó en esa sesión.

A continuación se listan las áreas de exploración como guía y preguntas, a modo de ejemplos que pueden ser usadas flexiblemente. No es necesario hacer todas las preguntas que aparecen en cada área, son sólo una guía o referencia.

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| **Diagnóstico y noción de enfermedad** | *** Indagar respecto a la experiencia del paciente y sus padres o familiares.**<br>**¿Por qué motivo llegó este paciente a terapia?** (indagar motivo de consulta explícito y latente). **Indagar motivo desde el paciente y sus padres o familiares.**<br>¿Qué cree que ocasionó lo que llevó al paciente a consultar? (factores personales, familiares, sociales, biológicos). **Desde dónde surge la demanda.**<br>¿Por qué cree que el paciente y/o sus padres o familiares decidieron pedir ayuda a un psicólogo/a?<br>¿Qué le dijo al paciente/ padres sobre su problema? **¿Qué le devolvió usted al paciente/ padres? (Devolución o reformulación del motivo de consulta/ Diagnóstico)** ¿En qué momento lo hizo? ¿Cómo lo tomó él/ella/ellos?<br>Si el terapeuta comunicó un diagnóstico: ¿Otro(s) profesional(es) le habían comunicado algún diagnóstico previo al paciente/padres? ¿Coincidían las distintas opiniones? ¿Cómo abordó usted esto? |
| **Cuénteme una situación/acontecimiento que refleje o ejemplifique esto.** | |
| **Expectativas (Proceso)** | **¿Cómo pensaba que la psicoterapia podía ayudar a este paciente/padres?**<br>¿Esas expectativas se cumplieron? ¿En qué aspectos se cumplieron? ¿En qué aspectos no se cumplieron?<br>¿Qué significó esto para usted?<br>¿Su paciente/padres tenía experiencias previas con psicólogos/ psicoterapeutas? Si es así, ¿cómo influyeron en esta terapia?<br>**¿Sucedieron cosas en la terapia que no esperaba que pasaran y que le llamaron la atención?** |
| **Cuénteme una situación/acontecimiento que refleje o ejemplifique esto.** | |
| **Relación Terapéutica (Proceso)** | ***Indagar en la relación del terapeuta con el paciente**<br>**¿Cómo describiría la relación que estableció con _____ (el paciente)? (especificar calidad de la relación).**<br>**¿Cómo describiría a su paciente?** ¿Qué le gustaba de su paciente? ¿Qué no le gustaba?<br>**¿Cómo se sentía con su paciente?**<br>¿Cómo describiría sus sentimientos hacia su paciente? ¿Variaron en algo estos sentimientos a lo largo de la terapia?<br>¿Cuáles cree que eran los sentimientos de su paciente hacia usted? ¿Sintió usted que éstos variaron a lo largo de la terapia?<br>**¿Hubo situaciones de incomodidad o desencuentro en la interacción con su paciente?**<br>¿Cómo fueron?<br>¿De qué manera manejaron estas situaciones? ¿Cómo se sintió?<br>¿De qué manera cree usted que lo que ocurría y cómo se sentían en la relación influyó en el proceso terapéutico de su paciente? |

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| | **¿Cómo se describiría usted como terapeuta en esta terapia?**<br>¿De qué manera cree usted que el diagnóstico del paciente influyó en su proceso terapéutico?<br>**¿Cómo manejó el tema de la confidencialidad con el paciente? ¿Cree que esto influyó en la relación que estableció con él/ella?**<br><br>*** Indagar también respecto a la relación con los padres o familiares del paciente.**<br>¿Cómo fue la relación con los padres? (especificar)<br>¿Cómo fue su participación en la terapia?<br>¿Cómo influyó la relación con los padres en el proceso psicoterapéutico del niño/a o adolescente?<br>¿Hubo situaciones de incomodidad o desencuentro con los padres?<br>**¿Cómo manejó el tema de la confidencialidad con los padres/familiares del paciente? ¿Cree que esto influyó en la relación que estableció con ellos?** |
| **Cuénteme una situación/acontecimiento que refleje o ejemplifique esto.** | |
| **Aspectos de proceso (Intervenciones y momentos significativos)** | **¿Cómo describiría la evolución de este proceso de terapia? ¿Hubo algún elemento que usted calificaría como "clave" en esta terapia?**<br>**¿Recuerda algún momento específico de la terapia en que Ud. haya sentido que algo significativo ocurrió en la relación con el paciente?** (indagar por algún momento especialmente saliente del proceso)<br>¿Hubo **interacciones entre Ud. y su paciente** que hayan influido en cómo se dio su terapia? ¿Cuáles? ¿De qué manera?<br>¿Qué **intervenciones/acciones/técnicas realizó/utilizó** que recuerda como importantes para esta terapia? ¿Recuerda algún evento en particular? ¿Cree usted que estas intervenciones influyeron en los logros (o no logros) de su paciente en terapia? ¿Cómo?<br>¿Hubo **actitudes suyas** que hayan influido en cómo se dio esta terapia? ¿Cuáles? ¿De qué manera?<br>¿Hubo **actitudes del paciente** que hayan influido en cómo se dio la terapia? ¿Cuáles? ¿De qué manera?<br>¿Hubo **actitudes o acciones de los padres** que hayan influido en cómo se dio la terapia? ¿Cuáles? ¿De qué manera?<br>¿Qué **intervenciones/acciones/técnicas que realizó con los padres** recuerda como importantes? ¿Cree usted que estas intervenciones influyeron en los logros (o no logros) de su paciente en terapia? ¿Cómo?<br>De todos estos factores mencionados, ¿cuál(es) cree usted que influyeron más en este proceso? ¿Los que más lo facilitaron? ¿Los que más lo dificultaron?<br><br>**Elementos del contexto que hayan influido** en el proceso y experiencia de la terapia:<br>¿Hubo elementos del contexto institucional/laboral/escolar que hayan influido en su experiencia de la terapia? ¿Cuáles? ¿De qué manera?<br>¿Contó usted con instancias de supervisión clínica? (entre pares, supervisor externo, etc.). ¿Cómo influyeron en el proceso terapéutico? |

