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# THE INTERRELATIONSHIP OF THERAPEUTIC ALLIANCE WITH AFFECT EXPRESSION AND AFFECT REGULATION THROUGHOUT PLAY IN PSYCHODYNAMIC CHILD PSYCHOTHERAPY

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The Interrelationship of Therapeutic Alliance with Affect Expression and Affect Regulation throughout Play in Psychodynamic Child Psychotherapy

Psikodinamik Çocuk Terapisinde Terapötik İttifak ile Oyundaki Duygu İfadesi ve Regülasyonu Arasındaki İlişki

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## ABSTRACT

Therapeutic alliance refers to the relationship between client and therapist. Affect expression and affect regulation are capacities developing within the relationship. Although there are several studies investigate the effect of therapeutic alliance on affect expression and regulation in adult psychotherapies, in children literature there is not any research. Theoretical background supports the association between these two constructs, but it is a new developing area in child research literature. The aim of this study was to examine the prediction of therapeutic alliance with children's affect expression and affect regulation in play. Participants were 131 children who took psychodynamic play therapy at Istanbul Bilgi University Psychological Counseling Center. Four hundred ninety-one sessions were transcribed and coded separately. Therapeutic alliance between children and therapists were assessed with the Therapy Process Observational Coding System - Alliance scale (TPOCS-A). In order to assess affect expression and affect regulation of children in play, the Children's Play Therapy Instrument (CPTI) were utilized. Multilevel modeling was used with three levels as analysis method. Results of the current study supported that therapeutic alliance has an influence on children's affect expression and affect regulation. According to findings, therapeutic alliance positively predicted the variety of children's affect, the intensity of sadness expression, the intensity of pleasure expression, and children's affect regulation in play over the course of treatment at significant level. Another significant association was found as therapeutic alliance negatively predicted the intensity of anger/aggression expression in play over the course of treatment. Because it is a preliminary study related the relationship between therapeutic alliance and affect expression or affect regulation in child psychoanalytic play therapy, findings and clinical implications were discussed in detail. Results indicated the importance of therapeutic alliance for creating a safe environment for a child to play and express suppressed affects with increasing regulation capacity.

*Keywords:* therapeutic alliance, affect expression, affect regulation, psychodynamic child therapy

## ÖZET

Terapötik ittifak, danışan ve terapist arasındaki ilişkiyi ifade eder. Duygu ifadesi ve duygu regülasyonu kapasitesinin bir ilişki içerisinde geliştiği bilinmektedir. Yetişkin psikoterapisinde terapötik ittifak ile duygu ifadesi-regülasyonu konusunda araştırmalar bulunurken, çocuk literatüründe doğrudan buna bakan araştırmalar bulunmamaktadır. Teorik altyapı düşünüldüğünde çocuk terapisinde de ittifak ve duygu ifadesi-regülasyonu arasında bir ilişki beklense de bu konudaki araştırmaların olduğu alan henüz yeni gelişmektedir. Bu çalışmanın amacı, oyun terapisi boyunca terapötik ittifağın çocukların duygu ifadesi ve regülasyonu üzerindeki yordayıcı etkisini incelemektir. Araştırmanın katılımcıları İstanbul Bilgi Üniversitesi Psikolojik Danışmanlık Merkezinde psikodinamik oyun terapisi alan 131 çocuktan oluşmaktadır. Araştırma datası olarak deşifresi yapılan 491 seans bağımsız kodlayıcılar tarafından ayrı ayrı kodlanmıştır. Çocuklar ve terapistler arasındaki terapötik ittifak, Therapy Process Observational Coding System - Alliance Scale (TPOCS-A) ile değerlendirilirken, duygu ifadesi ve regülasyonunu değerlendirmek için ise Children's Play Therapy Instrument (CPTI) kullanılmıştır. Analiz için üç seviyede çok düzeyli modelleme yöntemi kullanılmıştır. Çalışmanın bulguları terapötik ittifakın duygu ifadesi ve regülasyonu üzerindeki etkisini desteklemiştir. Sonuçlara göre; terapötik ittifak çocuğun oyunda çıkardığı duygu çeşitliliğini, üzüntü ifadesinin ve keyif ifadesinin yoğunluğunu, duygu düzenlemesini pozitif yönde ve anlamlı düzeyde yordarken oyundaki öfke yoğunluğunu da negatif yönde ve anlamlı düzeyde yordamaktadır. Bu çalışma çocuk psikanalitik oyun terapisinde terapötik ittifak ile duygu ifadesi ve regülasyonu arasındaki ilişkiye dair bir ön çalışma olduğu için, bulgular ve klinik uygulamalar detaylıca tartışılmıştır. Sonuçlar, terapötik ittifağın sağladığı güvenli ortamda oynanan oyun ile çocukların duygu ifadesinin çeşitliliğinin ve duygu regülasyonunun arttığını göstermiştir. Bu da terapötik ittifağın çocuk oyun terapisindeki önemine dair fikir vermektedir.

*Anahtar Kelimeler:* terapötik ittifak, duygu ifadesi, duygu regülasyonu, psikodinamik çocuk terapisi

# CHAPTER 1
# INTRODUCTION

In the field of psychotherapy, there are many common factors affecting the outcome of psychotherapy which are empirically supported, such as client and therapist factors, specialized therapeutic interventions, and therapeutic alliance (Kelly, Bickman, & Norwood, 2010; Wampold, 2015). When researchers examine the relationship between components of psychotherapy and outcome, therapeutic alliance is highly related with client outcome. Literature shows that therapeutic alliance accounts for 30 percent of the variance in outcome when compared to other factors such as therapeutic interventions (Lambert & Barley, 2001). This indicates the importance of therapeutic alliance from common factors in the field of psychotherapy. While there is a substantial body of research investigating the effect of therapeutic alliance on the outcome of adult psychotherapies, child literature did not reach a conclusive link on alliance–outcome associations (Karver, De Nadai, Monahan, & Shirk, 2018; McLeod & Weisz, 2005; Noser & Bickman, 2000). Although therapeutic alliance is a significant predictor of outcome, it is found as a moderator by creating an appropriate setting for psychotherapy (Tschacher, Haken, & Kyselo, 2015).

In child psychotherapy, most of the process flows through play (Chazan, 2002). Play and relationship between therapist and child itself are therapeutic for children because it offers a chance to express a wider range of emotions (Chazan, 2002). From the perspective of psychodynamic child therapy, affect expression and regulation are issues explained based on object relations (Target, Slade, Cottrell, Fuggle, & Fonagy, 2005). A child can express and regulate deep emotions with the presence of a therapist who provides containment, attunement, reflection, and mirroring to the child. These expressions of affect result in affect regulation in time (Horvath & Luborsky, 1993; Shirk & Burwell, 2010). Although there is not any child-youth study related to the therapeutic alliance and affect relationship, there are a substantial amount of adult empirical studies. Adult studies found that the higher therapeutic alliance score predicts the deeper

emotional expression throughout psychotherapy (Fisher, Atzil-Slonim, Bar-Kalifa, Rafaeli, & Peri, 2016). When it comes to child psychotherapy literature, there is a substantial body of research investigating the therapeutic alliance, affect expression, and affect regulation separately. However, there is not any specific research focusing on therapeutic alliance and affect relationship in child psychodynamic play therapy.

The aim of this study is to examine the prediction between therapeutic alliance with children's affect expression and affect regulation. Based on this, literature review of the study will include therapeutic alliance and affect as two headings. Therapeutic alliance part includes definition and background of therapeutic alliance; it's outcome and process studies both in adult and child psychotherapy; then measurements of therapeutic alliance in child psychotherapy. Additionally, affect part includes affect expression and regulation in psychodynamic literature; the relationship between these constructs and therapeutic alliance; and the measurement of children's affect throughout play.

## 1.1. THERAPEUTIC ALLIANCE

### 1.1.1. Definition of Therapeutic Alliance

Therapeutic alliance is one of the prerequisites in psychotherapy process. In adult literature, the frequently used definition belongs to Bordin (1979). According to Bordin (1979), alliance is combined of three important parts which are "task" (therapeutic work of both therapist and client responsible for), "goals" (objectives which both two parties accepted), and "bond" (affective part of the relationship). Parallel with adult literature, the most common definition focuses on these three parts of therapeutic alliance. On the other hand according to McLeod (2010), therapeutic alliance is the combination of "*bond"* between client and therapist including positive affect with mutual trust and "*task*" including therapeutic interventions with client's willingness to use or follow it.

The definition and names of therapeutic alliance (Zetzel, 1956) went through a considerable amount of change in time, such as "therapeutic alliance"

(Zetzel, 1956), “working alliance” (Greenson, 1965), “helping alliance” (Luborsky, 1976), and “treatment alliance” (Dare, Dreher, Holder, & Sandler, 1992). These concepts took place primarily in adult literature. Zetzel (1956), who first used the term therapeutic alliance made its definition as a necessary condition for psychoanalysis. She made a distinction between transference and therapeutic relationship by stating therapeutic relationship is the neurotic part of transference. According to her, therapeutic alliance is a relationship between the client’s healthy part of ego and analyst (Zetzel, 1956). Greenson (1965) accepted overlap in these two terms but drew a line between transference and working alliance. Working alliance is defined as developing a reliable working relationship between the client and the analyst (Greenson, 1965). Luborsky (1976) defined the term helping alliance as not only therapists’ warmness and support but also the work of client and therapist on a mutual goal. In 1992, treatment alliance is defined as the client’s awareness and willingness to solve his/her problems (Dare et al., 1992). With the latter term, Dare and colleagues (1992) focused more on the client and centralized definition based on their effort.

Beside the broadness of terminology in alliance literature, the number of definitions was also increased over time. Bordin’s therapeutic alliance definition of Bordin combines the rational and self-observing parts of the client with therapeutic quality of relationship (Safran, Muran, & Rothman, 2006). According to Bordin (1979), a prerequisite of an effective psychotherapy which creates change and development is alliance. Alliance has three important components; “task”, “goals”, and “bond” (Bordin, 1979). Tasks are therapeutic work of both therapist and client responsible for engaging it. Goals are objectives which both two parties approved. Lastly, bond is the affective part of the relationship which includes trust and acceptance (Bordin, 1979).

Definition of the therapeutic alliance in child literature is derived from adult literature like its theoretical background. The difference between adult and child psychotherapy is that parents take the initiative to bring their child to psychotherapy. In general, the problem is also defined by parents or school. Then, child expects to have a relationship with the therapist in the same way with a

doctor or a teacher. Within the process, children may learn the fact that it is a different relationship than others (Kabcenell, 1993). In this regard, specifying a common goal with the client in the children's literature is not as important as in the adult literature (Kabcenell, 1993). Therefore, the therapeutic alliance should include two concepts; bond (the affective component of therapist-client relationship) and task (client responsibility and attendance in activities in therapy) in child psychotherapy (Shirk & Russell, 1998). In this study, the therapeutic alliance definition of McLeod (2010) which also includes bond and task concepts will be used in accordance with the recent child literature.

### 1.1.2. Background of Therapeutic Alliance

#### 1.1.2.1. Therapeutic Alliance in Adult Literature

The concept of alliance has been originated in psychoanalytic theory starting with adult psychotherapy of Freud (Kanzer, 1981). Freud explained the concept of alliance through transference in psychoanalysis. A rapport between analyst and client is called as requisite for psychoanalysis because it provides removal of initial resistance of the client. (Freud, 1913) In the first writings of Freud (1913) such as *On Beginning the Treatment*, he stated alliance is inescapable result of positive transference and client's distortion about real relationship between two parties. Then he expanded his concept in *Analysis Terminable and Interminable* paper by stating that alliance is the total of positive transference and real relationship between client and analyst (Freud, 1937/1964).

After Freud's alliance concept based on transference, Sterba (1934) took this concept one step further and revealed a different concept against the term transference. Besides the instincts, there is a client's rational ego coherent with reality. The client may gain insight by reflecting analytic work thanks to ego's participant and observant functions. Therefore, the concept of the alliance should be different from positive transference (Sterba, 1934). Literature started to be

shaped in accordance with this opposition of Sterba's namely "ego alliance" (Meissner, 1992).

Another important name for therapeutic alliance literature is Elizabeth Rosenberg Zetzel (1956) who is the first in literature to use the term "therapeutic alliance". She underlined the real aspects of the therapeutic relationship. With the help of therapeutic alliance, a client can differentiate past relationship pattern from the actual one (Zetzel, 1956). Greenson (1965) used the term "working alliance" and focused common goals between therapist and client more than relationship's characteristics or bond. However, later clinicians like Gaston (1990) argued that the working alliance is not a different term than therapeutic alliance. Moreover, the therapeutic alliance contains the working alliance (Gaston, 1990). According to him, therapeutic alliance has three parts "1. The alliance as being therapeutic in and of itself; 2. The alliance as being a prerequisite for therapist interventions to be effective; and 3. The alliance as interacting with various types of therapist interventions" (Gaston, 1990, pp. 148).

Then, Bordin (1979) also used the term "working alliance" but he developed the content of it with 3 three features; an agreement on goals, tasks, and bond. These concepts are not only applicable to psychoanalytic therapy but also to many other psychotherapy modalities. Agreement on goal is that; "the ecology of psychological help-seeking is such that the client's goals—or at least the groundwork for goals he agrees on with the therapist—are commonly laid in the client's commerce with other helpers prior to the first meeting with the analyst" (Bordin, 1979, pp. 253). These goals change from one theory to other. For instance; in psychodynamic therapy mutual agreement should be based on client's access to his/her stress, frustrations, aggression and drives under the symptoms. While in cognitive - behavioral psychotherapy, the mutual agreement may be more directive and specific to client's life (Bordin, 1979). Task is "collaboration between client and therapist involves an agreed-upon contract, which takes into account some very concrete exchanges" (Bordin, 1979, pp. 254). Therapist's skills and methods are kinds of tasks. For instance; empathic understanding, self-disclosure, interpretations, being neutral or being directive, etc (Bordin, 1979).

Lastly, bond is defined as “human relationship between therapist and client” (Bordin, 1979, pp. 254). Because therapeutic relationship is deeper than daily relationships, it requires and develops trust, security, and attachment (Bordin, 1979).

In the same year, several clinicians opposed the existence of a term called a therapeutic alliance. According to them, the relationship between client and therapist cannot be called therapeutic alliance because it is completely transference. Brenner (1979) and Curtis (1979) argued that the therapeutic alliance is a part of transference. Therapeutic alliance cannot be separated from transference and does not deserve an explanation (Brenner, 1979). Agreement on a mutual goal, commitment, needs for security/warm/support, and collaboration are client’s transference. Transference should be interpreted by the therapist (Curtis, 1979).

According to Meissner (1992), all these contradictions actually stem from the fact that the boundary between the concepts is not drawn clearly. Two distinctions between terms which are “alliance and transference” and “alliance and real relation” should be made (Meissner, 1992). Therapeutic relationship has three ingredients namely; “the therapeutic alliance, the transference, and the real relationship” (Meissner, 1992, pp.1062). These are overlapping terms but distinguishable at the same time (Meissner, 1992). The alliance and transference have different roots and process in analytic psychotherapy (Meissner, 1992). Meissner (1992) explained these differences based on sub-terms in the alliance and the transference like trust and autonomy. For instance; basic trust is a part of the alliance. Many theoreticians evaluated it as early infantile positive transferential material. However, Meissner (1992) explained the difference; “primitive positive transference carries other connotations that are not part of basic trust—wishes for dependency, merger, symbiotic reunion, even idealization, for example, that are not germane to basic trust and are in many ways antithetical to it” (Meissner, 1992, pp. 1064). Autonomy is another sub-term which carries part from both the alliance and the transference. However, “clearly the autonomy itself is a present and concurrent quality of the object relation and cannot be

regarded as synonymous with any of the related transference dynamics" (Meissner, 1992, pp. 1064). On the other hand, the differentiation of the alliance and the real relationship is another controversial topic. Because most of the effort was expended to differentiate alliance from transference, nontransferential parts of therapeutic relationship which are the alliance and the real relationship stayed in the background (Meissner, 1992). "The alliance concerns itself with specific negotiations and forms of interaction between therapist and client that are required for effective and meaningful therapeutic interaction" (Meissner, 1992, pp. 1070). While client's capacity for trust or autonomy is a part of client's personality that shapes his/her real relations, basic trust and autonomous functioning in process is related to the alliance (Meissner, 1992). Moreover, Meissner (2007) explained the components of therapeutic alliance which prepare an effective ground for therapy process. These are; therapeutic framework, participation, empathy, trust, autonomy, being initiative, freedom, and ethical concepts (confidentiality and again being trustworthy) (Meissner, 2007). In this regard, the therapeutic relationship and transference are complex terms. Theoreticians should accept the fact that good therapeutic relationship is prerequisite for the transference instead of giving negative reaction towards work related to therapeutic relationship (Meissner, 1992).

While psychodynamic literature supports that therapeutic alliance is essential for psychotherapy process, person-centered or humanist theoreticians argue that therapeutic alliance is curative itself (Rogers, 1957). According to Rogers, "significant positive personality change does not occur except in a relationship" (1957, pp.96). This relationship can be curative if the therapist has several features. The client can bring out the inherent capacity of coping in the atmosphere created by the therapist (Rogers, 1961). Rogers (1961) stated that these are necessary and important elements of psychotherapy; therapist's genuineness in relationship, unconditional positive regard, and empathy. Being genuineness means that therapist's authenticity and being unique to relationship with each client (Rogers, 1957). Unconditional positive regard is accepting the client as is. Each experience is important for client and there is no condition for

acceptance of therapist in psychotherapy sessions (Rogers, 1957). Lastly, empathy is another necessary and sufficient condition of Rogers (1957) which is therapist's openness to client's awareness and perspective about his/her experiences.

In cognitive-behavioral therapy literature, Beck accepted the importance of empathy and genuineness for therapeutic improvements (1962). However, therapeutic techniques and specifying common goals are also important in order to make necessary interventions (Beck, Rush, Shaw, & Emery, 1979). Therefore, techniques, interventions, and alliance are inseparable in cognitive-behavioral psychotherapy process (Goldfried & Davila, 2005).