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| | ¿Hubo elementos del contexto de investigación? (grabación, espejo, observadores, cuestionarios) que hayan influido en su experiencia de la terapia?<br>¿Cree que hay otros aspectos involucrados que influyeron en cómo usted experimentó la terapia? (situación familiar / educacional / social / económica / situaciones de vida / otros acontecimientos). ¿Cuáles? ¿Cómo? |
| **Cuénteme una situación/acontecimiento que refleje o ejemplifique esto.** | |
| **Resultados** | **¿Cómo evalúa esta psicoterapia?**<br>**¿Cree que fue exitosa? ¿Por qué?**<br>**¿Cambió algo en el paciente con la terapia? ¿Qué? ¿A qué cree que se debió?** (IMPORTANTE **distinguir entre cambios sintomáticos y otro tipo de cambios)**<br>**¿Cómo se fueron dando estos cambios?**<br>**¿Cómo logró darse cuenta o percibir estos cambios?**<br><br>¿Cambió su percepción inicial acerca de lo que estaba padeciendo el paciente (problema/diagnóstico) durante/después de la terapia?<br>¿Cómo? ¿En qué? ¿Qué cosas influyeron en este cambio?<br>¿De qué manera cree usted que el diagnóstico del paciente influyó en los resultados de esta terapia? ¿Y la etapa del desarrollo?<br>¿Qué aspectos de usted cómo terapeuta cree que influyeron en los resultados de la terapia?<br>**¿Cree que se solucionó el (los) problema(s) que llevaron al paciente/padres a consultar? ¿Cómo? ¿Cree que se solucionaron otros problemas? ¿Cómo? ¿Cómo se dio cuenta de eso?**<br>**¿Hubo cambios en los padres/familia?**<br>¿Hubo resultados que no esperaba o le sorprendieron? **¿Hubo algunos cambios que esperaba y no se lograron?**<br>¿Cree que en algún aspecto o área no hubo resultados (o éxito o logros)? ¿Por qué? ¿Cómo cree que se dio eso?<br>**¿Hubo resultados negativos en algún aspecto? ¿Cuáles? ¿Por qué? ¿Cómo se dio eso?**<br>¿Qué cosas podrían haber sido mejores?<br>¿Qué aprendió usted con esta terapia? ¿Percibió cambios en usted con esta terapia? ¿Cuáles?<br><br>**Elementos del contexto que hayan influido** en los resultados de la terapia:<br>¿Hubo elementos del contexto institucional/laboral que hayan influido en los resultados de la terapia? ¿Cuáles? ¿De qué manera?<br>¿Contó usted con instancias de supervisión clínica? (entre pares, supervisor externo, etc.). ¿Cómo influyeron en los resultados terapéuticos?<br>¿Hubo elementos del contexto de investigación (grabación, espejo, observadores, cuestionarios) que hayan influido en los resultados de la terapia? |

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| | ¿Cree que hay otros aspectos involucrados que influyeron en los resultados de la terapia? (situación familiar / educacional / social / económica / situaciones de vida / otros acontecimientos). ¿Cuáles? ¿Cómo? |
| **Cuénteme una situación/acontecimiento que refleje o ejemplifique esto.** | |
| **Término del proceso** | **¿De qué manera se dio término a la psicoterapia? ¿Quién propuso la finalización?**<br>**- Si fue de mutuo acuerdo o propuesto por el terapeuta: ¿Qué elementos tomó en consideración para planificar el término de la psicoterapia**? ¿Qué cree que llevó al paciente a continuar hasta el final? ¿Cómo fue el manejo del cierre? ¿Qué temas se abordaron?<br>**- Si fue propuesto por el paciente/ padres: ¿Qué razones dieron?** ¿Cómo acogió usted esta iniciativa? ¿Estaban el paciente y sus padres de acuerdo con esto?<br>- Si el paciente/ padres abandonan de manera abrupta la psicoterapia: ¿Qué cree que los llevó a tomar esa decisión? ¿Estaban el paciente y sus padres de acuerdo con esto?<br><br>**¿Cree que la terapia terminó en el momento adecuado? ¿Cree que para el paciente hubiera sido necesario más/menos tiempo?**<br><br>En caso que el término haya sido prematuro o unilateral: ¿Cómo cree que eso contribuyó a los resultados que me acaba de relatar?<br><br>**¿Qué implicancias para la vida del paciente cree que este tratamiento pueda tener a futuro?**<br><br>**¿Cree que el paciente/sus padres volverían a consultar a un psicólogo/a? ¿Por qué?**<br><br>**¿Cómo se sintió con el modo en que terminó esta psicoterapia? ¿Con qué elementos se queda de este término?** |
| **Cuénteme una situación/acontecimiento que refleje o ejemplifique esto.** | |

Para finalizar, se le agradece al entrevistado su colaboración y se enfatiza la importancia de haber compartido su experiencia para efectos de mejorar nuestros conocimientos acerca de la terapia.
Y se le pregunta si hay algo más que quisiera agregar.

### *7.4.2. Semi-Structured interview protocol study 2 (paper 3)*

**GUIÓN DE ENTREVISTA NIÑO/A**

Proyecto Tesis Doctoral: "Therapeutic relationships and change processes in child psychotherapy: integrating subjective experiences of patients, parents and therapists".

**I. INSTRUCCIONES PARA EL ENTREVISTADOR**

El objetivo de esta entrevista es conocer la experiencia subjetiva de niños/as acerca de participar en psicoterapia, especialmente su vivencia de la relación terapéutica y su rol en el cambio. Se busca que el entrevistado se explaye lo más posible en la descripción detallada de su experiencia, incluyendo la emergencia de reflexiones, recuerdos y sentimientos asociados. Se espera que la entrevista sea una experiencia fluida.

Dependiendo del momento de la terapia, esta entrevista pretende abarcar las siguientes temáticas:

**Momento Inicial: Expectativas, motivo de consulta y motivación hacia la psicoterapia.** Explorar qué piensan y sienten los niños/as respecto de asistir a psicoterapia, cuáles son sus expectativas de cambio, del proceso y de la relación terapéutica. Además indagar su motivación hacia la terapia y la presencia de un motivo de consulta propio y/o de los adultos que acompañan su proceso.

**La experiencia de la relación terapéutica**. Explorar cómo el/la niño/a percibe su relación y la del adulto responsable con el terapeuta, en diferentes momentos del proceso terapéutico. Interesa indagar la descripción del terapeuta, los sentimientos hacia él/ella, las interacción entre niño/a, padres y terapeuta, el tipo, dinámica y estructura de las relaciones, el proceso de construcción de la relaciones. También explorar la descripción que el niño/a hace de sí mismo en la relación y la que hace de su padres/cuidadores. Indagar como las diferentes relaciones en terapia (niño/a o padres y terapeuta) se asocian entre sí. Conocer la valoración de todos los elementos en términos de facilitadores u obstaculizadores del proceso de la terapia y de cambio del niño/a y su familia.

**Experiencia de cambio psicoterapéutico**: Interesa conocer la visión del niño/a respecto de los cambios percibidos en sí mismo y/o en su familia asociados a la experiencia de psicoterapia. Ahondar en los procesos de cambio; es decir, cómo cambia. Específicamente, conocer el rol de las diversas relaciones terapéuticas (niño/a o padres y terapeuta) como facilitadores y obstaculizadores del proceso de cambio terapéutico. Por último, es relevante conocer cómo experimenta el término del proceso terapéutico, de la relación terapéutica y la evaluación global del proceso.

Teniendo en cuenta estas grandes temáticas, se sugiere que el entrevistador guíe la entrevista de manera fluida, y, en base a lo que el paciente vaya narrando, ir flexiblemente profundizando en dichas temáticas. Si es necesario, el entrevistador puede tomar nota de los contenidos que parezcan importantes y retomarlos en el curso de la entrevista.

## II. PAUTA ENTREVISTA

### ENCUADRE INICIAL

Antes de empezar asegúrese de explicar los siguientes aspectos: **a) Consigna:** Mi nombre es _____ y pertenezco al equipo de investigación del proyecto de relaciones y cambio terapéutico de niños, niñas y sus familias. Esta entrevista es para conversar sobre la terapia con el/la psicólogo/a _____ y conocer tu experiencia y opinión sobre la terapia hasta ahora; **b) Confidencialidad:** Este estudio tiene la intención de ayudar a mejorar los tratamientos psicológicos a partir de la experiencia y opinión de los niños y niñas que han ido al psicólogo/a. Todo lo que hablemos aquí es confidencial, no se lo contaremos a tu psicólogo/a ni a tus papás. Pero si tú quieres, puedes contarles de lo que hablamos. Lo que tú nos cuentes servirá para saber cómo ayudar a otros niños que vengan al psicólogo/a; y **c) Grabación en audio:** Para no tomar nota, me gustaría grabar la entrevista.

### PREGUNTA DE APERTURA DE LA ENTREVISTA

Dependiendo de las características del niño/a, se puede realizar un "rompe hielo", con aspectos generales, como por ejemplo: Ahora me gustaría que me contaras un poco de ti y de tu vida, para saber cómo eres tú, qué edad tienes, en qué curso estás, qué te gusta hacer, qué música escuchas, etc.

**"Cuéntame sobre cómo es venir al psicólogo/a _____. Me gustaría conocer lo que tú quieras contarme de esto. Lo que venga a tu mente, lo que se te ocurra".**

**Quedarse lo más posible en esta fase**: Dejar que el sujeto construya la narración, con la menor cantidad de intervenciones posibles. Evitar orientar el curso del pensamiento, sólo intervenir cuando sea necesario pedir aclaraciones, profundizar (pedir ejemplos concretos) o reflejar para confirmar que se está entendiendo lo que el paciente dice. El orden del guion puede alterarse de acuerdo a lo que vaya emergiendo en el discurso del paciente, lo importante es que se aborden los diferentes tópicos.

### PROFUNDIZACIÓN

Una vez que el/la niño/a haya desarrollado su narración, el entrevistador debe profundizar y abarcar las siguientes áreas relevantes, pidiendo ejemplos específicos de lo que está contando, lo más concretos posibles. A continuación se listan las áreas de exploración que pueden ser usadas flexiblemente. No es necesario hacer todas las preguntas que aparecen en cada área, éstas son sólo una guía o referencia. De todos modos se enfatizan ciertas preguntas de la guía, las que se encuentran subrayadas. Las preguntas con asterisco (*), se espera que sean abordadas en todos los momentos (inicio, proceso y final). **Es importante adecuar la formulación de las preguntas al momento de la entrevista.**

## PREGUNTAS GUÍA PARA LA PROFUNDIZACIÓN

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| **Momento inicial:**<br>**Motivación**<br>**Motivo de consulta**<br>**Expectativas** | **Nota: se enfatiza en esta temática en la entrevista inicial, en entrevistas posteriores, repasar las preguntas con asterisco (*).**<br>¿Sabes por qué viniste al psicólogo/a? * ¿Pasa algo? ¿Hay algo que está siendo difícil?<br>¿Cómo te sentiste de venir?*<br>¿De quién fue la idea que vinieras al psicólogo/a?<br>¿Qué dice tu mamá/papá/cuidador de por qué vienes? ¿El/la psicólogo/a te dijo por qué vienes?<br>¿Tenías ganas de venir al psicólogo/a? ¿Te gusta venir?*<br>¿Piensas que te va a ayudar? ¿En qué, para qué? *<br>¿Cómo te imaginabas que iba a ser esto? ¿Es como lo que imaginabas que iba a ser?<br>¿Cómo te imaginabas que iba a ser el psicólogo/a? ¿Es cómo te imaginabas? *<br>¿Habías ido antes al psicólogo/a? ¿Cómo fue?<br>Cuéntame un ejemplo o situación de esto. |
| **Relación Terapéutica** | **Nota: Temática central de entrevista del proceso y cierre. Solicitar aquí dibujo de la relación terapéutica: "mi psicólogo/a y yo". Abordar en todos los momentos las preguntas con asterisco (*).**<br>¿Cómo es tu psicólogo/a? Descríbemelo/a *<br>¿Qué piensas de tu psicólogo/a? ¿Cómo te sientes con tu psicólogo/a? *<br>¿Qué es lo que más te gusta del psicólogo/a? ¿Y lo que menos te gusta? *<br>¿Qué tipo de persona es tu psicólogo/a? ¿Se parece a algún otro adulto que conozcas? *<br>¿Qué hacen con tu psicólogo/a? ¿Cómo lo pasas tú con el/la psicólogo/a? ¿Y él/ella contigo?<br>¿Cómo eres tú con el/la psicólogo/a? *<br>¿Cómo te llevas con él/ella? ¿Por qué crees que se llevan así?<br>¿Crees que cómo se llevan influye en tu terapia? ¿Cómo influye?<br>¿Cómo eras con él/ella al principio y después? ¿Y cómo era él/ella al principio y después?<br>¿Cómo te sentías con él/ella al principio y después? ¿Hubo cambios? ¿Por qué?<br>¿El psicólogo/a conversa a veces con tu mamá/papá/cuidador/a?<br>¿Cómo es tu mamá/papá/cuidador/a con el/la psicólogo/a? *<br>¿Cómo era tu mamá/papá/cuidador/a con el/la psicólogo/a principio y después? ¿Y cómo era el/la psicólogo/a con ella/el al principio y después?<br>¿Cómo se lleva tu mamá/papá/cuidador/a con él/ella? ¿Por qué crees que se llevan así? ¿Qué te parece a ti que se lleven así?<br>Cuéntame un ejemplo o situación de esto. |
| **Experiencia de cambio terapéutico y evaluación** | **Nota: Temática central de entrevista del proceso y cierre. Solicitar aquí dibujo de cambio terapéutico. Abordar en todos los momentos las preguntas con asterisco (*).** |