#### 1.1.2.2. Therapeutic Alliance in Child Literature

Child and adolescent literature of therapeutic alliance showed similar progress with adult literature. There are also discussions in child literature related to whether therapeutic alliance is curative itself or catalyst for psychotherapy process. Literature of therapeutic alliance between therapist and child has a long background starting with Anna Freud (1946). A. Freud (1946) stated that good relationship between therapist and child is a necessity for later child analyses. Many children may be deprived of satisfying relationships with their caregivers in which they cannot find the opportunity to play. Moreover, many of these children form insecure attachment style in their life. Therefore, these children fulfill their deprivation with this therapeutic relationship. However, this relationship is not lasting forever. According to A. Freud, child accepts therapist as helper and the therapy as safety, supportive place thanks to the therapeutic alliance (Shirk & Saiz, 1992). In this sense, therapeutic alliance is facilitator for improvement in later work of therapy and deeper interpretations (A. Freud, 1946).

In contrast to A. Freud's therapeutic alliance as catalyst view, Axline (1947) argued that therapeutic alliance is healer itself. In child-adolescent psychotherapy especially "in play therapy experiences, the child is given an opportunity to learn about himself in relation to therapist" (Axline, 1947, pp.1). The relationship between therapist and child has curative nature because it

includes empathy, warmness, sensitivity to affects, stable frame, and limits. These ingredients create secure experiences and relationships which result in "self-exploration, self-in-relation-to-others, self-expansion, and self- expression" of child client (Axline, 1947, pp.1). C. Rogers (1957) also indicated that child finds opportunity for growth in therapeutic relationship which is curative enough for child. Therefore, therapist should provide "relational conditions of empathy, genuineness, and positive regard were posited as active ingredients of therapy" (Shirk, Karver, & Brown, 2011, pp. 17). If the relationship includes them, connection between therapeutic relation and outcome will be direct instead of being a facilitator (Shirk et al., 2011).

Later theoreticians explained the therapeutic relationship based on the attachment theory. One of the founders of attachment theory Ainsworth (1978) stated the importance of relationship between child and therapist on the basis of early mother-infant interaction. In childhood, each person develops attachment style in relation to primary caregiver who is a mother in general (Ainsworth, 1978). If mother is available and satisfies the needs of child, child develops a secure perception related to relationship and others. On the other hand, if child is deprived of this secure relationship with the caregiver, he/she develops insecure attachment style (Ainsworth, 1978). Winnicott (1971) explains the same relational patterns and its importance with different terms such as; good enough mother and holding environment. If child has good enough mother who creates safe environment, satisfy the needs of baby, is available, supportive, shares mutual interest with her baby and responsive to baby; child can experience secure bonding (Winnicott, 1971). In play, child gets a chance to repair his/her insecure attachment with secure adult in holding therapy environment (Winnicott, 1968). Therapy makes it possible to go back and develop trust and more supportive mother model by gathering external reality and inner world with manipulation power of play (Winnicott, 1968). In this regard, relationship between child and therapist is important and curative for child psychotherapy (Winnicott, 1968).

Transference and therapeutic alliance are overlapping and controversial topics not only in adult literature but also in child literature. According to

Meissner (1988), therapeutic alliance is shaped and becomes active from very first moment even from the telephone call. Moreover, the alliance does not come into play only. It is generated throughout each therapeutic interaction. So, it is total of child's relationship with real therapist and therapist in play (Meissner, 1988). On the other hand; transference may or may not come into play at early sessions. In general, the emergence of transference is more gradual and delayed in contrast to therapeutic alliance (Meissner, 1988).

Considering the debates related to transference and therapeutic alliance in child literature especially in play, Chethik (2001) states that play includes both transference and therapeutic alliance. According to him, there is a significant relationship between play in early childhood with parents and therapeutic alliance of children with therapist (Chethik, 2001). "The alliance is less a rational connection and much more a libidinal attachment" (Chethik, 2001, pp.20). Child goes into play and creates his/her inner models. Then he/she unconsciously repairs and changes his/her past experiences with new satisfying experience of therapy (Chethik, 2001). While the child experiences transference in the characters of play, he/she has real relationship with the other player who is a therapist. This relationship is therapeutic alliance. If trust, creativeness, support is experienced in therapeutic alliance, dyad can deepen transference interpretations. Therefore, the alliance enables transference which makes both of them curative in psychotherapy process of children (Chethik, 2001).

Psychodynamic child literature focuses on bond between child and therapist rather than task and goal. Although the dominance of emotional part of therapeutic alliance is accepted in other theories, behavior and cognition-oriented theoreticians give importance to task and common goals (Shirk & Saiz, 1992). From this perspective, agreement regarding treatment goals and collaboration for tasks are important because they are the curative part of therapy (DiGiuseppe, Linscott, & Jilton, 1996). DiGiuseppe and colleagues (1996) criticize overemphasis on bond between child and therapist. Because children are brought to therapy by their parents or referral from another adult, generally they do not

have opinion or motivation for change and problem (Shirk et al., 2010). In this regard, even if child develops positive bond with the therapist, he/she cannot benefit from therapy without working alliance including goal and task (DiGiuseppe et al., 1996). Therapist and child should have collaboration. When child has resistance to collaboration, therapist's work is making interpretation related to this resistance until collaboration is achieved (Chethik, 2003). Moreover, task is also a necessity for working alliance. Therapist and child should have task like rules about "not to harm". In psychotherapy, therapist is responsible to set limits and shows child more appropriate way for solving problems of him/her (Chethik, 2003).

In conclusion, there are differences and controversial issues related to therapeutic alliance throughout child psychotherapy literature. However, there is a point which is "common to all perspectives is an emphasis on the *affective quality* of the relationship between child and therapist" (Shirk & Saiz, 1992, pp. 716). While several theoreticians calls therapeutic alliance as mediator, others states that it is curative itself. The commonly accepted point across theoreticians is that a positive therapeutic alliance between child and therapist is important and a necessity for an effective psychotherapy (Shirk & Saiz, 1992).

### 1.1.3. Empirical Studies of Therapeutic Alliance

#### 1.1.3.1. Outcome Research

Therapeutic alliance is one of common topics in empirical adult psychotherapy literature. Most of the literature focuses on the fact that therapeutic alliance predicts outcome of psychotherapy (Martin, Garske, & Davis, 2000). However, there are studies that asserting therapeutic alliance as outcome itself (Barber, Khalsa, & Sharpless, 2010).

In *Relation of the Therapeutic Alliance with Outcome and Other Variables: a Meta-Analytic Review,* 79 studies were examined then average correlation between the therapeutic alliance and outcome is reached as .22 (Martin

et al., 2000). After this meta-analysis, Horvath and colleagues made several meta-analyses related to the same topic. Although these studies vary according to psychotherapy school of thoughts, length of psychotherapy, measurement of the alliance and outcome; there is a correlation between the alliance and outcome at moderate level (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011). Another meta-analysis *Alliance in Individual Psychotherapy* examined electronic databases with these words; "alliance, helping alliance, working alliance, and/or therapeutic alliance" (Horvath et al., 2011, pp. 9). Two hundred-one empirical studies were assessed from 1973 to 2009. Results showed that there is a significant relation between the alliance and outcome with .28 effect size which indicates almost moderate but highly reliable relation.

The most recent meta-analysis *The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis* examined 295 adult psychotherapy studies with over 30.000 clients (Flückiger, Del Re, Wampold, & Horvath, 2018). Although there was variability among the effect sizes of research, overall average effect size is .278 which is very close to prior meta-analysis of Horvath and colleagues (2011). Results strongly supported the positive correlation between therapeutic alliance and psychotherapy outcome (Flückiger et., 2018).

Most of the studies found significant correlation between two variables (Horvath et al., 2011). In general, literature about the relation between alliance and outcome is based on assessment of alliance from different point (early, middle, and last sessions) and assessment of change in symptoms (comparing pretreatment with posttreatment). Many researchers explore and state that alliance is the predictor of outcome while others couldn't find this direct relation and supportted the mediation or moderation effect of therapeutic alliance over outcome (Barber et al., 2010).

In adult meta-analyses, researchers investigated the reasons behind heterogeneity of therapeutic alliance and outcome relation. Then they found several moderators such as; "publication year of the study, treatment type, client diagnosis, alliance measure, rater of the alliance, time of the alliance assessment,

outcome measures, specificity of outcome, source of outcome data, type of research design, and country of study" (Flückiger et al., 2018, pp. 327). To start with the study year, effect size was lower if the research is more recent. It can be explained with using more simplified measurements in more recent literature (Flückiger et al., 2018). Treatment type is another moderator for therapeutic alliance-outcome relationship. Treatment approaches were not found significantly different from each other (Horvath et al., 2011; Flückiger et al., 2018). Considering client diagnosis, substance use disorder and eating disorder had lower effect size than other adult disorders. Alliance measurements were another moderator which was not found significant from each other. Raters of alliance can be clients, partner or parent of clients, therapists, and observers. According to results, observers' rating effects were slightly having smaller effect size than others. When the time of alliance assessment is concerned, "the relation between alliance and outcome is higher when the alliance is measured late in therapy in comparison to the early alliance assessment" (Flückiger et al., 2018, pp. 328). On the other hand, outcome measures also found significantly different from each other. All measures were classified into 10 categories in accordance with their frequent use in studies and therapeutic alliance-outcome effect for each category is different. When it comes to the specificity of outcome, alliance is more predictive for broader assessment rather than specific measurements. Research design was not found significant whether it is randomized controlled trial or not. Lastly, country of study was a moderator which affected the correlation size of alliance and outcome relation. For instance; Belgium and Luxemburg had lower associations than U.S. (Flückiger et al., 2018).

Considering the abundance of adult literature on the relationship between therapeutic alliance and treatment outcome, it can be said that children literature is a more limited and developing field at the relevant topic. Because children are referred to therapy by parent or teacher and self-report is problematic at early ages, studies about therapeutic alliance focuses on more youth (Shirk & Karver, 2003). After theoreticians claimed that therapeutic alliance is more critical issue in child psychotherapy than adults, relationship between alliance and outcome

studies started (Shirk & Saiz, 1992). Shirk and Karver (2003) examined 23 child adolescent studies as meta-analysis. They used not only therapeutic alliance measures but also general relationship measures for including criteria of the meta-analysis. According to results, relationship between alliance and outcome was at modest level and it matched with adult studies (Shirk & Karver, 2003). Another meta-analysis related to this relationship in child-adolescent literature (McLeod, 2011) includes 38 studies. Studies which used a measure of child or parent alliance and which used a statistically testable relationship hypothesis between alliance-outcome were included. The mean age of clients was below 19 in studies. Thus, it focused more alliance terminology instead of just focusing on the relationship terminology (McLeod, 2011). Results showed that the overall mean of association between alliance and outcome was .14, suggesting the stronger alliance the better the treatment outcome. However, in child-youth literature results were found more contradictory and inconsistent than adult literature (McLeod, 2011).

Last meta-analysis about therapeutic alliance and treatment outcome relationship is *Meta-Analysis of the Prospective Relation Between Alliance and Outcome in Child and Adolescent Psychotherapy* (Karver et al., 2018). Analysis includes 28 studies which used explicit measure of therapeutic alliance. Results indicated small to medium .19 effect size which is parallel with prior meta-analyses. After this heterogeneity in results, multiple moderators were found and examined (Karver et al., 2018).

When research examining the relationship between alliance and outcome is concerned, literature dates back to 1991. Colson and colleagues (1991) searched the relationship between treatment team (psychiatrist, social worker, child care worker) report of alliance and outcome. Sixty-nine adolescent clients diagnosed with personality disorders or conduct disorders, or major affective disorders or psychotic disorders were included in research (Colson et al., 1991). According to results, therapeutic alliance difficulty was found significantly correlated with overall treatment difficulty and negatively correlated with client progress. This correlation indicated that clients who had difficulties at therapeutic alliance

showed less improvement as treatment outcome (Colson et al., 1991). Research conducted with therapist reports of therapeutic alliance continued with Gorin's (1993) study on 31 adolescents. Results indicated that higher therapeutic alliance score with children were associated with positive effect on treatment outcome (Gorin, 1993).

Noser and Bickman (2000) conducted a study of 240 outpatient youth with the mean age was 14.2. This time the therapeutic alliance was assessed by adolescents and parents. Although results were evaluated as weak and inconsistent, researchers found significant relationship between therapeutic alliance and improvement in treatment outcome (Noser & Bickman, 2000). In 2005, two team conducted studies related to alliance prediction of outcome; McLeod & Weisz and Kazdin, Marciano & Whitley. McLeod and Weisz (2005) included 22 children and adolescents diagnosed with depressive or anxiety disorders. Sessions were coded by educated reliable observers then means of scores were analyzed. According to results, therapeutic alliance did not predict all symptoms reduction. While therapeutic alliance scores were found associated with anxiety symptoms reduction, it was not associated with depressive symptoms reduction (McLeod & Weisz, 2005). On the other hand, Kazdin, Marciano & Whitley (2005) worked with 185 children ranging from 3 to 14-year-old who took cognitive-behavioral therapy. Results were based on both therapist and child evaluation of therapeutic alliance. There was an association between therapeutic alliance and externalizing symptom reduction (Kazdin et al., 2005). In contrast to this study, Liber and colleagues (2010) found that therapeutic alliance and internalizing symptom reduction were associated. Fifty-two children diagnosed with anxiety disorders and sessions were coded by observers. Although there was not an association between alliance and outcome directly, stronger alliance was predicting more symptom reduction in internalizing behaviors (Liber et al., 2010). Another research examining the relation between therapeutic alliance of therapist-children with externalizing symptoms and outcome is *Therapeutic Alliance and Outcomes in Children and Adolescents Served in a Community Mental Health System* (Abrishami & Warren, 2013). Unlike two other studies, Abrishami &

Warren (2013) and Özsoy (2018) did not find any association between therapeutic alliance score and symptom reduction.

Chiu, McLeod, Har, and Wood (2009) conducted a study with 34 children diagnosed with anxiety disorders. Because researchers used The Therapy Process Observational Coding System for Child Psychotherapy – Alliance scale (TPOCS-A; McLeod, 2005), observers coded both early and last sessions of cognitive-behavioral therapy (Chiu et al., 2009). Results showed that "a stronger child-therapist alliance early in treatment predicted greater improvement in parent-reported outcomes at mid-treatment but not post-treatment. However, improvement in the child–therapist alliance over the course of treatment predicted better post-treatment outcomes" (Chiu et al., 2009, pp.751).

In child and adolescent literature, researchers looked for some characteristics which have relation with therapeutic alliance of children; gender, age, and diagnose (especially grouping problems as externalizing or internalizing). Considering the impact of gender, Özsoy (2018) found that girls had higher therapeutic alliance score than boys. Zorzella, Muller, and Cribbie (2015) also supported this finding with failed to reject; girls have higher scores at early alliance measurement than boys. Age is another factor which has impact on therapeutic alliance. Therapeutic alliance score between therapist and child was higher when the child was younger (Abrishami & Warren, 2013).

Considering all these empirical studies and their contradictory results, it is hard to summarize them. While some studies indicated significant relationship between alliance and outcome others found partial or no association. There can be several potential mediators which studies also searched for; client characteristics, treatment characteristics, measurements as much as relation between the alliance and the outcome (McLeod, 2011). Child-adolescent literature related to therapeutic alliance also focuses on factors of psychotherapy in order to understand the alliance deeply (McLeod, 2011).

Meta-analysis of McLeod (2011) indicated that pre-treatment problems of children are strong moderator on the relationship between therapeutic alliance-outcome. According to results, youth with externalizing problems showed higher

therapeutic alliance score than internalizing problems and substance abuse problems (McLeod, 2011) Contrary to this result, several child studies found that children with internalizing problems have higher therapeutic alliance scores than children with externalizing problems (Özsoy, 2018; Abrishami & Warren, 2013). Last meta-analysis of Karver and colleagues (2018) found that "Several categorical moderators did show statistically significant group differences. Randomized control trials had a smaller alliance–outcome relation relative to non-randomized control trials. Relative to internalizing disorders, smaller alliance–outcome associations were observed for treatment for substance abuse and eating disorders. Larger effect sizes were observed for outpatient relative to inpatient treatment. Behavioral treatment showed a stronger alliance–outcome relationship than treatment that was a mix of behavioral and non-behavioral components, though only two effect sizes represented a mix treatment approach. Although the therapist–parent alliance to outcome association was somewhat larger than the therapist–child alliance, this was not a statistically significant difference" (Karver et al., 2018, pp. 348).

#### 1.1.3.2. Process Research

Because therapeutic alliance is a dyadic and changeable relationship, evaluating it at the beginning and termination give limited information (Dales & Jerry, 2008). Adult process literature about therapeutic alliance is narrower but developing area comparing to outcome studies. In process research of therapeutic alliance, trajectory studies take an important space. Researchers examine and find different results about the question "How the therapeutic alliance proceeds?". Sexton, Hembre, & Kvarme (1996), and Hilsenroth, Peters, & Ackerman (2004) stated that therapeutic alliance increases with linear growth, while others (Golden & Robbins, 1990; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998; Piper, Ogrodniczuk, Lamarche, Hilscher, & Joyce, 2005; Kramer, de Roten, Beretta, Michel, & Despland, 2009) indicated more stable growth for therapeutic alliance. Moreover, there are adult studies supporting U shape of therapeutic

alliance over time (such as Horvath & Luborsky, 1993; Gelso & Carter, 1994; Kivlighan & Shaughnessy, 2000) and V shapes with more rupture and repair loop (Stiles et al., 2004; Strauss et al., 2006).