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| **global del proceso** | ¿Crees que es bueno venir al psicólogo/a? ¿Por qué? ¿Encuentras que te sirve o te ayuda venir? ¿En qué o para qué? *<br>¿Cambió algo (en ti, en otros)? ¿Qué cambió? ¿Por qué?, ¿qué habrá influido en eso? *<br>¿Crees que la forma de ser de tu psicólogo/a influyó en ti? ¿Cómo influyó? *<br>¿Crees que hubieras cambiado igual con otro psicólogo/a? ¿Cómo? *<br>¿Sientes que ayuda a tu mamá/papá/cuidador/a? ¿Cómo y en qué los ayudó? *<br>¿Crees que hubieran cambiado igual con otro psicólogo/a? ¿Cómo? *<br>¿Alguien más sabe que vienes al psicólogo/a?<br>Cuéntame un ejemplo o situación de esto. |
| **Término del proceso** | **Nota: abordar esta temática sólo en la entrevista de cierre.**<br>¿Tú sabías cuándo se iba a terminar la terapia?<br>¿Qué pensaste y sentiste cuando terminaste/dejaste de venir?<br>¿Cómo te sentiste al dejar de ver a tu psicólogo/a?<br>¿Crees que haber venido te va a servir para cuando seas más grande? ¿En qué?<br>Para el cierre de la entrevista, no olvidar preguntar:<br>¿Qué consejo le darías a otros niños que empiezan a venir al psicólogo/a?<br>¿Qué consejo le darías a los psicólogos de cómo ayudar a los niños que vienen a verlos?<br>¿Qué consejo le darías a los/papás/adultos que traen a los niños/as al psicólogo/a?<br>¿Volverías a ir al psicólogo/a si lo necesitaras (a este/ otro)? |

## III. DIBUJOS

A los niños/as se les solicitará la realización de dibujos durante la entrevista. Recuerde llevar los materiales para ello: lápiz mina, lápices de colores, goma, saca punta y hojas.

El uso del dibujo es para favorecer la narrativa, no como técnica de evaluación, por lo cual se sugiere conversar con el/la niño/a a medida que va realizando el dibujo. Si el/la niño/a no ha verbalizado o generado un relato en relación a los dibujos mientras los realiza, al finalizarlos pedirle que cuente acerca de ellos: "¿qué me puedes contar acerca de este dibujo?". Se solicitan dos dibujos en cada entrevista, diferentes según el momento de la terapia. Se sugiere utilizar este dibujo en **TODOS** los casos, salvo que el/la niño/a no quiera realizarlo.

1. **Dibujo de la Relación Terapéutica: "Mi psicólogo/a y yo en la terapia".** Se espera que este dibujo genere diálogo acerca del proceso y la relación terapéutica. La consigna a utilizar es: "me gustaría pedirte que hagas un dibujo que se llama "mi psicólogo/a y yo en la terapia". Se solicita el mismo dibujo en todas las entrevistas.

2. **Dibujo de Cambio Terapéutico.** Se espera generar un diálogo acerca del inicio de la terapia, las expectativas de cambio, los cambios vivenciados y el término de la terapia. Tiene 3 posibilidades según el momento de la entrevista**:**

a) Entrevista inicial: “Cómo estaba antes/quiero estar después de la terapia”. La consigna es: “me gustaría pedirte que hagas un dibujo que se llama “antes/después”, y que tiene que ver con cómo estabas y te sentías antes de empezar tu terapia con psicólogo/a, y cómo quieres estar y sentirte después de la terapia, cuando termine. Verás que la hoja tiene una línea al medio. Al lado izquierdo dice ‘antes de venir al psicólogo/a’ y al lado derecho dice ‘después de venir al psicólogo/a’. El dibujo que te voy a pedir entonces tiene dos partes (o dos dibujos), uno en que puedas dibujarte cómo estabas y te sentías antes de empezar a venir con el/la psicólogo/a, y otro cómo quieres estar, sentirte después que termines de venir al psicólogo/a”.

b) Entrevista de 6 y 12 meses: “Cómo estaba antes/ahora en la terapia”. La consigna es: “me gustaría pedirte que hagas un dibujo que se llama “antes/ahora”, y que tiene que ver con cómo estabas y te sentías antes de empezar tu terapia con psicólogo/a, y cómo estás y te sientes ahora en la terapia con psicólogo/a. Verás que la hoja tiene una línea al medio. Al lado izquierdo dice ‘antes de venir al psicólogo/a’ y al lado derecho dice ‘ahora’. El dibujo que te voy a pedir entonces tiene dos partes (o dos dibujos), uno en que puedas dibujarte cómo estabas y te sentías antes de empezar a venir con el/la psicólogo/a, y otro cómo estás y te sientes ahora”.

c) Entrevista final: “Cómo estaba antes/después de la terapia”. La consigna es: “me gustaría pedirte que hagas un dibujo que se llama “antes/después”, y que tiene que ver con cómo estabas y te sentías antes de empezar tu terapia con psicólogo/a, y cómo estás y te sientes después de la terapia, ahora que ya terminó. Verás que la hoja tiene una línea al medio. Al lado izquierdo dice ‘antes de venir al psicólogo/a’ y al lado derecho dice ‘después de venir al psicólogo/a’. El dibujo que te voy a pedir entonces tiene dos partes (o dos dibujos), uno en que puedas dibujarte cómo estabas y te sentías antes de empezar a venir con el/la psicólogo/a, y otro cómo estás y te sientes después de haber venido, o sea, ahora”.