As in trajectories of therapeutic alliance studies, there are conflicting results in the study of relationship between this progress of therapeutic alliance and the outcome. While several researchers (Kramer, de Roten, Beretta, Michel, & Despland, 2008), found that stable progress of therapeutic alliance through psychotherapy is more predictive for symptom reduction while others (de Roten et al., 2004) stated linear growth of therapeutic alliance in process is more predictive for treatment outcome. Contrary to these studies, literature leaned to rupture-repair studies which indicate the importance of U shape or V shape therapeutic alliance and their positive prediction on treatment outcome (Safran, Muran, & Eubanks-Carter, 2011). Safran and his colleagues (2011) made meta-analysis including studies related to therapeutic alliance ruptures and repairs in psychotherapy. Rupture can be defined as "a dramatic breakdown in collaboration" that "vary in intensity from relatively minor tensions, which one or both of the participants may be only vaguely aware of, to major breakdowns in collaboration, understanding, or communication" (Safran et al., pp. 80). According to results of meta-analysis including 148 clients' psychotherapy process, correlation between rupture-repair loop and outcome is .24 which indicates positive effect of rupture-repair episodes on treatment outcome (Safran et al., 2011).

According to rupture-repair studies, the more rupture-repair episodes mean more improvement in psychotherapy. There are several points supporting that breakdown in collaboration; client can express more negative emotion in therapy if the therapist stays nondefensive and behaves topic effable. Moreover, therapist finds a chance to link this tension with clients' pattern which also provides improvement in psychotherapy process (Safran et al., 2011).

Besides the process studies in adult literature, there are studies exploring the process of therapeutic alliance between child and therapist in child-youth literature. These studies are limited in comparison to outcome studies and

generally focused on the trajectory of therapeutic alliance over the course of treatment. Results of studies were again contradictory and changing from research to research similar to outcome studies in child literature. Liber and colleagues (2010) found that therapeutic alliance had positive linear growth for cognitive behavioral therapy of 52 children with anxiety problems. On the contrary, Hudson and his colleagues (2014) indicated negative linear incline of therapeutic alliance throughout psychotherapy. Research population was also children with anxiety problems who were taking cognitive behavioral therapy (Hudson et al., 2014). Zorzella, Rependa, and Muller (2017) made research with maltreated children who had trauma history. Trauma focused cognitive behavior therapy sessions of 65 children ranging from 6 years to 12 years were coded (Zorzella et al., 2017). To examine the therapeutic alliance changes over the course of psychotherapy, researchers collected data from three different perspectives (parent, child, and therapist ratings). Then multi rater results indicated that "despite how hard it was for children to participate in this intensive treatment method, children, therapists and parents reported positive ratings of the therapeutic alliance throughout treatment. Furthermore, child and therapist's ratings of alliance became significantly more positive from therapy start to finish." (Zorzella et al., 2017, pp.147).

Moreover, other several studies disapproved the linear findings of therapeutic alliance with exploring concave and U-shaped progression of it. One of these studies examined the psychotherapy process of children with anxiety disorders. Each session was coded by both therapist and child then therapeutic alliance trajectory was explored as concave curve (Kendall et al., 2009). Chu, Skriner, and Zandberg (2014) made a research and examine therapeutic alliance process based on both youth report and therapist report. Results showed that therapists pointed more concave curve throughout the psychotherapy process while result of adolescents were most heterogeneous (Chu et al., 2014).

Other studies (Özsoy, 2018; Hurley, Lambert, Ryzin, Sullivan, & Stevens, 2013) indicated U shaped of therapeutic alliance and its' meaning in psychotherapy. Özsoy (2018) examines the characteristics and development of

therapeutic alliance throughout psychodynamic child therapy. Sessions from beginning, middle, and end phase were coded by observers. Then therapeutic alliance of children with behavioral problems was found as U-shaped quadratic growth trajectory (Özsoy, 2018). Another study also found U shaped trajectory of therapeutic alliance between youth with disruptive behavior and therapist (Hurley et al., 2013).

In addition to trajectory researches in child literature, there are several studies searching the alliance process from different research questions. For instance, Keeley, Geffken, Ricketts, McNamara and Storch (2011) made a study with 25 youth with obsessive compulsive disorder and their therapists. Therapeutic alliance was measured by youth and therapist report at several points. According to results the more alliance improvement, the better outcome of psychotherapy (Keeley et al., 2011). Another study examined the trajectory of therapeutic alliance found that positive trajectories predicted more improvement at the middle phase of psychotherapy of externalizing children (Hurley, Ryzin, Lambert, & Stevens, 2015). Research of Goodman, Chung, Fischel and Athey-Lloyd (2017) can be an example of rupture-repair studies in child-youth literature. Results of the study showed that the rupture-repair in therapeutic alliance process had positive effects on symptom reduction (Goodman et al., 2017).

### 1.1.4. Measurements of Therapeutic Alliance in Child Psychotherapy

Concept of therapeutic alliance has been assessed with various measurements both in adult literature and child-youth literature. There are diversity in therapeutic alliance concepts and measures because there is not any measurement which “meets all the predefined criteria in either adult or child populations” (Elvins & Green, 2008, pp.1167). In child-youth literature, therapeutic alliance differs in the person who evaluates the alliance score. It can be observer coding, child self-report, parent report or therapist report. Although versions of measurements are mostly reliable and valid, findings support observer

forms and therapist forms are more reliable than others (McLeod, Southam-Gerow, & Kendall, 2017).

First therapeutic alliance measurement is Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992). Shirk and Saiz (1992) developed TASC based on concepts of Bordin (1979) namely; bond, goal, and task. This scale includes three versions in order to assess therapeutic alliance from each party in psychotherapy process. Therapeutic Alliance Scale for Children-revised (TASC-r) is used for evaluating alliance between the therapist and child. On the other hand, Therapeutic Alliance Scale for Caregivers and Parents (TASCP) is used for assessing alliance between therapist and the caregiver/parent of child in psychotherapy. All forms have 12 items with 4-point likert scale ranging from "not at all" to "very much" (Accurso, Hawley, & Garland, 2013). Psychometric properties of TASC were studied with 62 children and their therapists. Then, moderate internal consistency was found for the scale (Shirk & Saiz, 1992). TASCP was also studied with 209 caregivers of children in psychotherapy process. Thus; reliability, temporal stability, convergent validity, and discriminant validity of the scale were utilized as psychometric properties (Accurso et al., 2013).

In 1993, Child Therapeutic Alliance Scale (CTAS) was developed by Grienenberger & Foreman (1993). The alliance scale includes 8 items with 7-point likert scale which is evaluated by a child or an independent observer (CTAS; Grienenberger & Foreman, 1993). These items point several concepts; communication, self-observation, emotion, salience, safety, closeness, and engagement. Although data was limited to evaluate psychometric properties, results supported high internal consistency and construct validity of CTAS (Foreman, Gibbins, Grienenberger, & Berry, 2000). Child's Perception of Therapeutic Relationship (CPTR; Kendall, 1994) is another measure based on child self-report. CPTR is administered by independent person to child. And child answers 10 items with 5-point likert scale like "how much child likes therapist or talk to therapist". Study with 488 children who have anxiety disorders supported good internal consistency of CPTR (Cummings et al., 2013). There is another

measure based on child evaluation of therapeutic alliance which is Therapeutic Alliance Quality Scale (TAQS; Bickman et al., 2010). TAQS focuses on both goal, bond, and task concepts of the alliance. It includes 5 items with 5-point likert scale ranging from “not at all” to “totally” (Hurley et al., 2013). Hurley and colleagues (2013) made a longitudinal study with 135 youth in order to assess psychometric properties of TAQS. Although youth psychometric properties have lower significance than adults, it found as significant enough (Hurley et al., 2013).

Moreover, Working Alliance Inventory for Children and Adolescents (WAI-CA; Figueiredo, Dias, Lima, & Lamela, 2016) is another measure which is one of the most used scales in child/adolescent literature (Shirk et al., 2011). Measure is shortened and adapted version of Working Alliance Inventory including 36 items with 5-point likert scale. Psychometric properties also studied by Figueiredo and colleagues (2016) with 109 children then the scale was found reliable and valid. WAI-O (S-WAI-O; Berk, Eubanks-Carter, Muran, & Safran, 2010) is observer version for children and therapist therapeutic alliance evaluation. An independent observer watches the recorded session and evaluate 12 items with 7-point likert scale (Berk et al., 2010). Another form derived from WAI-S short adult version is Children’s Alliance Questionnaire (CAQ; Roest, Helm, Strijbosch, Brandenburg, & Stams, 2016). Roest and colleagues (2016) created two separate forms based on age; child form has 10 items with 3-point likert scale while adolescent form has 9 items with 5-point likert scale. Psychometric properties were also studied by Roest and colleagues (2016) and the scale was found reliable and valid.

Finally, Therapy Process Observational Coding System-Alliance scale (TPOCS-A; McLeod & Weisz, 2005) is another measure which evaluates therapeutic alliance between child and therapist based on independent observer coding. Recorded sessions are watched/listened by an observer. Then, observer points 9 items ranging from 0 to 5 likert scale. Items include bond and task concepts of Bordin (1979). Psychometric properties of TPOCS-A were studied with 22 children having depression, anxiety or internalizing symptoms. Inter-rater reliability, internal consistency, and validity were found good enough to be

utilized in other studies (McLeod & Weisz, 2005). While examining validity of TPOCS-A McLeod and Weisz (2005) measured the correlation between TASC and TPOCS-A. Then, results indicated that there is strong correlation between TPOCS-A and TASC self-report (McLeod & Weisz, 2005). TPOCS-A was translated into Turkish and used in a study by Özsoy (2018). Manual was translated by Özsoy with consultation of McLeod and Halfon. Then, undergraduate psychology students and clinical psychology students coded 179 psychodynamic play therapy sessions of 49 children (Özsoy, 2018). In this study, TPOCS-A used for therapeutic alliance coding, because it is an observer form with high reliability and validity scores. Also, it was already used in other psychodynamic research (Özsoy, 2018).

## 1.2. AFFECT

### 1.2.1. Affect Expression and Affect Regulation in Psychodynamic Psychotherapy

In order to better understand of the relationship between affect expression and affect regulation with therapeutic alliance, it is more meaningful to mention affect in psychodynamic psychotherapy first. Before the definition of affect regulation, it is important to clarify the difference between emotion and affect. Throughout the literature and discussion part, both two terms were used but they were not interchangeable. In literature if the original text used emotion it does not changed. For this study, affect is more umbrella term which is used as the experiencing of emotion. Affect regulation is defined as “the intrinsic and extrinsic processes responsible for monitoring, evaluating and modifying emotional reactions, especially their intensive and temporal features, to accomplish one’s goals" (Thompson, 1994, pp.27). According to object relation theory, children start to learn the regulation of their emotion in relation to their primary caregiver. Affect regulation is a term which is explained based on relationship, attachment, mother-child interaction, and social interaction etc…

(Beebe, Lachmann, Markese, & Bahrick, 2012). When the emotional arousal happened, a child needs to the regulation of caregiver for himself/herself. If the mother is sensitive to child's emotional situation and she can read or mirror these emotions, then child starts to carry and give meaning to them also (Beebe, Lachmann, Markese, & Bahrick, 2012). In order to build a self-soothing regulation mechanism child needs to caregiver having co-regulation capacity, social interaction, non-verbal and verbal regulation support (Galyer & Evans, 2001). In this regard, "the exact interactions during childhood that promote these behaviors are somewhat unclear, however, one mode of social interaction that has been proposed as having a unique influence on emotional development is children's pretend play with others" (Galyer & Evans, 2001, pp. 94). In play, child has an opportunity to process and modify the emotional experiences. This provides mastery and practice over emotions and creates a safe place to express emotion (Galyer & Evans, 2001).

Play is used as a communication way by children. Because emotional material cannot explain or reflect by just talking, children use play as a common toll between them and their therapists. In this point, play is "a form of symbolic representation of the concerns, conflicts, fears, and urges that underlie children's emotional and behavioral difficulties" (Shirk & Burwell, 2010, pp. 190). From the psychodynamic perspective, play itself is curative for a child and child brings problems into play. Therefore, play can be a solution or the way a child communicates through. Therapist is included in this play world and contact with the child throughout play patterns (Shirk & Burwell, 2010). Play also triggers emotions. During play child expresses emotions based on not only verbal interaction but also nonverbal cues (Chazan, 2002). For this reason, play is called as "universal language of communication" thanks to its' expressiveness (Chazan, 2002, pp.19). Generally in play, there is not any limitation (except harmful situations) and children express a wide variety of affects (Halfon, Oktay, & Salah, 2016b).

Affect expression in play is adaptive because children use play as a tool which provides expression of unconscious material, anxieties, and problems. They

can imagine and replay these points to regulate themselves (Chazan, 2002). In an adaptive play; a child has capacity for wide ranges of representations, plays without interruption, may switch between emotions smoothly, may regulate and modulate emotions, and has curiosity or focus related to the play. Moreover, there should be negative emotions in adaptive play but it should be meaningful in the content. The child should use adaptive coping mechanisms to continue play and work with the material (Chazan, 2002; Halfon, 2017). Studies found that the children who express negative affect in play are better at working through their traumas. The reason behind that is raising negative emotions to the surface adaptively (Gaensbauer & Siegel, 1995).

It is known that children with externalizing or internalizing problems have difficulties in play such as disorganization or dysregulation (Fonagy, Gergely, Jurist, & Target, 2002). Considering the facts that play is an area that children reflect their inner self and daily routine, emotion expression and regulation of children in play may vary in accordance with their psychopathology (internalizing or externalizing symptomatology of child). In this point, the clinical sample should be examined based on two categories namely internalizing and externalizing. These categories influence or related to expression and regulation of emotions (Achenbach & Edelbrock, 1981). According to Achenbach and Edelbrock (1981), children with internalizing problems are expected to show more depressed and anxious affect expression while children with externalizing symptoms are expected to express more anger and overactivity. Internalizing problems are related to overcontrol while externalizing problems are related to undercontrol (Achenbach & Edelbrock, 1981).

According to Eisenberg and her colleagues, “both internalizing and externalizing problems were associated with negative emotionality. Externalizers were low in effortful regulation and high in impulsivity, whereas internalizers, compared with nondisordered children, were low in impulsivity but not effortful control” (2005, pp. 193). Moreover, both internalizing and externalizing psychopathology are associated with negative emotionality. Externalizing problems are mostly related with anger and irritability while internalizing

problems are related to anxiety, fear, and sadness/hurt (Eisenberg et al., 2005). One's affect regulation specifies and stems from not only his/her behavior but also others' behaviors. For instance, a child with externalizing problems is irritable and has difficulties with controlling his/her emotions, it may cause attention deficits. Because the child needs more energy to regulate himself/herself, this makes him/her behind at several issues (Eisenberg et al., 2005). Eisenberg, Fabes, Guthrie, and Reiser (2000) explained how the differences in emotion regulation have an influence on social functioning. Results indicated that negative emotionality and emotion regulation predicts social relationships of people. When it comes to mediator and moderator of this relationship, it is found that "the effects of attention regulation on social functioning were mediated by resiliency, and this relation was moderated by negative emotionality at the first" (Eisenberg et al., 2005, pp.136). Also, the relation between behavior regulation and socially appropriate behavior is mediated by negative emotionality (Eisenberg, 2005).

When it comes to play of children with externalizing and internalizing problems, adaptive play turns into "inhibited/conflicted, impulsive/aggressive, and disorganized play". Inhibited/conflicted play is a profile in that child has difficulties in spontaneous play. In general, child with inhibited play profile shows less representation of characters, limited range of affects, and lower hedonic tone in play segments. These silent children may prefer to play alone in sessions and uses several defenses like isolation of affect and rationalization. Children with internalizing problems usually show this type of play profile. In other respects, children with impulsive/aggressive play have more externalizing patterns. In this play profile, child shows acting outs and affects are limited with anger and anxiety. Child with impulsive play profile needs interruptions in the play and uses generally denial or splitting as a defense mechanism. Lastly, disorganized play profile includes strong anxieties and overwhelming situations. Child with that profile shows bizarre affect expressions and extreme aggression in play. Generally, child loses control and awareness over play and it results in chaos in play narrative (Chazan, 2002; Halfon, 2017).

Warren, Oppenheim, and Emde (1996) examine the themes and emotions in child's play and their prediction for problems that the child is having. Fifty-one children's story stem plays were coded. Results showed that "distress and destructive themes in the play of 4- and 5-year olds were found to correlate with externalizing behavior problems as rated by parents and teachers" (Warren et al., 1996, pp. 1331). In psychodynamic play therapy, externalizing children were expressing more aggression. On the other hand, children with internalizing problems showed more negative emotions but less affective arousal (Halfon et al., 2016b). Contrary to externalizing and internalizing categorizations, several studies stated that all clinical children groups show more negative affect expression rather than positive (Feng et al., 2009; Bulut, 2016). Bulut (2016) examined affect expression and regulation of the clinical child sample throughout the psychodynamic psychotherapy process. According to results, the expression of negative affects especially aggression is common for all groups at the beginning. Throughout the process, the expression of negative valence and aggression observed in play were decreasing. Positive affect expression and pleasure were increasing regardless of the child's externalized or internalized symptoms (Bulut, 2016).

Thanks to the recognition of the importance of play, many empirical outcome studies have been searched for play-based therapy and children's dysfunctional aspects (Yılmaz, 2018). Bratton, Ray, Rhine, and Jones (2005) made a meta-analysis to examine the difference between play therapy approaches and their effect on children's emotional and behavioral problems. According to results, non-directive play therapies such as psychodynamic play therapy and child-centered play therapy were more effective than others like cognitive-behavioral play therapy (Bratton et al., 2005). Children with externalizing or internalizing problems express more negative emotions with a low level of affect regulation in play (Butcher & Niec, 2005). Galyer and Evans (2001) examine the emotion regulation of children within the pretend play context. Fifty-one children ranging from 4 years old to five years old and their family were included in the study. Results indicated that there is a strong relationship between the frequency

of pretend play and emotion regulation of children (Galyer & Evans, 2001). Chazan and Wolf (2002) examined the play therapy process of a 6-year-old boy who is a suicidal outpatient. In the beginning he had temper tantrums. After psychotherapy, his affect regulation capacity was developed and tantrums were decreased. When the play is concerned, shift in coping strategies and play profiles were more interesting. Although the dominant profile was conflicted at the end, he had switch to adaptive play (Chazan & Wolf, 2002). This was possible with the help of play. Child started to confront with his desires and needs in play. These were more adaptive, playful, and sublimated way which gives control to him (Chazan & Wolf, 2002). Another study (Halfon et al., 2016a) which supports the positive effect of psychodynamic play therapy includes the long-term play therapy of three 6-year-old children. Results showed two trends; decrease in less adaptive strategies and decrease in interruptions through play segments.

Regardless of whether externalizing symptoms or internalizing symptoms, psychodynamic play therapy process was found effective for affect regulation of clinical children population (Bulut, 2016). Another study including 40 children with externalizing and internalizing behavior problems examined negative emotion expression, symbolic play and affect regulation in psychodynamic child psychotherapy. It was one of limited child process research related to this topic (Yılmaz, 2018). Results indicated that "children's symbolic play activity in the previous session predicted their gains in affect regulation in the following session" (Yılmaz, 2018, pp.23).

Although there are many studies related to children's expression and regulation of affect in psychotherapy, there are fewer studies related to change of these affects or regulations over the course of treatment. When increase in positive emotions or decrease in negative emotions were considered, the hypothesis "fits with the idea that play is one way in which children learn to regulate their emotions. However, these ideas need to be empirically investigated" (Halfon et al., 2016b, pp.5). In this regard, the influence of the therapeutic alliance on affect expression and affect regulation is interesting when it is considered that affect regulation develops in the relationship with the significant other in the play.

### 1.2.2. The Relationship of Therapeutic Alliance with Affect Expression and Affect Regulation

From the perspective of psychodynamic child therapy, affect expression and regulation are issues explained on the basis of object relations (Target et al., 2005). In psychotherapy process, therapist replaces the significant other like mother of the child by accepting the emotions of child, staying with him/her, mirroring and naming these emotions, making interpretations about unconscious desires or emotions, supporting child's self-awareness over emotions, and pointing to defenses of the child (Shirk & Burwell, 2010). All these can only be possible in the context of the therapeutic alliance between the therapist and the child. Therapeutic alliance is accepted as a core construct for self-disclosure and emotion regulation in all therapy perspectives including psychodynamic theory (Horvath & Luborsky, 1993). When child psychodynamic therapy is taken into consideration, "the central psychodynamic hypothesis then, with regard to emotion processing is that the quality of the therapist's attunement and reflection, mirroring, of the child's emotional experience, should facilitate children's awareness of their own and others' emotions, and result in improved emotion regulation" (Shirk & Burwell, 2010, pp. 198). Although child-youth literature does not include any specific study related to the therapeutic alliance and affect relationship, there are a substantial amount of adult emprical studies.

Iwakabe, Rogan, and Stalikas (2000) found that emotional expression is an improvement in adult psychotherapy which is moderated by working alliance. Clients can benefit from high arousal and expression only if there is a strong alliance between them and their therapists (Iwakabe et al., 2000). Another adult study also indicated that emotional processing is only possible and mediated or moderated by therapeutic alliance (Pos, Greenberg, & Goldman, 2003). Stronger therapeutic alliance predicts more intense emotions. According to the results of Pos and colleagues' (2003) study, emotion expression predicted outcome directly while therapeutic alliance was predicting outcome indirectly by affecting emotion expression. Other researches (Auszra, Greenberg, & Herrmann, 2013; Beutler,

Clarkin, & Bongar; 2000) supported similar results about mediation relationship between alliance, emotion expression, and psychotherapy outcome. Another research is related to childhood trauma but includes adult participants ranging 18 to 70 year old. Cloitre, Stovall-McClough, Miranda, and Chemtob (2004) searched for *Therapeutic Alliance, Negative Mood Regulation, and Treatment Outcome in Child Abuse-Related Posttraumatic Stress Disorder.* Clients who had a childhood abuse history were included in that study. According to result, "strength of the therapeutic alliance established early in treatment reliably predicted improvement in PTSD symptoms at posttreatment. Furthermore, this relationship was mediated by participants' improved capacity to regulate negative mood states" (Cloitre et al., 2004).

In contrast with these results, a study found that affect regulation and affect expression predict each other and outcome but independently of the therapeutic alliance. Watson, Mcmullen, Prosser, and Bedard (2011) conducted a study to examine the relationship among 66 clients' affect regulation capacities, emotional processing in sessions, outcome, and the working alliance throughout cognitive behavior therapy or experiential emotion-focused therapy for depression. According to results, clients' initial affect regulation predicted their early emotional processing at sessions called as initial and working phase. And, clients' affect regulation at the end of psychotherapy predicted outcome regardless of the working alliance between clients and therapists (Watson et al., 2011).

Fisher and colleagues (2016) made another research to examine the emotional experience and alliance relationship in psychodynamic therapy. One hundred-one clients of outpatient university clinic were included in the study. The results indicated that "higher therapeutic alliance scores at the end of 1 session predicted a greater emotional experience in the next session but that emotional experience did not predict subsequent levels of the alliance. The results provided evidence of reciprocal prediction in which a previous emotional experience predicted a subsequent change in functioning and vice versa. Finally, the alliance predicted emotional experience, which, in turn, predicted functioning; hence, alliance strength indirectly predicted clients' level of functioning" (Fisher et al.,

2016, pp.1). Thus, the higher therapeutic alliance score predicts the deeper emotional experience throughout psychotherapy (Fisher et al., 2016). There is another study investigated the affect experiencing (AE) of clients with major depressive disorder and association between affect experiencing, alliance, and outcome in short term dynamic therapy process (Town, Salvadori, Falkenström, Bradley & Hardy, 2017). Result of the study is more complex and showed that "higher AE mostly predicted higher client-rated alliance across participants but typically not vice versa; higher AE predicted higher therapist-rated alliance and in both 'recovered' cases higher therapist-rated alliance predicted higher AE" (Town et al., 2017, pp.154).

Lastly, Mackay, Barkham, Stiles, and Goldfried (2002) investigated a study related to emotion arousal of clients in cognitive behavioral therapy or in psychodynamic-interpersonal therapy. Results showed that cognitive therapy sessions were including more pleasant comparing to psychodynamic ones. However, the interesting result is that within sessions, emotional arousal of clients in cognitive therapy was U shape while clients in psychodynamic therapy were showing opposite of it. Clients experience increasing stress in sessions while they were confronted with difficult material but left with less stress by trusting therapeutic alliance (Mackay et al., 2002). In this regard, therapeutic alliance and affect regulation should be examined in process research in psychodynamic therapy (Shirk & Burwell, 2010).

### 1.2.3. Measurement of Affect Throughout Play in Child Psychotherapy

Affect expression and affect regulation are common concepts in assessment which are mostly from adult psychotherapy. Like in therapeutic alliance, there are both self-report measures (PANAS-C; Laurent et al. 1999; PANAS-C-P; Ebesutani, Okamura, Higa-McMillan, & Chorpita, 2011; ERC; Shields & Cicchetti, 1997) and observer coding systems. Besides self-reports, as stated above play is accepted as children's way of communication (Shirk & Burwell, 2010). Thus, instead of taking verbally or written self-report to young

ages children it is more reflective to code their play sessions or play assessments by an observer.

In this regard, there are some assessment tools to evaluate children's play which are; Play Therapy Observation Instrument (PTOI; Howe & Silvern, 1981), Affect in Play Scale (APS; Russ, 1987), NOVA Assessment of Psychotherapy (NAP; Faust & Burns, 1991), Trauma Play Scale (TPS; Findling, Bratton & Henson, 2006), and Children's Play Therapy Instrument (CPTI; Kernberg, Chazan & Normandin, 1998). PTOI is a measurement including 13 items related to play session of a child rating by an observer. Raters watch the play segments in short parts and point the frequency of behaviors in accordance with different subscales namely social inadequacy, use of phantasy in play, and emotional discomfort (Howe & Silvern, 1981). On the other hand, Affect in Play Scale focuses more on emotional expression than PTOI. In that measurement, there is a pretend play protocol with puppets and blocks given to a child. Then, the play of child is recorded. Videotaped play segments are coded according to organization of play, phantasy investment, and emotion types (happiness, aggression, sadness, etc.). APS is accepted as a measure which assesses affective and cognitive parts of play (Russ, 1987). NOVA Assessment of Psychotherapy (NAP) is another psychotherapy instrument which examines several concepts based on the relationship between child and therapist in play. Rater scores videotaped play session according to child verbal and nonverbal messages, therapist facilitating and therapist channeling behaviors. The affect related part of NAP is that coder scores child's valence of emotion expression and aggressive behavior (Faust & Burns, 1991). Findling and colleagues (2006) developed the Trauma Play Scale with its' five subscales related to posttraumatic play of children. This scale is also scored by an observer. The rater watches videotaped play session and gives points from five points likert scale to each item. Items are related to several domains; "intense play, repetitive play, play disruptions, avoidant play behavior, and negative affect" (Findling et al., 2006, pp.7). The TPS has good inter-rater reliability, intra-rater reliability, and discriminant validity. However, for affect

evaluation and measurement, it is limited because it only includes item related to lack of joy and negative emotions in play sessions.

In addition to all these measurements, there is an instrument which is more comprehensive compared to others. Children's Play Therapy Instrument (CPTI; Kernberg et al., 1998) was developed to examine child's play in accordance with psychodynamic constructs. It is one of the detailed play instruments in child psychotherapy by making micro analysis under several main dimensions. CPTI has an observer coding system like others. Play session of child is recorded than videotaped of play segments is coded by an observer. Coding includes descriptives (play type, facilitation, and inhibition of child), sphere (child's play area), affect (overall hedonic tone, spectrum, regulation, transition, and appropriateness of affective tone; specific affects like anger, fear, pleasure, sadness), cognition (level, stability, and style of representation) language in play, social level (alone, reciprocal or cooperative), and functional level (awareness and adaptive/conflicted/polarized/disorganize level of child) composites (Kernberg et al., 1998). Thus, CPTI has many advantages to use and it provides an assessment of child's play from verbal and nonverbal sides (Tessier et al., 2006). In this study, CPTI will be used for affect expression and affect regulation coding, because it is an observer form with high reliability and validity scores. Cohen, Chazan, Lerner, and Maimon (2010) examined traumatic play of children with Children's Play Therapy Instrument–Adaptation for Terror Research (CPTI-ATR). Results showed that CPTI can differentiate traumatic play from normal play (Cohen et al., 2010).

### 1.3. THE CURRENT STUDY

Building on all these theoretical and empirical literature on therapeutic alliance and affect as stated above, the purpose of the study is to examine the relation between these two constructs. While there is a substantial body of research investigating the therapeutic alliance, affect expression, and affect regulation separately; there is not any specific research focusing on therapeutic

alliance and affect relation in child psychodynamic therapy. Although studies supported that capacity of affect regulation develops in play, what supports or develop with that improvement in play therapy is not clear yet (Halfon et al., 2016b).

In psychodynamic child therapy, relationship between the therapist and the child is essential like mother-child relation for affect expression and affect regulation of the child. Therapeutic alliance is another bond which is similar with the bond between the mother and the child. It is known that mother-child relationship has an impact on affect expression and regulation capacity of children. Children's affect expression and regulation ways and competencies are determined by the quality of relationship they are in. If the therapeutic alliance is also considered a type of secure relationship, it can be hypothetically suggested that the affect arousal-expression and regulation in the play sessions is predicted by the therapeutic alliance in that play sessions.

Moreover, adult literature includes several studies related to that topic, however in child literature there is not any study searched for that. Because children use play as a way of communication, generally they express their emotions in play. So, in this study affect expression and affect regulation will be examined in the longest play segments while therapeutic alliance will be measured throughout all play session. The findings of the current study contributed to limited child psychodynamic process research literature.

In this regard, this present study aims to test whether;

1. Therapeutic alliance positively predicts the variety of children's affect over the course of treatment.
2. Therapeutic alliance predicts the intensity of children's affect over the course of treatment.

   2a) Therapeutic alliance negatively predicts the intensity of children's anger over the course of treatment.

   2b) Therapeutic alliance positively predicts the intensity of children's anxiety over the course of treatment.

2c) Therapeutic alliance positively predicts the intensity of children's sadness over the course of treatment.

2d) Therapeutic alliance positively predicts the intensity of children's pleasure over the course of treatment.

3. Therapeutic alliance positively predicts children's affect regulation over the course of treatment.

# CHAPTER 2
# METHOD

## 2.1. DATA

The data of this study is obtained from the Istanbul Bilgi University Psychotherapy Research Laboratory, which provides low-cost outpatient psychodynamic psychotherapy for children. Therapy and research center is located in university campus which has referrals made by parents, children themselves or by mental health, medical, and child welfare professionals. The parents and the children were interviewed by a licensed child-adolescent clinical psychologist in order to determine whether the clients fit the inclusion criteria of Bilgi University Psychological Counseling Center (BUPCM) protocol. Parents sign two separate forms which include informed consent for research and approval for recording of the sessions. The approval of this study was provided by Istanbul Bilgi University Ethics Committee.

## 2.2. PARTICIPANTS

### 2.2.1. Children

As a screening procedure children were accepted to clinic if they meet the inclusion criteria; between 3-11 years old, no psychotic symptoms, no significant developmental delays, no significant risk of suicide attempts, and no drug abuse. Participants of the current study will 131 children (56.5 % male and 43.5 % female) who are clients between the fall 2014 and spring 2017. Participants who give permission to record their sessions were included. Istanbul Bilgi University Ethics Committee provided an approval for the current research. Ages of the participants were ranging from 3 to 11 (15.2 % of the children were 3-5; 28.3 % of the children were 6-7; 29 % of the children were 8-9; and 27.5 % of the children were 10-11). Referral problems of the children were most frequently

behavioral problems such as rule-breaking and aggressive acts (43.5 %), followed by anxiety and depressive problems (18.4 %), school-related problems (17.6 %), social problems (11.4 %) and somatic complaints (6.1 %). Demographic characteristics of the sample are presented in Table 2.1.

**Table 2.1.** Demographic Characteristics of the Sample (N = 131).

| **Age (years):** | *N* (%) |
|---|---|
| 3-5 years old | 20 (15.2) |
| 6-7 years old | 37 (28.3) |
| 8-9 years old | 38 (29) |
| 10-11 years old | 36 (27.5) |
| Mean (*SD*) | 6.92 (2.05) |
| Median | 7.00 |
| **Gender:** | *N* (%) |
| Female | 57 (43.5) |
| Male | 74 (56.5) |
| **Reason for Referral:** | *N* (%) |
| Rule-breaking and aggressive acts | 57 (43.5) |
| Anxiety and depressive complaints/problems | 24 (18.4) |
| School-related problems | 23 (17.6) |
| Social problems | 15 (11.4) |
| Somatic Complaints | 8 (6.1) |
| Other | 4 (3) |
| **Clinical Characteristics: CBCL** | *N* (%) |
| Internalizing – Clinical | 19 (14.5) |
| Externalizing – Clinical | 20 (15.3) |
| Comorbid | 41 (31.3) |
| Non-clinical range | 51 (38.9) |

***Notes***. CBCL = The Child Behavior Checklist Cutoff criteria for CBCL = T score ≤ 59: Non-clinical, 60 ≤ T score ≤ 63: Borderline, T score ≥ 64 Clinical (Achenbach, 1991). Gender was dummy coded as (0 = female, 1 = male).

### 2.2.2. Therapists

The therapists were 40 clinicians who were second and third-year students at Istanbul Bilgi University clinical psychology master program. They were continuing their clinical practicum under licensed psychodynamic supervisors with minimum 10 year of experience. Each therapist had average 5 clients throughout the practicum year. In the same year, the therapists took 4 hours of supervision per a week (1-hour individual and 3-hour as a group).

### 2.2.3. Treatment

Although the treatment process is not manualized, there are several steps that each therapist follows. Sessions start with parent interviews, then mother-child / father-child dyadic play observations, and child only sessions. All therapists implement child-oriented and psychodynamic psychotherapy techniques even though there are personal differences. In general, therapist accompanies and invites child to explore his/her inner self throughout play and talk. Instead of directing the child, therapist encourages the child's to reflect his/her feelings, ideas, needs, wishes, defenses, behaviors, patterns. Then therapist makes interpretations and works through these materials based on the relationship between two of them. Psychodynamic play therapy sessions continue once a week for 45 minutes. Treatments are conducted in play rooms which are equipped with cameras and microphones to record sessions.

## 2.3. MEASURES

### 2.3.1. Therapy Process Observational Coding System-Alliance (TPOCS-A)

Therapy Process Observational Coding System-Alliance scale (TPOCS-A; McLeod & Weisz, 2005) is a measure which evaluates the quality of therapeutic alliance between child and therapist. Sessions and transcripts are transmitted to independent observer coders. Observer coders are also student at master program

who took the training for coding system. Then, coders watch entire recorded play therapy session. Coders point 9 items with 6-point likert scale ranging from 0 to 5 (0 = not at all, 2-3 = somewhat, 5 = great deal). The evaluation of the quality of therapeutic alliance items are made by coder according to frequency and intensity for 1, 2, 3, 7, 8, 9. On the other hand, item 4, 5, 6 are evaluated based on frequency only. The items are; "1)…indicate that s/he experiences the therapist as understanding and/or supporting?, 2) …act in a hostile, critical, or defensive manner toward the therapist?, 3) …demonstrate positive affect toward the therapist?, 4) …share his/her experience with the therapist?, 5) …appear uncomfortable when interacting with the therapist?, 6) …appear anxious or uncomfortable interacting with one another?, 7) …use therapeutic tasks to make changes outside the session?, 8) …not comply with therapeutic tasks?, 9) …work together equally on therapeutic tasks?"(McLeod, 2005). In the current study, TPOCS-A used as total score with the exclusion of item 7 (children use therapeutic tasks to make changes outside the session). The reason behind that exclusion is that in psychodynamic psychotherapy therapist does not use homework like in cognitive behavioral therapy. Thus, children rarely talk or play about therapy tasks which cause outside changes. Because the item is generally taking 0 point, it is excluded from the analysis of data.