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| Dibujos entrevista inicial | - “Mi psicólogo/a y yo”<br>- “Cómo estás antes/quiero estar después de la terapia” |
| Dibujos entrevistas 3, 6, 9, etc. meses | - “Mi psicólogo/a y yo”<br>- “Cómo estaba antes/ahora en la terapia” |
| Dibujo entrevista final | - “Mi psicólogo/a y yo”<br>- “Cómo estaba antes/después de la terapia” |

Para finalizar, se le agradece al entrevistado su colaboración y se enfatiza la importancia de haber compartido su experiencia para efectos de mejorar nuestros conocimientos acerca de la terapia con niños/as. Entregar en este momento pequeña retribución y recordar que se volverá a entrevistar en tres meses si corresponde.

**GUIÓN DE ENTREVISTA MADRE/PADRE(S)/CUIDADOR(ES)**

Proyecto Tesis Doctoral: "Therapeutic relationships and change processes in child psychotherapy: integrating subjective experiences of patients, parents and therapists".

## I. INSTRUCCIONES PARA EL ENTREVISTADOR

El objetivo de esta entrevista es conocer la vivencia subjetiva de madres/padres/cuidadores acerca de que su hijo/a participe de terapia psicológica, especialmente su vivencia de la relación terapéutica y su rol en el cambio. Se busca que el entrevistado se explaye lo más posible en la descripción detallada de su experiencia, incluyendo la emergencia de reflexiones, recuerdos y sentimientos asociados. Se espera que la entrevista sea una experiencia fluida.

Esta es una entrevista que abarca dos niveles, por una parte lo que madres/padres/cuidadores vivencian respecto de la experiencia de su hijo/a, y por otra, la propia vivencia subjetiva como actores del proceso terapéutico.

Dependiendo del momento de la terapia, esta entrevista pretende abarcar las siguientes temáticas:

**Momento Inicial: Expectativas, motivo de consulta y motivación hacia la psicoterapia.** Explorar qué piensan y sienten los niños/as y sus madre/padre/cuidador respecto de asistir a psicoterapia, cuáles son sus expectativas de cambio, del proceso y de la relación terapéutica. Además indagar su motivación hacia la terapia y la presencia de un motivo de consulta propio y/o del niño/a.

**La experiencia de la relación terapéutica**. Explorar cómo la/el madre/padre/cuidador/a percibe su relación y la relación del niño/a con el terapeuta, en diferentes momentos del proceso terapéutico. Interesa indagar la descripción del terapeuta, los sentimientos hacia él/ella, las interacción entre niño/a, padres y terapeuta, el tipo, dinámica y estructura de las relaciones, el proceso de construcción de la relaciones. También explorar la descripción que la/el madre/padre/cuidador/a hace de sí mismo en la relación y la que hace de su hijo/a. Indagar como las diferentes relaciones en terapia (niño/a o padres y terapeuta) se asocian entre sí. Conocer la valoración de todos los elementos en términos de facilitadores u obstaculizadores del proceso de la terapia y de cambio del niño/a y su familiar.

**Experiencia de cambio psicoterapéutico**: Interesa conocer la visión del la/el madre/padre/cuidador/a respecto de los cambios percibidos en el/la niño/a y en sí mismo asociados a la experiencia de psicoterapia. Ahondar en los procesos de cambio; es decir, cómo cambia. Específicamente, conocer el rol de las diversas relaciones terapéuticas (niño/a o padres y terapeuta) como facilitadores y obstaculizadores del proceso de cambio terapéutico. Por último, es relevante conocer cómo experimenta el término del proceso terapéutico, de la relación terapéutica y la evaluación global del proceso.

Teniendo en cuenta estas grandes temáticas, se sugiere que el entrevistador guíe la entrevista de manera fluida, y, en base a lo que el entrevistado vaya narrando, ir flexiblemente profundizando en dichas temáticas. Si es necesario, el entrevistador puede tomar nota de los contenidos que parezcan importantes y retomarlos en el curso de la entrevista.

## II. PAUTA ENTREVISTA

### INTRODUCCIÓN Y ENCUADRE DE LA ENTREVISTA

Antes de empezar asegúrese de explicar los siguientes aspectos: **a) Consigna:** Mi nombre es _____ y pertenezco al equipo de investigación del proyecto de relaciones y cambio terapéutico de niños, niñas y sus familias. Esta entrevista es para conversar sobre la terapia de su hijo/a con el/la psicólogo/a _____ y conocer su experiencia y opinión sobre esta terapia; **b) Confidencialidad:** Este estudio tiene la intención de ayudar a mejorar los tratamientos psicológicos a partir de la experiencia y opinión de quienes han ido al psicólogo/a. Todo lo que hablemos aquí es confidencial, no se compartirá ni con el/la psicólogo/a ni con su hijo/a. Pero si usted quiere, puede contarles lo que hablamos. Lo que usted nos cuentes servirá para saber cómo ayudar a otras familias que vengan al psicólogo/a con sus hijos/as; y **c) Grabación:** Para no tomar nota, me gustaría grabar la entrevista.

**PREGUNTA DE APERTURA DE LA ENTREVISTA**

**"Cuénteme sobre cómo es (fue) venir al psicólogo/a _____ para usted y para su hijo/a. Quisiera conocer su experiencia, lo que quiera contarme al respecto, lo que se venga a su mente".**

**Quedarse lo más posible en esta fase**: Dejar que el sujeto construya la narración, con la menor cantidad de intervenciones posibles. Evitar orientar el curso del pensamiento, sólo intervenir cuando sea necesario pedir aclaraciones, profundizar (pedir ejemplos concretos) o reflejar para confirmar que se está entendiendo lo que el paciente dice. El orden del guion puede alterarse de acuerdo a lo que vaya emergiendo en el discurso del entrevistado, lo importante es que se aborden los diferentes tópicos.

**PROFUNDIZACIÓN**

Una vez que el entrevistado haya desarrollado su narración, profundizar y abarcar las siguientes áreas relevantes, pidiendo ejemplos específicos de lo narrado. Las áreas pueden ser usadas flexiblemente. No es necesario hacer todas las preguntas que aparecen en cada área, éstas son sólo una guía o referencia. De todos modos se enfatizan ciertas preguntas de la guía, las que se encuentran subrayadas. Adecuar las preguntas de acuerdo al momento del proceso terapéutico.