Psychometric properties of TPOCS-A are studied and found adequate. It has adequate inter-rater reliability (ICC > 0.40; M = 0.59, SD = 0.10) and excellent internal consistency ($\alpha = 0.95$). While examining validity of TPOCS-A McLeod and Weisz (2005) measured the correlation between TASC self-report and TPOCS-A. Then, results indicated that convergent validity of scale is ranging from .48 to .53 which is adequate (McLeod & Weisz, 2005).

TPOCS-A was translated into Turkish and used in a thesis study by Özsoy (2018). Manual was also translated by Özsoy with the consultation of Bryce D. McLeod and Sibel Halfon. Then, undergraduate psychology and clinical psychology students coded 179 psychodynamic play therapy sessions which belongs to 49 children. After, coders achieved enough inter-rater reliability

(ICC=.70), they were certified and started to code real data. In translation study, 65 % of the sessions were double-coded and the ICC was 0.70- 1.

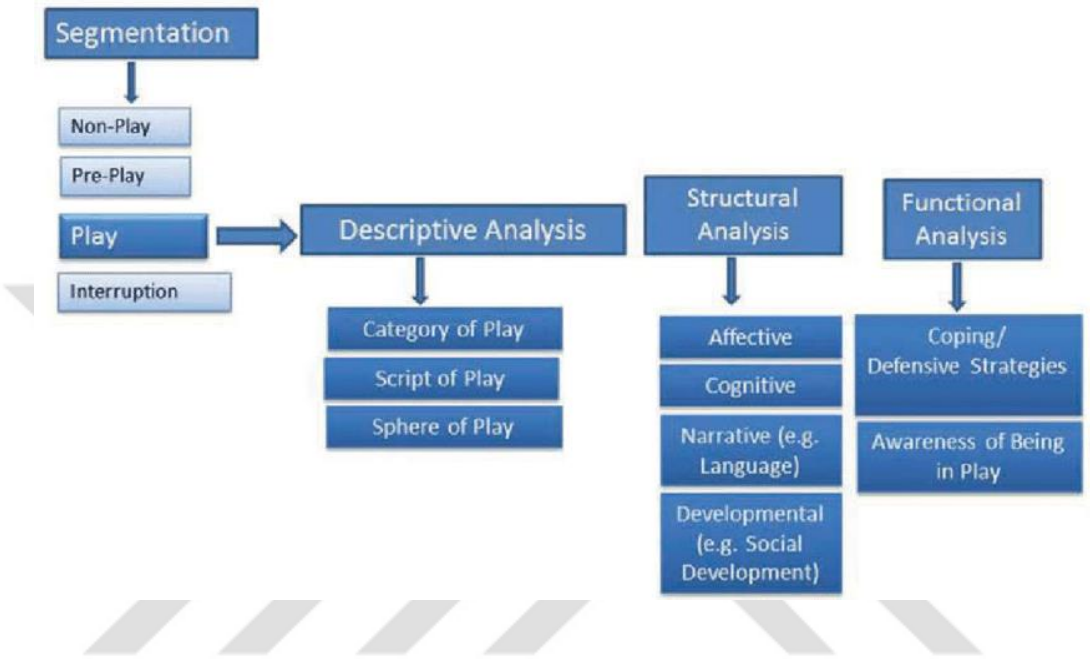
In the current study, coders followed the same training and reliability process. After they completed pilot training videos with enough inter-rater reliability which is over .70, they started to code sessions as a pair. Mean scores of pair coding are used in analysis if the coding were reliable. Forty-five % of the data was double coded, and then raters started to code individually because the inter-rater reliabilities (ICC) were ranged from 0.70 to 1 which is good to excellent ($M$ = .91; $SD$ = .06). The measure provides good internal consistency ($\alpha$ = .78).

### 2.3.2. Children's Play Therapy Instrument (CPTI)

Children's Play Therapy Instrument (CPTI; Kernberg et al., 1998) is an assessment tool which examines children's play in several levels. In first level, play activity is segmented into pre-play, play activity, non-play, or interruption. Then the longest play segment is coded. Pre-play segments involve preparation for play activity like choosing and exploring toys. Play segments includes obvious engagement to an activity. Non-play segments can be talking parts of the session or child may refuse to play, drink/eat something. Interruption is a segment which child left the room during session. The reason behind leaving is not important, child may go to the toilet, want to tell/show something to caregiver, and refuse to stay with the therapist. After the longest play segment is specified, it is analyzed according to descriptives (play type, facilitation, and inhibition of child), sphere (child's play area), affect (overall hedonic tone, spectrum, regulation, transition, and appropriateness of affective tone; specific affects like anger, fear, pleasure, sadness), cognition (level, stability, and style of representation) language in play, social level (alone, reciprocal or cooperative), functional level (awareness and adaptive/ conflicted/ polarized/ disorganize level of child). These categories were coded 5-point likert scale ranging from 1 to 5 or categorical (like play type and segment type). With these analyses, child's play activity will be measured based

on various components. Figure 2.1. shows schema of CPTI coding system as summary.

**Figure 2.1.** "Children's Play Therapy Instrument (CPTI)" (Halfon, 2017, pp.224)




Affect Components includes overall hedonic tone, spectrum, regulation, transition, appropriateness of affective tone, and affect types. For overall hedonic tone, rater scores child's pleasurable involvement in playing ranging from obvious pleasure to overt distress. If the play is less conflictual and more fulfilling, it is expected that the child expresses more pleasure. While overt distress took 1 point; child gets 2 for sober tone; he/she gets 3 point for neutral interest; pleasurable interest equal to 4 point; and he/she gets 5 point for obvious pleasure.

Spectrum is about variety of emotion which emerges during play. Rater can give 1 point to constricted play with no affect/just one; can give 2 points as narrow with 2-3 affect types; can give 3 points as medium with 4 affect types; can give 4 points as wide with 5 affect types; or can give 5 point to very wide affects of 5 or more affect types. The variety of emotions is essential. Thus, the rater should be careful about non-verbal affect. For instance; non-verbal expression (crying at play) is as important as affects which are expressed verbally like "I am sad now".

In CPTI, rater scores not only affect expression but also affect regulation. Besides first expression codes, rater codes regulation and transition subheadings under affective component. Regulation and modulation of affect is a code which examines child's capacity to cope with difficult emotions emerging in play. After child expressed an intense affect, whether he/she can control that affect and calm down or he/she stuck that affect. Regulation is also coded based on 5-point likert scale system ranging from 1 to 5 (1 = very rigid, 2 = rigid, 3 = medium, 4 = flexible, 5 = very flexible). Child gets 1 point if he/she cannot calm down during emotional arousal and shows extreme feelings like temper tantrum. However, he/she gets 5 points if he/she has full control over intense feelings emerging in play. It is critical that whether child can continue to play or intense emotions end in interruptions. In addition to regulation, it is measured that child's capacity of transition between affective states throughout play. Child takes point according to whether he/she jumps one feeling to other or shows a coherent structure with affects following each other. In transition coding, rater can give 5 points (1 = always abrupt, 2 = abrupt, 3 = fluctuates, 4 = smooth, 5 = always smooth) to how the child moves one emotion to another. Child gets 1 point if he/she jumps manically from one emotion to other; gets 2 points if he/she jumps one emotion to other but with considerably amount of time in one emotion; gets 3 points even though child can stay in emotions but there is still a fluctuation; gets 4 points if there is more coherent narrative about following emotions; gets 5 points if emotions easily followed each other in coherent structure. Appropriateness is about consistency between child's experienced affect and play narrative at that time. If the child expresses always appropriate affect to the content, he/she gets 5. On the other side never appropriate expression in general means 1 point.

Lastly, specific affect types are also coded in affective component of play which are; anger-aggression, anxiety-fear, happiness-pleasure, sadness-hurt. For instance; if child uses these affects just as non-personalized reference, he/she gets 1 point; uses personalized reference to affect, he/she gets 2; uses current experience in play, he/she gets 3; uses stronger statement or experience, he/she gets 4; uses strong statement with strong experiencing, he/she gets 5 points. For

instance; if a child points a knife and just said that “Here it is a knife” it is counted as reference to aggressive content without personalization so gets 1 point only at anger expression. However, if the theme and expression turn into “I will cut you” then he/she gets 5 point. The child gets 0 point if the affect type is not at all at play segment (Kernberg, Chazan & Normandin, 1998).

In the current study, one composite score which is affect regulation is used with relevant parts of the scores. Affect regulation composite scores calculated by averaging Regulation, Transition, and Appropriateness codes. Affect regulation composite showed a good internal consistency ($\alpha$ = .70; $M$ = 10.6; $SD$ = 1.64). Moreover, affect expression is evaluated by both looking at the spectrum (variety of the affects that child expressed) and affect types (the intensity of affect that child expressed).

CPTI was translated and adapted to Turkish by Asst. Prof. Sibel Halfon who received the training from Chazan. The adaptation of CPTI was conducted and the reliability results varied between .75 and .97, suggesting good reliability for all subscales (Halfon, 2017). Then, Halfon give training to her laboratory assistants who are independent raters. 10 practice play session were coded until the team get adequate ICC of 0.70. After they were certified with enough reliability, raters started to code real data as a pair. Sessions in this study were coded by 15 coders. Pairs of independent coders reached good to excellent ICC scores (.76–1) in sessions ($M$ = .95; $SD$ = .06).

## 2.4. PROCEDURE

After parents applied to Psychological Counseling Center of Istanbul Bilgi University, first interview is made by licensed psychologist of clinic in order to decide whether they fit the inclusion criteria or not. If the decision is positive, the clinician asks parents to consent about research process of children beside the therapy. Parents can give permission to research or not voluntarily. Then, if the consent form was approved by the parents, it includes video and audio recording

of sessions as well as intake and termination implications. After implementation therapy process starts.

Psychotherapy sessions with 131 children are randomly chosen from sessions 1-10, 11-20, 21-30, 31-40, …, 91-100 in each psychotherapy process. First chosen session from the 1-10 interval should be the first child-therapist session. Then others are randomly chosen like 21, 31, 41, …, 101. In the present sample ($N$ = 491), psychotherapy process of children ranged from 3 session to 101 session ($M$ = 22.99, $SD$ = 18,79). There is only one selecting criterion that session should be a play session which child and therapist only are in the room. These selected sessions were transcribed by psychology students. Then, transcribed play sessions are coded by reliable raters using Therapy Process Observational Coding System-Alliance Scale (TPOCS–A), and Children's Play Therapy Instrument (CPTI) independently. Selected session is the same for TPOCS-A and CPTI but sessions are coded by different coding teams for different constructs. Timepoints which are coded sessions belonging to children are ranging from 1 to 11 with $M$ = 3.7; $SD$ = 2.04. TPOCS-A coders use the whole session which is 45 minutes on average per session. CPTI sessions were coded based on the longest play segments which is ranged from 3.5 to 58 minutes $M$ = 26.06; $SD$ = 11.21. All coding are entered into SPSS (IBM Statistics 20) and prepared for analysis.

# CHAPTER 3
# RESULTS

## 3.1. DATA ANALYSIS

In our data psychotherapy sessions ($N$ = 491) were nested within clients ($N$ =131) who were nested within therapists ($N$ =40). Therefore, we used a multilevel modeling approach using MLwin Version 3 (Rasbash, Steele, Browne, & Prosser, 2014).

## 3.2. RESULTS

Means, standard deviations and intercorrelations of the variables are investigated in Table 3.1. The results showed that the age was associated with therapeutic alliance and anger expression. Older children had higher therapeutic alliance score than younger ones. Therapeutic alliance was found significantly correlated with all other variables (age, pretreatment problem, spectrum, anger expression, anxiety expression, sadness expression, pleasure expression, and affect regulation) except gender. While there is a significant positive association between therapeutic alliance and anxiety, sadness, pleasure; there is a negative significant correlation between the alliance and anger expression of children in play.

In order to demonstrate variance explained by therapeutic alliance, simple regressions were calculated. In the equation in which spectrum of affect is regressed on therapeutic alliance, the $R^2$ was 0.02, F(1,489) = 10.46, $p$ = 0.001. In the equation in which intensity of anger expression is regressed on therapeutic alliance, the $R^2$ was 0.05, F(1,489) = 26.9, $p < 0.001$. In the equation in which intensity of anxiety expression is regressed on therapeutic alliance, the $R^2$ was 0.01, F(1,489) = 4.6, $p$ = 0.033. In the equation in which intensity of sadness expression is regressed on therapeutic alliance, the $R^2$ was 0.02, F(1,489) = 11.6, $p$ = 0.001. In the equation in which intensity of pleasure expression is regressed on therapeutic alliance, the $R^2$ was 0.02, F(1,489) = 9.55, $p$ = 0.002. In the

equation in which affect regulation is regressed on therapeutic alliance, the $R^2$ was 0.10, F(1,489) = 56.90, $p < 0.001$.

Since multiple clients were treated by the same therapists, we investigated the degree of interdependency due to therapists. We used two-level (sessions nested within clients) and three level (sessions nested within clients nested within therapists) "empty" multilevel models, where spectrum of affect, anger, anxiety, sadness, pleasure, and affect regulation were entered as the dependent variable with no predictor variables.

For the variety of affect (spectrum), the therapist level ICC was 0, *ns.*, which showed that therapists accounted for about 0% of the variance in spectrum, suggesting that the variance in the session measures is not attributable to differences among therapists. In contrast, the between client ICC was 0.15, $p<$ 0.008, accounting for 18% of the variance in spectrum, which is significant and suggests that a two-level model is appropriate and enough. On the other hand, for anger/aggressiveness expression, the therapist level ICC was found as 0.06, *ns.*, which showed that therapists accounted for about 15 % of the variance in anger, suggesting that the variance in the session measures is not attributable to differences between therapists. In contrast, the between client ICC was 0.26, $p<$ 0.008, accounting for 64 % of the variance in anger, which is significant. But, it still suggests that a two-level model is appropriate. However, when it comes to anxiety/fear expression, the therapist level ICC was 0.21, $p<$ 0.008, which showed that therapists accounted for about 41 % of the variance in anxiety, suggesting that the variance in the session measures is attributable to differences between therapists. In contrast, the between client ICC was 0.06, *ns.*, accounting for 13 % of the variance in anxiety. Because there is a variance in therapist level, this model requires a three-level model is appropriate. As another dependent variable pleasure expression, the therapist level ICC was 0, *ns.*, which showed that therapists accounted for about 0% of the variance in pleasure, suggesting that the variance in the session measures is not attributable to differences between therapists. In contrast, the between client ICC was 0.16, $p<$ 0.008, accounting for 22 % of the variance in pleasure, which is significant and supports that a two-level

model is appropriate. As a final affect type sadness/hurt expression, the therapist level ICC was 0.05, *ns.*, which showed that therapists accounted for about 10 % of the variance in sadness, suggesting that the variance in the session measures is not attributable to differences between therapists. In contrast, the between client ICC was 0.18, $p < 0.008$, accounting for 33 % of the variance in sadness, which is significant and suggests that a two-level model is enough. Lastly for affect regulation, the therapist level ICC was 0.16, $p < 0.008$, which showed that therapists accounted for about 5 % of the variance in anxiety, suggesting that the variance in the session measures is attributable to differences between therapists. In contrast, the between client ICC was 0.16, *ns.*, accounting for 5 % of the variance in anxiety. Because not all variance is attributable to session-level variables. Therefore, we used only three-level models because some of our dependent variables (anxiety expression, affect regulation) had significant variance at the therapist level.

Next, we ran six separate mixed effects multilevel models with maximum likelihood (ML) estimation to analyze the data that nests change in time within the clients within therapists. In each model, therapeutic alliance was the predictor and we controlled for gender, age, and pre-treatment problem levels. All variables were grand mean centered. Because we tested six models with the same predictors, in order to reduce the probability of finding statistical differences due to chance Bonferroni correction was applied, considering a significance level equal or lower to 0.0083.

In the first model where affect spectrum was the dependent variable, therapeutic alliance significantly and positively predicted change in affect spectrum and none of the other variables were significant. In the second model where the intensity of anger/aggression expression was the dependent variable, therapeutic alliance significantly and negatively predicted change in anger expression. Also, gender which is one of controlling variable is found significant for anger/aggression expression. Boys express more anger/aggression than girls in play. In the third model where the intensity of anxiety was the dependent variable, therapeutic alliance positively but not significantly (at trend level) predicted

change in anxiety expression and none of the other variables were significant. In the fourth model where the intensity of sadness expression was the dependent variable, therapeutic alliance significantly and positively predicted change in sadness and none of the other variables were significant. In the fifth model where the intensity of pleasure expression was the dependent variable, therapeutic alliance significantly and positively predicted change in pleasure and none of the other variables were significant. In the last model where affect regulation was the dependent variable, therapeutic alliance significantly and positively predicted change in affect regulation and none of the other variables were significant. (please see Table 3.2.)

**Table 3.1.** Mean, Standard Deviation and Inter-Correlations Among Variables Per Sessions

| Variables | *M* | *SD* | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (1) Age | 6.92 | 1.99 | - | | | | | | | | | |
| (2) Gender | .55 | .49 | - .06 | - | | | | | | | | |
| (3)Pre_Treatment Problem | 56.68 | 24.88 | -.22** | .06 | - | | | | | | | |
| (4) Therapeutic Alliance | 28.12 | 6.07 | .26** | -.27 | -.12** | - | | | | | | |
| (5) Spectrum (Diversity) | 3.51 | 1.09 | .01 | .01 | -.07 | .14** | - | | | | | |
| (6)Anger | 2.47 | 1.55 | -.16** | -.28** | .04 | -.23** | .35** | - | | | | |
| (7)Anxiety | 2.16 | 1.39 | -.03 | -.02 | -.01 | .10* | .32** | .16** | - | | | |
| (8)Sadness | 1.43 | 1.34 | .04 | -.03 | .04 | .15** | .36** | .14** | -.30 | - | | |
| (9)Pleasure | 2.74 | 1.17 | .08 | -.05 | -.08 | .14** | .31** | .05 | -.15 | .15** | - | |
| (10)Affect Regulation | 3.51 | .55 | .09 | -.09* | -.12** | .32** | .07 | -.30** | -.24** | .20** | .04 | - |

*Notes.* Gender was dummy coded as (0 = female, 1 = male).

$**p < .01$.

$*p < .05$.

**Table 3.2.** Multilevel Models Predicting Spectrum (Diversity), Intensity of Affects, and Affect Regulation by Age, Gender, Pretreatment Problem, and Therapeutic Alliance

| | Spectrum(Diversity) | | | AngerEx. | | | AnxietyEx. | | | SadnessEx. | | | PleasureEx. | | | AR | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Predictors | *β* | *SE* | *t*-Ratio | *β* | *SE* | *t*-Ratio | *β* | *SE* | *t*-Ratio | *β* | *SE* | *t*-Ratio | *β* | *SE* | *t*-Ratio | *β* | *SE* | *t*-Ratio |
| Age ($\beta_{00}$) | -0.014 | 0.031 | -0.45 | -0.084 | 0.043 | -1.95 | -0.073 | 0.033 | -2.21 | 0.043 | 0.039 | 1.10 | 0.007 | 0.033 | 0.21 | 0.009 | 0.014 | 0.64 |
| Gender ($\beta_{01}$) | 0.144 | 0.124 | 1.16 | 0.831 | 0.175 | 4.74* | 0.230 | 0.137 | 1.67 | 0.040 | 0.158 | 0.25 | -0.003 | 0.133 | -0.02 | -0.050 | 0.057 | -0.87 |
| Pre. Prob. ($\beta_{02}$) | -0.003 | 0.002 | -1.5 | -0.002 | 0.004 | -0.5 | -0.003 | 0.003 | -1 | 0.004 | 0.003 | 1.33 | -0.002 | 0.003 | -0.6 | -0.001 | 0.001 | -1 |
| TA ($\beta_{03}$) | 0.031 | 0.009 | 3.44* | -0.032 | 0.012 | -2.66* | 0.026 | 0.011 | 2.36 | 0.032 | 0.011 | 2.90* | 0.029 | 0.010 | 2.9* | 0.026 | 0.004 | 6.5* |

*Notes*. Pre. Prob. = Pretreatment Problem; TA = Therapeutic Alliance; AngerEx. = Anger Expression; AnxietyEx. = Anxiety Expression; SadnessEx. = Sadness Expression; PleasureEx. = Pleasure Expression; AR = Affect Regulation

Sex was dummy coded as (0 = female, 1 = male).

*$p < 0.008$.

# CHAPTER 4
# DISCUSSION

The purpose of this study was to explore the relationship of therapeutic alliance with affect expression and affect regulation. Affect expression was discussed as both diversity or variety of affects and intensity of them. In addition to affect expression, affect regulation is handled by computing composite score with regulation, transition, and appropriateness codes of CPTI. Therapeutic alliance scores of children were coded with TPOCS-A. Then, the collected data was analyzed with multilevel modeling. Strong mediators such as age, gender, and pretreatment problems which were found significant on studies related to therapeutic alliance and affect regulation were included in the model of analysis as control variables. Overall, the results of the current study showed that in psychodynamic play sessions therapeutic alliance positively predicts the spectrum of affect; the alliance score also positively predicts the intensity of sadness and pleasure; however therapeutic alliance negatively predicts the intensity of anger; the hypothesis about the positive prediction relationship of therapeutic alliance and intensity of anxiety was not significant; lastly affect regulation of children is positively predicted by therapeutic alliance as expected. In this section, hypotheses which are significant or non-significant will be discussed in detail.

## 4.1. HYPOTHESES

From the perspective of psychodynamic theory, the therapist addresses children's unpleasant affect and defenses which suppress these affects (Hoffman, Rice, & Prout, 2016). Considering the psychodynamic play therapy, the results of this study can be explained as follows; increased variety and depth of affective characteristics of play and expression of avoided affects. Firstly, children's expression of the variety and depth of affective components of play increases based on the strengthening of therapeutic alliance. Play brings spontaneity and comfort for the child to express a wide variety of emotions. Moreover, play is a

secure place which provides deepening on affects and regulating them (Hoffman & Russ, 2012). Results showed that children express more and deeper affects within the context where there is a high therapeutic alliance (Hoffman & Russ, 2012).

Another keynote is related to the power of therapeutic alliance on suppressed emotions. While the alliance between the therapist and the child strengthens, the child starts to express avoided emotions. The child brings core avoided affects such as sadness, hurt, pain, shame, guilt, fear, and anxiety to surface. Decreasing the intensity of anger/aggression also opens space for other emotions. Because anger is secondary emotions it covers all other emotions and expressed like hostility with inappropriate intensity. Therapeutic alliance creates safe, containing place for children to express and work on their avoided, deep emotions (Preter et al., 2018). Thus, the more therapeutic alliance predicts more variety of affect, more intense affects (anxiety, sadness, and pleasure) in play, and higher affect regulation. Expression of intense affects in play is not like symptom increase. In fact, the symptoms will decrease with this intense expression of real feelings in play. After all, these expressions of avoided affects in a secure relationship provide affect regulation (Preter et al., 2018).

### 4.1.1. The Associations between Therapeutic Alliance and Spectrum in Play

One of the aims of the current study was to examine the relationship between therapeutic alliance and spectrum in psychodynamic play therapy. The analysis supported the hypothesis; therapeutic alliance in a play session positively predicts the variety of affect in that play session of child psychodynamic therapy. The more child has higher therapeutic alliance score the more he/she expresses different affects in that session. Although there is not any children study related to the prediction relationship between therapeutic alliance and variety of affect expression, there is a substantial body of theoretical background about it. A child can express the variety of emotions when he/she was in a relationship including reflection and mirroring. Child literature has studies which search the concepts

separately as therapeutic alliance or affect expression. In non-clinical toddler sample, the exhibited emotion is not correlated with maternal involvement at early ages. However if the child develops insecure attachment without a mother involved in the long run, it restricts the variety of affect the child expresses. Expression of emotions is related to context and the significant other's approach to the child (Roque & Verissimo, 2011). In clinical population, it is known that children with internalizing or externalizing problems project limited variety of affect (Halfon, 2017). Children with externalizing problems generally express negative affect like anger and hostility while internalizing children shows more negative emotions but with less arousal (Halfon et al., 2016b). Children with post-traumatic stress disorder show constricted affect in play (Chazan & Cohen, 2010). Throughout the play and psychotherapy process, child and therapist create a bond and alliance to repair the child's internal working models. If the therapist shows attunement and achieves to develop a good therapeutic alliance, it facilitates the child to experience more emotion and express not only his/her emotions but also others' emotions in play (Shirk & Burwell, 2010). Therefore, the therapist and techniques are essential for expression. In psychodynamic therapy and child center therapy provide non-directive play to the child (Bratton et al., 2005). Children may express more affect within the environment which includes containment, non-judgmental response, unconditional positive regard, and empathy (Bratton et al., 2005). Play also creates its' own safe environment and children express diverse emotions in play. However, children in the clinical population can achieve to play symbolically with the presence of the therapist (Chazan, 2002).

Based on all these theoretical backgrounds as stated above, results supported the expected prediction. Children learn and experience a different type of relationship which creates space to express each emotion and makes the child feel each emotion is important in that room. Within this relationship; the therapist provides a safe environment by limits, contains the child, reflects and interprets intense affects, and continue to be with the child despite problematic behaviors (Chethik, 2001; Göçek, 2017). In the current study regardless of child

internalizing or externalizing psychopathology, therapeutic alliance positively predicts the variety of affect in that play session. If therapeutic alliance between the therapist and the child is high, the child expresses a wide variety of affect. On the other hand, if the alliance is low the child expresses constricted or narrow variety of affect. The relationship between spectrum and therapeutic alliance is meaningful but in order to get detailed information the intensity of specific affect types and therapeutic alliance relationship is also discussed.

### 4.1.2. The Associations Between Therapeutic Alliance and Intensity of Affects in Play

When it comes to separate affect types and their relationship with therapeutic alliance, hypotheses vary from positive prediction to negative prediction or insignificant. Results supported the hypotheses that, therapeutic alliance negatively predicts the intensity of children's anger in play over the course of treatment; therapeutic alliance positively predicts the intensity of children's sadness in play over the course of treatment; and therapeutic alliance positively predicts the intensity of children's pleasure in play over the course of treatment. Because Bonferroni correction is applied in model analysis, the hypothesis related to anxiety expression was not found significant. According to hypothesis therapeutic alliance in a play session was expected to positively predicts the intensity of anxiety in play over the course of treatment. It is found significant but at the trend level. These findings will be discussed in detail in this part.

The explanations of these hypotheses are not separated from each. Because the reason behind the intensity of anxiety, sadness, and pleasure in play is related to decreasing of the intensity of anger. The positive prediction of therapeutic alliance on anxiety, sadness, and pleasure is meaningful with the negative prediction of anger. Because the anger decreases, other emotions find a place to express. As stated above, decreasing the intensity of anger/aggression opens space for avoided emotions. If the child expresses anger/aggression to cover other

intense affects, it is expressed inappropriately. When therapeutic alliance provides a safe containing environment to all emotions, anger decreases and the child can bring intolerable affects to the surface. These intolerable emotions generally includes sadness, hurt, pain, anxiety, fear, and guilt (Hoffman et al., 2016).

In this study, the intensity of emotions in play was assessed with CPTI. According to affect type child get a higher score if he/she uses more personal reference. Child experiences affect slightly if he/she just refers to affect content. It is accepted as moderate if there is affect with a conversational mode in play. Moreover, it is deeper if there is a strong feeling state which includes action with intense affect. For instance; if the child gives a reference like "there is a gun" there is anger expression but with low intensity. However, if he/she is attacking a toy and shouting like "I will kill you" this is the most intense expression.

To begin with anger hypothesis, the results supported the fact that therapeutic alliance in play negatively predicts the intensity of anger/aggression in play. The higher therapeutic alliance between the child and the therapist at the session means the less anger and aggression expression in play. Children with externalizing problems have difficulties to control their anger (Hoffman et al., 2016). Moreover, it is a secondary emotion which covers other suppressed emotions (Hoffman et al., 2016). Thus in child psychotherapy, it is expected from a child to control his/her extreme anger. The results of this study showed that therapeutic relationship has an effect on controlling and working the anger throughout play. Child transfers his anger from personal experiences to play based on the relationship with the therapist. The intensity of anger and aggression decreases with this transfer. In time, when the therapeutic alliance is established between the child and the therapist, the emotions under the anger begin to work. The therapist does not tell a child to behave in the right way, he/she helps the child to find the emotions that trigger this intense anxiety (Hoffman et al., 2016). As a result, the intensity of hostility and anger decreases while the relationship increases. Bizarre, destroying and very harsh themes in play start to solve and control. Although the child continues to have space for anger and expresses it, he/she starts to regulate them. In the model which tested therapeutic alliance

prediction of anger, gender is also found significant predictor. It is found that boys express more anger/aggression than girls in play.

Another hypothesis under the intensity of affects heading is related to sadness/hurt affect expression of children. The results of the current study supported that therapeutic alliance between the child and the therapist positively predicts the intensity of sadness expression. The higher therapeutic alliance score provides the more deeper sadness expression. In play children start to express deeper sadness, illness, injury, pain, and loneliness thanks to safe/containing environment and the presence of the therapist. What is meant by deeper is the use of a more personalized language. Conversations and themes in play turn from non-personalized reference to strong current experience and actions. Moreover, a child starts to work with suppressed problems throughout the play. In this process, it may bring sadness to face with all these materials and the way to the inner self. Children from clinical population hide core emotions and avoid sharing them because of several reasons. However, when the intensity of anger decreases and the child finds a safe atmosphere, they meet with their deep injuries, sadness, shame, guilt, and pain. In psychodynamic theory, these emotions are the most avoided ones and therapist should help the child to explore them in a safe relationship (Hoffman et al., 2016). For instance, children with externalizing problems deny the fragility in them. In the play, therapist makes comments behind the hostility and figures it out like by saying “The guy attacked him because maybe he was scared and hurt because she left him alone”. This confrontation and acceptance process are only possible with good therapeutic alliance, but it still includes sadness and hurt. Because these comments and confrontations take time in psychotherapy, the therapist does it when he/she can trust the relationship. Therefore, the alliance predicts the intensity of the session indirectly. In CPTI coding, sadness/hurt is more relational than other affects. When the child expresses more sadness in a more personalize way, it is sharing of the hidden agendas with the therapist. Also, sadness is important for affect regulation. Diverse spectrum of affect expression is not sufficient for affect regulation. The

child should express negative affects like sadness, anxiety, and fear (Halfon, Yılmaz, & Çavdar, 2019).

Thirdly, the intensity of children's happiness/pleasure is another affect predicted positively by therapeutic alliance. When the intolerable affects like anxiety and sadness were expressed, it creates the pleasure of expression. Results of the current study supported the hypothesis. One of the reasons behind that can be related to therapy technique and the therapist's characteristics. In general, children with externalizing or internalizing problems express more negative emotions (Butcher & Niec, 2005). Child may express more personalized pleasure when there is a good therapeutic relationship between the child and the therapist. The child finds a new place which provides to talk his/her positive sides in addition to problems. This secure and containing relationship make child to feel pleasure. In addition to therapeutic techniques, play itself is a pleasurable for a child. Play already contains spontaneity and freedom within itself. Children in the clinical population have difficulty with playing symbolically. However, based on the development of therapeutic alliance between the child and the therapist, the intensity of enjoyment increases as the play capacity of the child increases.

Lastly, another hypothesis which is related to intensity of anxiety is found nonsignificant. Although it is not significant, therapeutic alliance score of children positively predicts the anxiety expression level of children in play at trend level. There may be several reasons behind that. Children who need to psychotherapy have generally insecure attachment style. They are experiencing a new relationship which they were unused to. Intimacy may provoke anxiety. Moreover, while the variety of affects and sharing were increasing, anxiety is one of these avoided affects which can express in play more easily. When a child finds a safe place, he/she starts to share and work on his/her anxieties and fears. The reason behind the trend-level significance of hypothesis that examines the relationship between therapeutic alliance and the intensity of children's anxiety expression may be related to CPTI. In coding, anxiety and fear are less relational than sadness and pleasure. Children play fear-provoking or anxiety-provoking themes based on characters and mostly does not look for help. They create

situations which characters tries to find a way. Also, there is a significant variance at the therapist level when the expressed emotion is anxiety. Maybe, the difference between the therapist's response to anxiety keeps the significance at trend level. It can be a question for further research but hypothetically I think that some of the therapist may behave in more containing way while others provoke the conflict in play and increase the anxiety to work on.

Affect expression and therapeutic alliance literature generally focus on the intensity of emotions rather than the spectrum/diversity of affects. Although there are not any therapeutic alliance and affect expression study in child literature, there are several adult studies supporting that therapeutic alliance positively predicts the intensity of emotions the client expresses in session. It is found that the therapeutic alliance positively predicts the intensity of emotions expressed by 101 adult outpatient clients (Fisher et al., 2016). Emotion expression predicts the change in functioning level while it is predicted by therapeutic alliance in psychodynamic therapy (Fisher et al., 2016). In adult literature, there is not any clarification between affect types. It generally examines the adults' self-report about the intensity of expressed emotion in session.

Considering therapeutic alliance is simply a relationship between client and therapist, the alliance is impossible to think separated from object relation theories and attachment like all other relationships. Children learn to express emotions in relationship with maternal involvement (Roque & Verissimo, 2011). Winnicott (1965) explained the importance of emotional arousal and experiencing in session. Because the client can experience intense emotions with the presence of his/her therapist and learn to stay with these emotions by observing the therapist's ability. This situation provides containment and tolerance to deep affects (Winnicott, 1965). According to Fisher and colleagues (2016), a good therapeutic relationship enables clients to re-experience and regulate intense emotions to provide symptom relief. Clients who have difficulties to experience and share emotions have different psychopathologies. In order to symptom reduction client should express affects and it is only possible with the help of therapeutic alliance.

### 4.1.3. The Associations Between Therapeutic Alliance and Affect Regulation in Play

Based on all these affect expression hypothesis and theoretical background, significance of affect regulation hypothesis is exactly what we expected. According to results, therapeutic alliance positively predicts children's affect regulation over the course of treatment. Play has an influence on this result. Therapeutic alliance increases symbolic play capacity which increases the affect regulation (Hoffman & Russ, 2012). "Children who exhibit more imagination and affect in pretend play tend to be better divergent thinkers and to be better able to self-regulate" (Hoffman & Russ, 2012, pp.177).

Besides the pretend play capacity, therapeutic alliance creates a safe environment for children to express deep, intense emotions in play. While they express their difficult emotions, explore ways to keep with these emotions and regulate them like the therapist does in play. This practice makes them self-regulator in time. Moreover, the decrease in anger and increase in the intensity of sadness expression is also found related to affect regulation. The child can regulate affects when he/she touches each emotion that suppressed and cause symptoms. Controlling the anger and aggression does not enough for regulation (Halfon et al., 2019).

In child literature, there is not any study directly related to affect regulation and therapeutic alliance. However in adult psychotherapy literature there are several studies. In psychotherapy, the therapist tries to create a secure relationship with his/her client, but it is affected by any other issues. Owens and colleagues (2013) examined the role of therapeutic alliance in affect regulation of clients with a diagnosis of schizophrenia, schizoaffective disorder or psychosis. According to results, "insecure attachment was significantly associated with greater difficulties in regulating emotions" and "a strong therapeutic alliance was associated with fewer difficulties in regulating emotions" (Owens et al., 2013, pp.523). Siefert and Hilsenroth (2015) found that an association between fearful

insecurity and declines in therapeutic alliance while secure clients with increasing therapeutic alliance scores especially bond.