**PREGUNTAS GUÍA PARA LA PROFUNDIZACIÓN**

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| **Momento inicial:**<br>**Motivación**<br>**Motivo de consulta**<br>**Expectativas** | **Nota: se enfatiza en esta temática en la entrevista inicial, en entrevistas posteriores, repasar las preguntas con asterisco (*).**<br>¿Por qué vino su hijo/a al psicólogo/a? * ¿Pasa algo? ¿Qué le dijo el/la psicólogo/a?<br>¿De quién fue la idea de consultar al psicólogo/a? ¿Qué piensa/siente al respecto?<br>¿Usted quería traer a su hijo/a al psicólogo/a?*¿Usted quiere participar?*<br>¿Su hijo/a quería venir al psicólogo/a? ¿Por qué, para qué?*<br>¿Piensas que le va a ayudar a su hijo/a? ¿En qué, para qué?*<br>¿Cómo pensaba que iba a ser la terapia? ¿Es como pensaba?<br>¿Cómo pensaba que iba a ser el psicólogo/a? ¿Es cómo pensaba?*<br>¿Habías ido antes usted o su hijo/a al psicólogo/a? ¿Cómo fue?<br>Cuéntame un ejemplo o situación de esto. |
| **Relación Terapéutica** | **Nota: Temática central de entrevista del proceso y cierre. Abordar en todos los momentos las preguntas con asterisco (*).**<br>¿Cómo es el/la psicólogo/a? Descríbemelo/a * |

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| | ¿Qué piensas del psicólogo/a? ¿Cómo se sientes con el/la psicólogo/a? *<br>¿Qué es lo que más le gusta del psicólogo/a? ¿Y lo que menos le gusta? *<br>¿Usted se reúne con el/la psicólogo/a? ¿Para qué?<br>¿Cómo es usted con el/la psicólogo/a? *<br>¿Cómo es su relación con el/la psicólogo/a? ¿Por qué crees que es así?<br>¿Cree que esta relación influye en la terapia de su hijo/a? ¿Cómo influye?<br>¿Cómo era usted con él/ella al principio y después? ¿Y cómo era él/ella?<br>¿Cómo se sentía usted con él/ella al principio y después? ¿Hubo cambios? ¿Por qué?<br>¿Cómo es su hijo/a con el/la psicólogo/a?* ¿Cómo es el/la psicólogo/a con su hijo/a?*<br>¿Cómo se llevan su hijo/a con el/la psicólogo/a? ¿Por qué cree que es así?<br>Cree que esta relación influye en la terapia de su hijo/a? ¿Cómo influye?<br>¿Cómo era su hijo/a con el/la psicólogo/a principio y después? ¿Y cómo era el/la psicólogo/a con ella/el?<br>¿Ha habido algún momento especial y/o incómodo entre el/la psicólogo/a y su hijo/a y/o usted?<br>Cuéntame un ejemplo o situación de esto. |
| **Experiencia de cambio terapéutico y evaluación global del proceso** | **Nota: Temática central de entrevista del proceso y cierre. Abordar en todos los momentos las preguntas con asterisco (*).**<br>¿Crees que es bueno que su hijo/a venga al psicólogo/a? ¿Por qué? ¿Encuentra que le ayuda venir? ¿En qué o para qué? *<br>¿Ha cambiado algo en su hijo/a? ¿Qué? ¿Por qué?, ¿qué habrá influido en eso?*<br>¿Crees que la forma de ser y/o de trabajar del psicólogo/a influyó en el cambio de su hijo/a? ¿Cómo influyó?*<br>¿Crees que su hijo/a hubiera cambiado igual con otro psicólogo/a? ¿Cómo?*<br>¿Ha cambiado algo en usted? ¿Qué? ¿Por qué?, ¿qué habrá influido en eso?*<br>¿Sientes que el/la psicólogo/a lo ayudó? ¿Cómo? ¿En qué?*<br>¿Crees que hubiera cambiado igual con otro psicólogo/a? ¿Cómo?*<br>Cuéntame un ejemplo o situación de esto. |
| **Término del proceso** | **Nota: abordar esta temática sólo en la entrevista de cierre.**<br>¿Usted sabía cuándo se iba a terminar la terapia? ¿Quién(es) propuso el término?<br>¿Cómo se sintió al dejar de traer a su hijo/a al psicólogo/a?<br>¿Crees que haber ido les servirá para el futuro? ¿En qué?<br>Para el cierre de la entrevista, no olvidar preguntar:<br>¿Qué consejo daría a los psicólogos de cómo ayudar a los niños y padres que consultan?<br>¿Qué consejo le daría a los/padres/adultos que traen a los niños/as al psicólogo/a?<br>¿Volverías a llevar a su hijo/a al psicólogo/a si lo necesitaras (a este/ otro)? |

Para finalizar, se le pregunta al entrevistado si quiere agregar algo más. Luego se le agradece su colaboración y se enfatiza la importancia de haber compartido su experiencia para efectos de mejorar nuestros conocimientos acerca de la terapia con niños/as. Entregar en este momento pequeña retribución y recordar que se volverá a entrevistar en tres meses si corresponde.

**GUIÓN DE ENTREVISTA TERAPEUTAS**

Proyecto Tesis Doctoral: "Therapeutic relationships and change processes in child psychotherapy: integrating subjective experiences of patients, parents and therapists".

## I. INSTRUCCIONES PARA EL ENTREVISTADOR

El objetivo de esta entrevista es conocer la vivencia subjetiva de los terapeutas acera de la terapia psicológica, especialmente su vivencia de la relación terapéutica (con los niños y con sus padres/cuidadores) y su rol en el cambio terapéutico. Se busca que el entrevistado se explaye lo más posible en la descripción detallada de su experiencia, incluyendo la emergencia de reflexiones, recuerdos y sentimientos asociados. Se espera que la entrevista sea una experiencia fluida.

Esta es una entrevista que abarca dos niveles, por una parte lo que el terapeuta vivencia respecto del niño/a, y por otra, su vivencia en relación con los padres/cuidadores del niño/a.

Dependiendo del momento de la terapia, esta entrevista pretende abarcar las siguientes temáticas:

**Momento Inicial: Expectativas, motivo de consulta y motivación hacia la psicoterapia.** Explorar la visión de los terapeutas respecto de la motivación de los niños/as y sus padres/cuidadores respecto de asistir a psicoterapia. Conocer las expectativas de cambio, del proceso y de la relación terapéutica con el/la niño/a y sus padres/cuidadores.