Greenberg, Auszra, and Herrmann (2007) made an analysis of emotional arousal and regulation of adult clients who has depression. Literature includes many studies about the relationship between emotional arousal in adult psychotherapy and outcome. While some of the studies found significant relation, others stated that there is not any direct relation between two variables. In this regard, Greenberg and colleagues underline the importance of emotion regulation. The expressed emotion may be regulated or underregulated or overregulated. "Rather than the degree of arousal of expressed emotions alone, it seems to be the manner in which the emotional experience is processed, once it is activated, that is important in producing emotional change" (Greenberg et al., 2007, pp. 483). Thus, the expression of affect is important for improvement but not enough. Clients need to regulate these affects in a secure relationship for recovery. The first step to regulate emotions is to realize and be aware of them. Then activated emotions can bring to sessions and work on them within the presence of a significant other. Therapists help client not to stuck on one emotion, or to disorganize through different emotions. He/she motivate the client to find more adaptive ways. Result of the study also showed that emotional expression alone does not significantly predict the outcome. On the contrary, if the client process emotion it predicts the outcome regardless of arousal frequency or intensity (Greenberg et al., 2007).

## 4.2. CLINICAL IMPLICATIONS

Findings of the study showed the importance of therapeutic alliance based on its' influence on affect expression and affect regulation. To begin with, the variety of children's affect expression is predicted by therapeutic alliance. The spectrum of affect will increase at the sessions which the alliance is better. Thus, the therapist should trust the power of relationship. He/she should clarify the limits, provide secure place to play and then should wait to work with diverse

emotion expression of the child. Instead of pushing or questioning the child to share emotions, therapist should make an investment to the relationship between them. Maybe the reason behind the effectiveness of non-directive play therapies on children's affect expression and regulation is about focusing on the alliance and following child's speed. Non- directive play therapies like psychodynamic play therapy and child-centered play therapy were found more effective for increasing children's affect expression than others such as cognitive-behavioral play therapy (Bratton et al., 2005).

Secondly, the prediction relation between therapeutic alliance and intensity of affects are important information therapist should keep in their mind in play sessions. Children with externalizing or internalizing problems express more negative emotions with a low level of affect regulation in play. Children with internalizing problems have difficulties to express intense emotions. In contrast externalizing children express intense anger/aggression, but it is not effective for regulation because they cannot express other emotions and cannot regulate anger (Butcher & Niec, 2005). The study showed that the intensity of anxiety, pleasure and sadness increase while the therapeutic alliance increases. And the intensity of hostility in play decrease while the alliance strengthens. Therefore again it is important to present and accompany the child in play. When the child trusts the relationship, he/she will express deeper affect in play like their pain, sadness, anxiety, fear, and pleasure. Lastly, it is known that clinical population have difficulties with symbolic play and affect regulation (Butcher & Niec, 2005). However, therapeutic alliance predicts not only the affect expression but also the children's regulation capacity. Therefore, the therapist should focus on the relationship and give chance to a child to regulate their emotions throughout play. It should be noted that in psychodynamic literature affect expression and working with these intense emotions were accepted as a road to recovery.

## 4.3. LIMITATIONS AND RECOMMENDATIONS FOR FURTHER RESEARCH

There were several limitations related to the current study. First of all, the analysis was made based on 491 separate session. Although sessions were chosen from different level of psychotherapies like beginning, middle phase and last sessions, the process was not included in the analysis as a variable. If the process was taking into consideration, the results may be discussed from different sides. Although it is representative to choose random sessions from beginning, middle, and end phase, it can be more meaningful to know the prediction relation throughout the process. Further research may expand the analysis with process.

When it comes to assessment of the study, the current study has strength related to scales and instruments. TPOCS-A is a scale which assessed the whole session but especially focusing the relationship between "real" child and therapist not the characters they transformed into the play, while CPTI is focusing on just a play segment of the same session and mostly characters. They have common sequence but separated parts at the same time. Therefore, the prediction relation is found between the therapeutic alliance of child and therapist in the session and the affect expression and regulation in play part of that session.

Second limitation of the study is based on the naturality of the therapy processes. Because the data consist of children's natural psychoanalytic play therapy sessions with the therapist under clinical master program, there is not any control group or several things cannot be manipulated. For instance, most of the therapists were female or length of psychotherapy changes from child to child. These limitations decrease the generalizability of the current study.

In the analysis of the current study, we used three-level models because some of our dependent variables (anxiety expression, affect regulation) had significant variance at the therapist level. This variance was not discussed in detail in this study, but it is interesting to find therapist variance only at anxiety expression and affect regulation. In this regard, future research might focus more on the therapists. The responses of the therapists when the child expresses anxiety

differ from one to another. So, micro-analysis which zooms to the therapist's differences and child's response to that differences could be interesting as a research topic. Also, therapist background and attachment security may be another topic for further studies.

Moreover, attachment security or bonding between mother-child dyad are not a variable for this study or not controlled. Although in discussion section attachment and therapeutic alliance relation is stated shortly, it would more appropriate to examine this relation at analysis. Further studies may include attachment or bonding between child and mother to get more comprehensive information. Coders can code the relationship pattern of children with their mother based on first sessions including mother-child play as a control variable.

CPTI is a very broad assessment for play therapy. And therapeutic alliance is expected to have other relationships with other composites of play. Because therapeutic alliance provides the baseline for symbolic play, it probably have an effect on other parts of play features. Further studies can investigate different subheadings of the play such as language, representation, social level or functional level of children. In the current study, the affect hypothesis and supportive results were exciting and important for quantitative child literature. On the other hand, for further studies these findings can be supported with qualitative analysis. Researchers can examine the play sessions in detail to find the similarities and differences with micro-analysis. Future studies may evaluate qualitative and quantitative analysis together.

Intensity of affects in CPTI are coded based on the observed expression without interpretation. Thus, nonverbal part of expression is not included in the analysis. Further studies may use different measurements to evaluate the intensity of affect types especially anxiety. It may be helpful to catch trill, turning child's eye away or bodily gesture. Moreover, data can be divided into children with internalizing and externalizing problems. Further analysis can use divided data for deeper analysis. Deeper analysis can be provided with increased timepoints. In this study, sessions were randomly selected from 1-10 intervals. Further studies can use mediational modelling with more frequent timepoints.

## 4.4. CONCLUSION

The study aimed to investigate the prediction relation of therapeutic alliance with affect expression and affect regulation. It is one of the preliminary studies in psychodynamic child therapy which examined this relation. In short, results showed that therapeutic alliance positively predicts (1) children's variety of affect, (2) the intensity of anxiety expression of children (at trend level significance), (3) the intensity of sadness expression of children, (4) the intensity of pleasure expression of children, (5) the children's affect regulation over the course of treatment and negatively predicts (6) the intensity of anger expression of children over the course of treatment. Results showed the importance of therapeutic alliance on affect expression and regulation regardless of the gender, age, pretreatment problems (internalizing or externalizing) of children.

## REFERENCES


Abrishami, G. F., & Warren, J. S. (2013). Therapeutic alliance and outcomes in children and adolescents served in a community mental health system. *Journal of Child and Adolescent Behaviour, 1*(2), 1-7.

Accurso, E. C., Hawley, K. M., & Garland, A. F. (2013). Psychometric properties of the Therapeutic Alliance Scale for Caregivers and Parents. *Psychological Assessment, 25*(1), 244-252.

Achenbach, T. M., & Edelbrock, C. S. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. *Monographs of the society for research in child development*, 1-82.

Ainsworth, M. D. S. (1978). *Patterns of attachment: A psychological study of the strange situation.* New York: Lawrence Erlbaum Associates.

Auszra, L., Greenberg, L. S., & Herrmann, I. (2013). Client emotional productivity-optimal client in-session emotional processing in experiential therapy. *Psychotherapy Research, 23,* 732–746.

Axline, V. (1947). *Play therapy.* Boston: Houghton Mifflin.

Barber, J. P., Khalsa, S.-R., & Sharpless, B. A. (2010). The Validity of the Alliance as a Predictor of Psychotherapy Outcome. In C. J. Muran, & J. P. Barber, *The Therapeutic Alliance* (pp. 29-43). New York-London: The Guilford Press.

Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy for depression*. New York: Guilford Press.

Beck, S.J. (1962). The Q-sort method in personality assessment and psychiatric research. *Archives of General Psychiatry, 7,* 230.

Beebe, B., Lachmann, F., Markese, S., & Bahrick, L. (2012). On the Origins of Disorganized Attachment and Internal Working Models: Paper I. A Dyadic Systems Approach. *Psychoanalytic Dialogues, 22*(2), 253–272.

Berk, E. A., Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2010). *Segmented Working Alliance Observer based measure (S-WAI-O) manual.* Unpublished training manual, Beth Israel Hospital, New York, NY.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guidebooks in clinical psychology. Guidelines for the systematic treatment of the depressed client.* New York, NY, US: Oxford University Press.

Bickman, L., Athay, M. M., Riemer, M., Lambert, E. W., Kelley, S. D., Breda, C., Andrade, A. R., (2010). *Manual of the Peabody Treatment Progress Battery* (2nd ed.). Nashville, TN: Vanderbilt University.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice* 16, 252-260.

Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-Analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36*(4), 376-390.

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association, 27*, 137-157.

Bulut, P. (2016). Affect expression and regulation in child psychotherapy: measuring affect with respect to psychopathology and tracking trends in treatment. (Unpublished master's thesis). İstanbul Bilgi University, İstanbul, Turkey.

Butcher, J.L., & Niec, L.N. (2005). Disruptive behaviors and creativity in childhood: The importance of affect regulation. *Creativity Research Journal, 17*(2-3), 181-193.

Chazan, S.E. (2002). Profiles of play: Assessing and observing structure and process in play therapy. New York, NY: Jessica Kingsley Publishers.

Chazan, S.E., & Cohen, E. (2010). Adaptive and defensive strategies in post-traumatic play of young children exposed to violent attacks. Journal of Child Psychotherapy, 36(2), 133–151

Chazan, S.E., & Wolf, J. (2002) Using the Children's Play Therapy Instrument to Measure Change in Psychotherapy: The Conflicted Player, *Journal of Infant, Child, and Adolescent Psychotherapy, 2*(3), 73-102.

Chethik, M. (2001). The play relationship and the therapeutic alliance. *Psychoanalytic Social Work, 8*, 9-20.

Chiu, A. W., Mcleod, B. D., Har, K., & Wood, J. J. (2009). Child-therapist alliance and clinical outcomes in cognitive behavioral therapy for child anxiety disorders. *Journal of Child Psychology and Psychiatry, 50*(6), 751-758.

Chu, B. C., Skriner, L. C., & Zandberg, L. J. (2014). Trajectory and predictors of alliance in cognitive behavioral therapy for youth anxiety. *Journal of Clinical Child & Adolescent Psychology, 43*(5), 721-734.

Cohen, E., Chazan, S., Lerner, M., & Maimon, E. (2010). Posttraumatic play in young children exposed to terrorism: An empirical study. *Infant Mental Health Journal, 31*(2), 159– 181.

Colson, D. B., Cornsweet, C., Murphy, T., O'Malley, F., Hyland, P. S., McParland, M., & Coyne, L. (1991). Perceived treatment difficulty and therapeutic alliance on an adolescent psychiatric hospital unit. *American Journal of Orthopsychiatry, 61*(2), 221-229.

Chethik, M. (2003). *Techniques of child therapy* (2nd ed.). New York, NY: Guilford Press.

Cloitre, M., Chase Stovall-McClough, K., Miranda, R., & Chemtob, C. M. (2004). Therapeutic Alliance, Negative Mood Regulation, and Treatment Outcome in Child Abuse-Related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology, 72*(3), 411-416.

Cummings, C. M., Caporino, N. E., Settipani, C. A., Read, K. L., Compton, S. N., March, J., . . . Kendall, P. C. (2013). The therapeutic relationship in cognitive-behavioral therapy and pharmacotherapy for anxious youth. *Journal of Consulting and Clinical Psychology, 81*(5), 859-864.

Curtis, H. C. (1979). The concept of therapeutic alliance: Implications for the "widening scope." *Journal of the American Psychoanalytic Association*, 27, 159-192.

Dales, S., & Jerry, P. (2008). Attachment, Affect Regulation and Mutual Synchrony in Adult Psychotherapy. *American Journal of Psychotherapy*, 62(3), 283-312.

Dare, C., Dreher, A. U., Holder, A., & Sandler, J. (1992). *The client and the analyst: The basis of the psychoanalytic process*. New York, NY: Karnac Books.

de Roten, Y., Fischer, M., Drapeau, M., Beretta, V., Kramer, U., Favre, N., & Despland, J.-N. (2004). Is one assessment enough?: Patterns of helping alliance development and outcome. *Clinical Psychology and Psychotherapy, 11,* 324-331.

DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child-adolescent psychotherapy. *Applied & Preventive Psychology*, 5, 85–100.

Ebesutani, C., Okamura, K., Higa-McMillan, C., & Chorpita, B. F. (2011). A psychometric analysis of the positive and negative affect schedule for children – parent version in a school sample. *Psychological Assessment.*

Eisenberg, N., Fabes, R. A., Guthrie, I. K., & Reiser, M. (2000). Dispositional emotionality and regulation: Their role in predicting quality of social functioning. *Journal of Personality and Social Psychology, 78*(1), 136-157.

Eisenberg, N., Sadovsky, A., Spinrad, T. L., Fabes, R. A., Losoya, S. H., Valiente, C., . . . Shepard, S. A. (2005). The Relations of Problem Behavior Status to Children's Negative Emotionality, Effortful Control, and Impulsivity: Concurrent Relations and Prediction of Change. *Developmental Psychology, 41*(1), 193-211.

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical Psychology Review, 28*(7), 1167-1187.

Faust, J., & Burns, W. (1991). Coding therapist and child interaction: Progress and outcome in play therapy. *Play Diagnosis and Assessment,* 663-690.

Feng, X., Keenan, K., Hipwell, A.E., Henneberg, A.K., Rischall, M.S., Butch, J., . . . Babinski, D.E. (2009). Longitudinal Associations Between Emotion Regulation and Depression in Preadolescent Girls: Moderation by the Caregiving Environment. *Developmental Psychology, 45*(3). 798-808.

Figueiredo, B., Dias, P., Lima, V. S., & Lamela, D. (2016). Working alliance inventory for children and adolescents (WAI-CA): Development and psychometric properties. *European Journal of Psychological Assessment,* 1-7.

Findling, J. H., Bratton, S. C., & Henson, R. K. (2006). Development of the trauma play scale: An observation-based assessment of the impact of trauma on play therapy behaviors of young children. *International Journal of Play Therapy, 15*(1), 7–36.

Fisher, H., Atzil-Slonim, D., Bar-Kalifa, E., Rafaeli, E., & Peri, T. (2016). Emotional experience and alliance contribute to therapeutic change in psychodynamic therapy. *Psychotherapy*, *53*(1), 105-116.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316-340.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Foreman, S.A., Gibbins, J., Grienenberger, J., & Berry, J.W. (2000). Developing methods to study child psychotherapy using new scales of therapeutic alliance and progressiveness. *Psychotherapy Research, 10*(4), 450-461.

Freud, A. (1946). *The psycho-analytical treatment of children.* New York: International Universities Press.

Freud, S. (1913). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 122-144). London: Hogarth Press.

Freud, S. (1937/1964). Analysis Terminable and Interminable. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 209-253). London: Hogarth Press.

Gaensbauer, T.J., Siegel, C.H. (1995). Therapeutic approaches to posttraumatic stres disorder in infants and toddlers. *Infant Mental Health Journal, 16*(4), 292–305.

Galyer, K. T., & Evans, I. M. (2001). Pretend play and the development of emotion regulation in preschool children. *Early Child Development and Care, 166,* 93-108.

Gaston, L. (1990). The Concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27,* 143-153.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41,* 296-306.

Golden, B., & Robbins, S. (1990). The working alliance within time-limited therapy: A case analysis. *Professional Psychology: Theory, Research, and Practice, 21,* 476-481.

Goldfried, M. R., & Davilla, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy Theory, Research, Practice, Training, 42,* 421–430.

Goodman, G., Chung, H., Fischel, L., & Athey-Lloyd, L. (2017). Simulation modeling analysis of sequential relations among therapeutic alliance, symptoms, and adherence to child-centered play therapy between a child with autism spectrum disorder and two therapists. Clinical Child Psychology and Psychiatry, 22(3), 455-466.

Gorin, S. S. (1993). The prediction of child psychotherapy outcome: Factors specific to treatment. *Psychotherapy, 30,* 152-158.

Göçek, E. A. (2017). Oyun terapisi ve duygular. In Dost-Gözkân, A., Kafescioğlu, N., & Tahiroğlu, D. (Eds.), *Gelişim Psikolojisi ve Terapi Perspektifinden Oyun,* (pp. 272-298). Istanbul: Özyeğin Üniversitesi Yayınları.

Greenberg, L. S., Auszra, L., & Herrmann, I. R. (2007). The relationship among emotional productivity, emotional arousal and outcome in experiential therapy of depression. *Psychotherapy Research*, *17*(4), 482-493.

Greenson, R. R. (1965). The working alliance and the transference neurosis. *Psychoanalysis Quarterly*, 34, 155-181.

Grienenberger, J., & Foreman, S. A. (1993). Development of the Child Therapeutic Alliance Scale (CTAS). Paper presented at the 24th Annual Meeting of the Society for Psychotherapy Research, Pittsburgh, PA.

Halfon, S. (2017). Play Profile Constructions: An Empirical Assessment of Children's Play in Psychodynamic Play Therapy. *Journal of Infant, Child, and Adolescent Psychotherapy, 16*(3), 219-233.

Halfon, S., Çavdar, A., Orsucci, F., Schiepek, G. K., Andreassi, S., Giuliani, A., & de Felice, G. (2016a). The non-linear trajectory of change in play profiles of three children in psychodynamic play therapy. *Frontiers in Psychology, 7,* 1-15.

Halfon, S., Oktay, E. A., & Salah, A. A. (2016b). Assessing affective dimensions of play in psychodynamic child psychotherapy via text analysis. In *International workshop on human behavior understanding* (pp. 15–34). Amsterdam: Springer International Publishing

Halfon, S., Yılmaz, M., & Çavdar, A. (2019). Mentalization, session-to-session negative emotion expression, symbolic play, and affect regulation in psychodynamic child psychotherapy. *Psychotherapy.* Advance online publication.

Hilsenroth, M. J., Peters, E. J., & Ackerman, S. J. (2004). The development of therapeutic alliance during psychological assessment: Client and therapist perspectives. *Journal of Personality Assessment, 83,* 332-344.

Hoffman, L., Rice, T., & Prout, T. (2016). *Psychological issues book series. Manual of Regulation-Focused Psychotherapy for Children (RFP-C) with externalizing behaviors: A psychodynamic approach.* New York, NY, US: Routledge/Taylor & Francis Group.

Hoffmann, J., & Russ, S. (2012). Pretend play, creativity, and emotion regulation in children. *Psychology of Aesthetics, Creativity, and the Arts, 6*(2), 175-184.

Horvath, A. O., Bedi, R. P. (2002). The alliance. In: Norcross J. C. (Ed.), *Psychotherapy relationships that work.* New York, NY: Oxford University Press.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(4), 561-573.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.

Howe, P. A., &Silvern, L. E. (1981). Behavioral observation of children during play therapy: Preliminary development of a research instrument. *Journal of Personality Assessment, 45(2),* 168-182.

Hudson, J. L., Kendall, P. C., Chu, B. C., Gosch, E., Martin, E., Taylor, A., & Knight, A. (2014). Child involvement, alliance, and therapist flexibility: Process variables in cognitive-behavioural therapy for anxiety disorders in childhood. *Behaviour Research and Therapy, 52,* 1-8.

Hurley, K. D., Lambert, M. C., Ryzin, M. V., Sullivan, J., & Stevens, A. (2013). Therapeutic alliance between youth and staff in residential group care: Psychometrics of the therapeutic alliance quality scale. *Children and Youth Services Review, 35*(1), 56-64.

Hurley, K. D., Ryzin, M. J., Lambert, M., & Stevens, A. L. (2015). Examining change in therapeutic alliance to predict youth mental health outcomes. *Journal of Emotional and Behavioral Disorders, 23*(2), 90-100.

Iwakabe, S., Rogan, K. & Stalikas, A. (2000). The relationship between client emotional expressions, therapist interventions, and the working alliance: An exploration of eight emotional expression events. *Journal of Psychotherapy Integration. 10*, 375–402.

Kabcenell, R.J. (1993). Some Aspects of the "Treatment Alliance" in Child Analysis. *Journal of Clinical Psychoanalysis, 2*(1):27-41.

Kanzer, M. (1981). Freud's "analytic pact": The standard therapeutic alliance. *Journal of the American Psychoanalytic Association, 29*(1), 69-87.

Karver, M. S., De Nadai, A. S., Monahan, M., & Shirk, S. R. (2018). Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy. *Psychotherapy, 55*(4), 341-355.

Kazdin, A. E., Marciano, P. L., & Whitley, M. K. (2005). The therapeutic alliance in cognitive-behavioral treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Consulting and Clinical Psychology, 73,* 726 730.

Keeley, M. L., Geffken, G. R., Ricketts, E., McNamara, J. P., & Storch, E. A. (2011). The therapeutic alliance in the cognitive behavioral treatment of pediatric obsessive-compulsive disorder. *Journal of Anxiety Disorders, 25*(7), 855-863.

Kelley, S. D., Bickman, L., & Norwood, E. (2010). Evidence-Based Treatments and Common Factors in Youth Psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble, *The Heart and Soul of Change: Delivering What Works in Therapy* (pp. 325-355). Washington, DC, US: American Psychological Association.

Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 62,* 100-110.

Kendall, P. C., Comer, J. S., Marker, C. D., Creed, T. A., Puliafico, A. C., Hughes, A. A., . . . Hudson, J. (2009). In-session exposure tasks and therapeutic alliance across the treatment of childhood anxiety disorders. *Journal of Consulting and Clinical Psychology, 77*(3), 517-525.

Kernberg, P. F., Chazan, S. E., &Normandin, L. (1998). The children's play therapy instrument (CPTI): description, development, and reliability studies. *The Journal of Psychotherapy Practice and Research, 7(3),* 196-207.

Kivlighan, D. M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology, 47,* 362-371.

Kramer, U., de Roten, Y., Beretta, V., Michel, L., & Despland, J. -N. (2009). Alliance patterns over the course of short-term dynamic psychotherapy: The shape of productive relationships. *Psychotherapy Research, 19,* 699-706.

Kramer, U., de Roten, Y., Beretta, V., Michel, L., & Despland, J.-N. (2008). Client's and therapist's views of early alliance building in dynamic psychotherapy: Patterns and relation to outcome. *Journal of Counseling Psychology*, 55, 89-95.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. Psychotherapy: Theory, Research, Practice, Training, 38(4), 357-361.

Laurent, J., Catanzaro, S. J., Joiner, T. E., Rudolph, K. D., Potter, K. I., … Lambert, S. (1999). A measure of positive and negative affect for children: Scale development and preliminary validation. *Psychological Assessment, 11,* 326–338.

Liber, J. M., McLeod, B. D., Van Widenfelt, B. M., Goedhart, A. W., van der Leeden, A. J. M., Utens, E. M. W. J., & Treffers, P. D. (2010). Examining the relation between the therapeutic alliance, treatment adherence, and outcome of cognitive behavioral treatment for children with anxiety disorders. *Behavior Therapy, 41*, 172-186.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Cleghhorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel.

Mackay, H.C., Barkham, M., Stiles, W.B., & Goldfried, M.R. (2002). Patterns of client emotion in helpful sessions of cognitive-behavioral and psychodynamic-interpersonal therapy. *Journal of Counseling Psychology, 49*(3), 376–380.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438–450.

McLeod, B.D. (2005). *The Therapy Process Observational Coding System for Child Psychotherapy – Alliance Scales.* Richmond, VA: Virginia Commonwealth University.

McLeod, B. D. (2010). *Scoring manual for the Therapy Process Observational Coding System For Child Psychotherapy Alliance Scale.* (2005) Scoring manual, Virginia Commonwealth University, Richmond, VA.

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4), 603-616.

McLeod, B. D., Southam-Gerow, M. A., & Kendall, P. C. (2017). Observer, youth, and therapist perspectives on the alliance in cognitive behavioral treatment for youth anxiety. *Psychological Assessment, 29*(12), 1550-1555.

McLeod, B., & Weisz, J. (2005). The therapy process observational coding system-alliance scale: Measure characteristics and prediction of outcome in usual clinical practice. *Journal of Consulting and Clinical Psychology, 73,* 323-333.

Meissner, W. W. (1988). The Borderline Spectrum: Differential Diagnosis and Developmental Issues. *Psychoanalytic Inquiry*. 8(3), 305-332.

Meissner, W. W. (1992). The concept of the therapeutic alliance. *Journal of the American Psychoanalytic Association, 40*(4), 1059-1087.

Meissner, W. W. (2007). Therapeutic alliance: Theme and variations. *Psychoanalytic Psychology, 24*(2), 231-254.

Noser, K., & Bickman, L. (2000). Quality indicators of children's mental health services: Do they predict improved client outcomes? *Journal of Emotional and Behavioral Disorders, 8*(1), 9-18.

Owens, K.A., Haddock, G., & Berry, K. (2013). The role of the therapeutic alliance in the regulation of emotion in psychosis: an attachment perspective. *Clinical Psychology and Psychotherapy. 20,* 523-530.

Özsoy, D. (2018). Therapeutic alliance in psychodynamic child psychotherapy: Growth trajectories and relations with outcome. (Unpublished master's thesis). İstanbul Bilgi University, İstanbul, Turkey.

Piper, W. E., Ogrodniczuk, J. S., Lamarche, C., Hilscher, T., & Joyce, A. S. (2005). Levels of alliance, pattern of alliance, and outcome in short-term group therapy. *International Journal of Group Psychotherapy, 55,* 527-550.

Pos, A.E, Greenberg, L.S. & Goldman, R.N. (2003). Emotional processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 71,* 1007–1016.

Preter, S.E., Shapiro, T., & Milrod, B. (2018). *Child and Adolescent Anxiety Psychodynamic Psychotherapy; A Treatment Manual.* United States of America, Oxford University Press.

Rasbash, J., Steele, F., Browne, W.J., & Prosser, B. (2014) *Multilevel Modelling (MLwiN).* Centre for Multilevel Modelling, University of Bristol.

Roest, J., Helm, P. V., Strijbosch, E., Brandenburg, M. V., & Stams, G. J. (2016). Measuring therapeutic alliance with children in residential treatment and therapeutic day care. *Research on Social Work Practice, 26*(2), 212-218.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Rogers, C. R. (1961). *On becoming a person.* Boston: Houghton Mifflin

Roque, L., & Verissimo, M. (2011). Emotional context, maternal behavior and emotion regulation. *Infant Behavior and Development, 34,* 617– 626.

Russ, S. (1987). Assessment of cognitive affective interaction in children: Creativity, fantasy, and play research. In J. Butcher & C. Spielberger (Eds.), *Advances in personality assessment* (Vol. 6, pp. 141–155). Hillsdale, NJ: Lawrence Erlbaum Associates.

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48* (1), 80-87.

Safran, J. D., Muran, J. C., & Rothman, M. (2006). The therapeutic alliance: Cultivating and negotiating the therapeutic relationship. In W. O'Donohue, N. A. Cummings ve J. L. Cummings (Eds.), *Clinical strategies for becoming a master psychotherapist* (pp.37–54). San Diego, CA: Academic Press.

Sexton, H. C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocess: A sequential analysis. *Journal of Consulting and Clinical Psychology, 64*(3), 471-480.

Shields, A., & Cicchetti, D. (1997). Emotion regulation among school-age children: The development and validation of a new criterion Q-sort scale. *Developmental Psychology*, *33*(6), 906.

Shirk, S. R., & Burwell, R. A. (2010). Research on therapeutic processes:In psychodynamic psychotherapy with children and adolescents. In J. Tsiantis, & J. Trowell, *Assessing Change in Psychoanalytic Psychotherapy of Children and Adolescent* (pp. 177-206). London: KARNAC.

Shirk, S. R., Caporino, N. E., & Karver, M. S. (2010). The alliance in adolescent therapy: Conceptual, operational, and predictive issues. In D. Castro-Blanco & M. S. Karver (Eds.), *Elusive alliance: Treatment engagement strategies with high-risk adolescents* (pp. 59-93). Washington, DC, US: American Psychological Association.

Shirk, S. R., Karver, M. S., & Brown, R. (2011). Alliance in child and adolescent psychotherapy. *Psychotherapy Research, 48*(1), 70-91.

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *Journal of Consulting and Clinical Psychology*, 71(3), 452-464.

Shirk, S. R., & Russell, R. L. (1998). Process issues in child psychotherapy. In A. Bellack, M. Hersen (Series Eds.), & T. Ollendick (Vol. Ed.), *Comprehensive clinical psychology*: Vol. 5. Children and adolescents: Clinical formulations and treatment (pp. 57–82). Oxford, England: Pergamon Press.

Shirk, S. R., & Saiz, C. C. (1992). Clinical, empirical, and developmental perspectives on the therapeutic relationship in child psychotherapy. *Development and Psychopathology*, *4*(4), 713-728.

Siefert, C.J., & Hilsenroth, M.J. (2015). Client attachment status and changes in therapeutic alliance early in treatment. *Clinical Psychology and Psychotherapy*, *22*, 677-686.

Sterba, R. (1934). The fate of the ego in analytic therapy. *The International Journal of Psychoanalysis, 15*, 117-126.

Stiles, W. B., Agnew-Davies, R., Hardy, G. E., Barkham, M., & Shapiro, D. A. (1998). Relations of the alliance with psychotherapy outcome: Findings in the Second Sheffield Psychotherapy Project. *Journal of Consulting and Clinical Psychology, 66,* 791-802.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., Agnew-Davies, R., Rees, A., & Barkham, M. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology, 51,* 81-92.

Strauss, J. L., Hayes, A. M., Johnson, S. L., Newman, C. F., Brown, G. K., Barber, J. P., . . . Beck, A. T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74*(2), 337-345.

Target, M., Slade, A., Cottrell, D. Fuggle, P., & Fonagy, P. (2005). Psychosocial therapies with children. In G. Gabbard, J. Beck & J. Holmes (Eds.), *Oxford textbook of psychotherapy.* New York: Oxford. 341-352.

Tessier, V.P., Normandin, L., Ensink, K., & Fonagy, P. (2006). Fact or fiction? A longitudinal study of play and the development of reflective functioning. *Play and Reflective Functioning, 80* (1), 60-79.

Thompson, R. A. (1994). Emotion regulation: A theme in search of definition. *Monographs of the Society for Research in Child Development, 59*(2-3), 25-52, 250-283.

Town, J.M., Salvadori, A., Falkenström, F., Bradley, S., & Hardy, G. (2017). Is affect experiencing therapeutic in major depressive disorder? Examining associations between affect experiencing and changes to the alliance and outcome in intensive short-term dynamic psychotherapy. *Psychotherapy. 54* (2), 148-158.

Tschacher, W., Haken, H., & Kyselo, M. (2015). Alliance: a common factor of psychotherapy modeled by structural theory. *Frontiers in psychology, 6*, 421.

Wampold, B. E. (2015). How Important Are The Common Factors In Psychotherapy? An Update. *World Psychiatry* , 14, 270-277.

Warren, S.L., Oppenheim, D., & Emde, R.N. (1996). Can emotions and themes in children's play predict behavior problems?. *]. Am. Acad . Child Adolesc. Psychiatry, 34*(10), 1331-1337.

Watson, J. C., Mcmullen, E.J., Prosser, M.C. & Bedard, D.L., (2011). An examination of the relationships among clients' affects regulation, in-session emotional processing, the working alliance, and outcome. *Psychotherapy Research, 21*(1), 86-96.

Winnicott, D. W. (1965). Failure of expectable environment on child's mental functioning. The International Journal of Psycho-Analysis, *46*, 81– 87.

Winnicott, D. W. (1968). Playing: Its theoretical status in the clinical situation. *International Journal of Psychoanalysis, 49,* 591-599.

Winnicott, D. W. (1971). *Playing and reality.* London: Tavistock.

Yılmaz, M. (2018). Mentalization, Negative Emotion Expression, Symbolic Play and Affect Regulation in Psychodynamic Child Psychotherapy with Behavioral Problems. (Unpublished master's thesis). Maastricht University, Maastricht, Netherlands.

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis*, 37, 369-376.

Zorzella, K. P., Muller, R. T., & Cribbie, R. A. (2015). The relationships between therapeutic alliance and internalizing and externalizing symptoms in Trauma-Focused Cognitive Behavioral Therapy. *Child Abuse & Neglect, 50*, 171-181.

Zorzella, K. P., Rependa, S.L., & Muller, R. T. (2017). Therapeutic alliance over the course of child trauma therapy from three different perspectives *Child Abuse & Neglect, 67,* 147-156.

**Appendix A: Scoring Sheet for the Therapy Process Observational Coding System-Alliance Scale (TPOCS-A)**
**A. Bağ Alt Ölçeği**

Aşağıdaki ölçeği kullanarak, lütfen çocuk ve terapistin bu seanstaki bağlarına dair değerlendirmenizi belirtin. Bu ölçekte bağ, çocuk ile terapistin ilişkisinde ne kadar

1) Olumlu duygulanım (örn. sevmek, anlamak, önemsemek) ve 2) Karşılıklı güven olduğudur. Lütfen aşağıdaki her puanlamayı tüm seansı düşünerek yapın. İlgili numarayı sorunun yanında bırakılan boşluğa yazın.

| **0** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| Hiç | | | Biraz | | Çok |

**1.** Çocuk ne sıklıkta/yoğunlukta terapistin anlayışlı ve destekleyici olduğunu belirtti? ___

**2.** Çocuk ne sıklıkta/yoğunlukta terapiste düşmanca, eleştirel veya savunmacı bir tutumla davrandı? ___

**3.** Çocuk ne sıklıkta/yoğunlukta terapiste olumlu duygular ifade etti? ___

**4.** Çocuk ne sıklıkta deneyimini terapist ile paylaştı? ___

**5.** Çocuk ne sıklıkta terapist ile etkileşiminde rahatsız görünüyordu? ___

**6.** Çocuk ve terapist ne sıklıkta birbirleriyle etkileşim halindeyken huzursuz veya rahatsız görünüyorlardı? ___

**B. Görev Alt Ölçeği**

Aşağıdaki ölçeği kullanarak, lütfen bu seanstaki terapötik görevlere dair değerlendirmenizi belirtin. Bu ölçekte terapötik görev, 1) Terapist tarafından uygulanan terapötik müdahaleler (yorum yapmak, soru sormak, terapötik sınır koymak, vb.) ve 2) Çocuğun terapötik müdahaleleri kullanma ve takip etmeye dair (oyun oynamak, duygu ve düşüncelerini ifade etmek, terapistin söylediğini detaylandırmak, konulan sınıra uymak, vb.) istekliliği. Lütfen aşağıdaki her puanlamayı tüm seansı düşünerek yapın. İlgili numarayı sorunun yanına yazın.

| **0** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| Hiç | | | Biraz | | Çok |

**7.** Çocuk ne sıklıkta/yoğunlukta terapötik görevleri seans dışında, hayatında değişiklik yapmak için kullandı? ___

**8.** Çocuk ne sıklıkta/yoğunlukta terapötik görevlere uyum göstermedi? ___

**9.** Çocuk ve terapist ne sıklıkta/yoğunlukta terapötik görevler üzerinde beraber, eşit bir şekilde çalıştılar? ___