**La experiencia de la relación terapéutica**. Explorar cómo el terapeuta percibe su relación con el/la niño/a, y con los padres/cuidadores, en diferentes momentos del proceso terapéutico. Interesa indagar la descripción del niño/a, de los padres/cuidadores, los sentimientos hacia ellos, las interacción entre niño/a, padres y terapeuta, el tipo, dinámica y estructura de las relaciones, y el proceso de construcción de la relaciones. También explorar la descripción que el terapeuta hace de sí mismo en las distintas relaciones. Indagar como las diferentes relaciones en terapia (niño/a o padres y terapeuta) se asocian entre sí. Conocer la valoración de todos los elementos en términos de facilitadores u obstaculizadores del proceso de la terapia y de cambio del niño/a y su familiar.

**Experiencia de cambio psicoterapéutico**: Interesa conocer la visión del terapeuta respecto de los cambios percibidos en el/la niño/a y en los padres/cuidadores asociados a la experiencia de psicoterapia. Ahondar en los procesos de cambio; es decir, cómo cambia. Específicamente, conocer el rol de las diversas relaciones terapéuticas (niño/a o padres y terapeuta) como facilitadores y obstaculizadores del proceso de cambio terapéutico. Por último, es relevante conocer cómo experimenta el término del proceso terapéutico, de la relación terapéutica y la evaluación global del proceso.

Teniendo en cuenta estas grandes temáticas, se sugiere que el entrevistador guíe la entrevista de manera fluida, y, en base a lo que el entrevistado vaya narrando, ir flexiblemente profundizando en dichas temáticas. Si es necesario, el entrevistador puede tomar nota de los contenidos que parezcan importantes y retomarlos en el curso de la entrevista.

## II. PAUTA ENTREVISTA

### INTRODUCCIÓN Y ENCUADRE DE LA ENTREVISTA

Antes de empezar asegúrese de explicar los siguientes aspectos: **a) Consigna:** Mi nombre es _____ y pertenezco al equipo de investigación del proyecto de relaciones y cambio terapéutico de niños, niñas

y sus familias. Esta entrevista es para conversar sobre la terapia que lleva a cabo con _____ y conocer su experiencia y opinión sobre esta terapia; **b) Confidencialidad:** Este estudio tiene la intención de ayudar a mejorar los tratamientos psicológicos a partir de la experiencia y opinión de los principales actores de la psicoterapia. Todo lo que hablemos aquí es confidencial, sólo es utilizado con fines de investigación y publicación de resultados, con absoluto resguardo del anonimato. Además, es importante que sepa que lo que usted mencione sobre la psicoterapia y su paciente no se comentarán con él o ella, su familia ni con ningún profesional de esta institución. Tampoco quedará registro de ello en la ficha del paciente. Disponemos de una hora para esta entrevista; y **c) Grabación:** Para no tomar nota, me gustaría grabar.

**PREGUNTA DE APERTURA DE LA ENTREVISTA**

**"Me gustaría preguntarle sobre la terapia que desarrolla con el/la paciente _____. Quisiera conocer su experiencia al respecto".**

**Quedarse lo más posible en esta fase**: Dejar que el sujeto construya la narración, con la menor cantidad de intervenciones posibles. Evitar orientar el curso del pensamiento, sólo intervenir cuando sea necesario pedir aclaraciones, profundizar (pedir ejemplos concretos) o reflejar para confirmar que se está entendiendo lo que el paciente dice. El orden del guion puede alterarse de acuerdo a lo que vaya emergiendo en el discurso del entrevistado, lo importante es que se aborden los diferentes tópicos.

**PROFUNDIZACIÓN**

Una vez que el entrevistado haya desarrollado su narración, profundizar y abarcar las siguientes áreas relevantes, pidiendo ejemplos específicos de lo narrado. Las áreas pueden ser usadas flexiblemente. No es necesario hacer todas las preguntas que aparecen en cada área, éstas son sólo una guía o referencia. De todos modos se enfatizan ciertas preguntas de la guía, las que se encuentran subrayadas. Adecuar las preguntas al momento de la terapia.

**PREGUNTAS GUÍA PARA LA PROFUNDIZACIÓN**

| | |
|---|---|
| **Momento inicial:**<br>**Motivación**<br>**Motivo de consulta**<br>**Expectativas** | **Nota: se enfatiza en esta temática en la entrevista inicial, en entrevistas posteriores, repasar las preguntas con asterisco (*).**<br>¿Por qué motivo llega este niño/a a terapia?* ¿Desde dónde surge la idea de consultar?<br>¿El/la niño/a quería venir a terapia? ¿Por qué, para qué?*<br>¿Los padres/cuidadores querían traer a su hijo/a a terapia? ¿Por qué, para qué?*<br>¿Los padres quieren participar?¿Tienen un motivo de consulta propio?*<br>¿Piensa que la psicoterapia va a ayudar al niño/a? ¿En qué, para qué?*<br>¿Cómo piensa que será la relación terapéutica con el niño/a? ¿Es cómo pensaba?*<br>¿Cómo piensa será la relación terapéutica con los padres/cuidadores? ¿Fue así?*<br>Cuénteme un ejemplo o situación de esto. |
| **Relación Terapéutica** | **Nota: Temática central de entrevista del proceso y cierre. Abordar en todos los momentos las preguntas con asterisco (*).**<br>***Con el/la niño/a:***<br>¿Cómo es la relación terapéutica con el niño/a? ¿Por qué crees que es así? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué? |

| | |
|---|---|
| | ¿Cómo se siente en esta relación? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?<br>¿Cómo describiría al niño/a?*<br>¿Cómo es la relación del niño/a con sus padres/cuidadores?*<br>¿Cómo se relaciona el/la niño/a con usted? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?*<br>¿Cómo se relaciona usted con el/la niño/a? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?*<br>¿Cree que esta relación con su paciente influye en la terapia? ¿Cómo influye?<br>¿Ha habido algún momento especial y/o incómodo con su paciente?<br>***Con los padres/cuidadores:***<br>¿Cómo es la relación terapéutica con los padres/cuidadores? ¿Por qué crees que es así? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?<br>¿Cómo se siente en esta relación? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?<br>¿Cómo describiría a los padres/cuidadores?*<br>¿Cómo se relacionan los padres/cuidadores con usted? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?*<br>¿Cómo se relaciona usted con los padres/cuidadores? ¿Esto ha ido cambiando? ¿Cómo? ¿Por qué?*<br>¿Cree que esta relación con los padres/cuidadores influye en la terapia? ¿Cómo influye?<br>¿Ha habido algún momento especial y/o incómodo con los padres/cuidadores?<br>Cuéntame un ejemplo o situación de esto. |
| **Experiencia de cambio terapéutico y evaluación global del proceso** | **Nota: Temática central de entrevista del proceso y cierre. Abordar en todos los momentos las preguntas con asterisco (*).**<br>¿Cómo evalúa esta terapia?*<br>¿Ha cambiado algo en el/la niño/a? ¿Qué? ¿Cómo? ¿Por qué? ¿Qué habrá influido en este cambio?*<br>¿Cree que la forma de relacionarse con el/la niño/a influyó en el cambio terapéutico? ¿Cómo influyó?*<br>¿Cree que el/la niño/a hubiera cambiado igual con otro terapeuta? ¿Cómo?*<br>¿Ha cambiado algo en la/el madre/padre/cuidador/a? ¿Qué? ¿Cómo? ¿Por qué? ¿Qué habrá influido en este cambio?*<br>¿Cree que la forma de relacionarse con la/el madre/padre/cuidador/a influyó en el cambio terapéutico? ¿Cómo influyó?*<br>Cuéntame un ejemplo o situación de esto. |
| **Término del proceso** | **Nota: abordar esta temática sólo en la entrevista de cierre.**<br>¿Cómo se dio el término de la terapia? ¿Quién(es) propuso el término?<br>¿Cómo enfrentó el término el paciente? ¿Y sus padres/cuidadores?<br>¿Cómo se sintió usted con el término? ¿Con dejar de ver al paciente? ¿Y a sus padres/cuidadores?<br>¿Qué implicancias para el paciente cree que la terapia pueda tener para el futuro? ¿En qué? ¿Y para sus padres/cuidadores?<br>¿Cree que el paciente y/o sus padres/cuidadores volverías a consultar al psicólogo/a si lo necesitaran (a usted/ otro)? |

Para finalizar, se le pregunta al entrevistado si quiere agregar algo más. Luego se le agradece su colaboración y se enfatiza la importancia de haber compartido su experiencia para profundizar el conocimiento acerca de la psicoterapia con niños/as. Recordar que se volverá a entrevistar en tres meses si corresponde.

## 7.5. Qualitative analysis guidelines for therapeutic process-outcome drawings

| Steps of analysis | Elements of analysis |
|---|---|
| 1. Context of the drawing | 1.1 What does the drawing respond to (instruction)? |
| | 1.2 When was the drawing done (temporality)? |
| | 1.3 Where was the drawing done (context)? |
| 2. Content of the drawing | 2.1 Central theme/Gestalt: What does the drawing convey, narrate or represent in its totality? |
| | 2.2 Central figure(s): Perception or representation of oneself and others in the drawing. |
| | 2.3 Environment: Perception or representation of the environment/context in the drawing. |
| | 2.4 Interaction: Relationship between the graphic elements represented (between figures and with environment). |
| | 2.5 Colour: its use as a tool for the child's graphic expression. |
| 3. Verbal narrative developed through the drawing | 3.1 Child's spontaneous narration and responses to open questions about the drawing |
| 4. What does it express beyond verbal narrative? | 4.1 Does the drawing add new elements to what the child said verbally? What does it contribute? |

*(Alamo, 2019; Núñez et al., 2021)

## 7.6. Appendix 6: Journals authorization for the use of papers in this thesis

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28 June 2021

Dear Lucía Núñez,

**Lucía Núñez, Nick Midgley, Claudia Capella, Nicolle Alamo, Rose Mortimer & Mariane Krause (2021) The therapeutic relationship in child psychotherapy: integrating the perspectives of children, parents and therapists, Psychotherapy Research, DOI: 10.1080/10503307.2021.1876946**

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SANTIAGO, julio 9 de 2021

Mg. Lucía Núñez Hidalgo

Estimada Lucía:

A través de la presente dejo constancia que su manuscrito denominado "Alianza terapéutica inicial, variables clínicas y demográficas: un análisis desde los niños/as, los padres y los terapeutas" (Goic, Olhaberry, García, Horta, Núñez y Álvarez, ID: 345), del cual usted es autora correspondiente, fue recepcionado en sistema con fecha 30 de octubre de 2020, estando aún en proceso de evaluación.

Con relación a este, dado que el manuscrito no se encuentra publicado o aceptado para publicar, los derechos sobre este aun son suyos, por lo cual podría ser incluido en su tesis doctoral y traducido al inglés, mencionando que es un artículo en revisión, pero no podría ser enviado a otra revista para su evaluación.

Esperamos a la brevedad poder concluir la evaluación de su manuscrito.

Mis cordiales saludos

Dr. Alfonso Urzúa Morales
**Editor**
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**RIPPPO - Research in Psychotherapy: Psychopathology, Process and Outcome [paper #556] - Submission Acknowledgement**

**Paola Granata** <paola.granata@pagepress.org>
Para: Lucia Nuñez <luciabn@gmail.com>

18 de junio de 2021, 22:01

Dear Lucia Nuñez:

Thank you for submitting the manuscript "The Therapeutic relationship and change process in child psychotherapy: A qualitative, longitudinal study of the views of children, parents and therapists" to Research in Psychotherapy: Psychopathology, Process and Outcome. With the online journal management system that we are using, you will be able to track its progress through the editorial process by logging in to the journal web site:

Manuscript URL: https://www.researchinpsychotherapy.org/index.php/rpsy/authorDashboard/submission/556
Username: lnunez

If you have any questions, please contact me. Thank you for considering this journal as a venue for your work.

Paola Granata

Research in Psychotherapy: Psychopathology, Process and Outcome

Gmail

lucia nuñez <luciabn@gmail.com>

**RIPPPO - Research in Psychotherapy: Psychopathology, Process and Outcome [paper #556] - Submission Acknowledgement**

**Paola Granata** <paola.granata@pagepress.org>
Para: Lucia Nuñez <luciabn@gmail.com>

23 de junio de 2021, 10:48

Dear Lucia,
Ok, no problem; this is our policy about pre-print and post-print: https://www.researchinpsychotherapy.org/index.php/rpsy/about

In case your dissertation will be published, please include in the revised manuscript a statement about it.

Kind regards,
Paola

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