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Young People's Perceptions of Therapist Interpersonal Skills and Alliance: How Distinct are They?

Mick Cooper

University of Roehampton

Department of Psychology, Holybourne Avenue, London SW15 4JD

mick.coooper@roehampton.ac.uk

https://orcid.org/0000-0003-1492-2260

Tomasz Jankowski

Institute of Psychology, John Paul II Catholic University of Lublin

Lublin, Poland

tojankowski@kul.pl

https://orcid.org/0000-0002-0636-3051

David Saxon

Department of Psychology, University of Sheffield

d.saxon@sheffield.ac.uk

https://orcid.org/0000-0002-9753-8477

Beata Zarzycka

Institute of Psychology, John Paul II Catholic University of Lublin

Lublin, Poland

beata.zarzycka@kul.pl

https://orcid.org/0000-0003-3004-4357

Michael Barkham

Department of Psychology, University of Sheffield

m.barkham@sheffield.ac.uk

https://orcid.org/0000-0003-1687-6376

Author Note

Corresponding author: Mick Cooper, University of Roehampton, Holybourne Avenue, London SW15 4JD, mick.cooper@roehampton.ac.uk, 07734-558155

Data sharing

Quantitative, participant-level data for the ETHOS study (with data dictionary), and related documents (e.g., parental consent form), are available from the 1st January 2021 via the ReShare UK Data Service (reshare.ukdataservice.ac.uk/853764/). Access requires ReShare registration.

Contributors

For the original ETHOS study, MC led on conceptualization, funding acquisition, conduct of the investigation, and design. MB advised on all aspects of the ETHOS study. DS curated data for the ETHOS study and led on the original analysis. TJ led on analysis for the present study and curated the data. BZ and MC developed the initial draft of this paper, with

input and guidance from TJ and MB. All authors had access to the data, contributed to writing and editing of the manuscript, and approved the final version.

Ethical Approval and Consent

Ethical approval for the study was obtained under procedures agreed by the University Ethics Committee of the University of Roehampton, Reference PSYC 16/227, 31st August 2016: "Effectiveness and cost-effectiveness trial of humanistic counselling in schools (ETHOS)".

This research complies with APA ethical standards in the treatment of participants, and with the research ethics of the British Association for Counselling and Psychotherapy (BACP) and the British Psychological Society (BPS).

Parents/carers of all young people provided consent (written or verbally recorded), and all young people provided written assent, prior to the young person's participation in the trial.

Declaration of interests

MC, DS, and MB report grants from ESRC, during the conduct of the trial.

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Abstract

Objective: The aim of this study was to investigate the degree of commonality between young people's perceptions of the alliance and the therapist interpersonal skills (TIS) of empathy, unconditional positive regard, and congruence. **Method:** Participants were 152 young people (aged 13-16 years old; 114 female, 70 of minoritized ethnicities) who were experiencing moderate to severe levels of emotional symptoms and participated in up to 10 sessions of school-based humanistic counseling. At 6-weeks post-randomization, TIS and the alliance were assessed using the Barrett-Lennard Relationship Inventory: Form OS-40: T-S (Student Form, version 3) and the Working Alliance Inventory Short Form (WAI-S), respectively. Structural equation modeling was used to identify latent constructs. **Results:** A model with two correlated second-order factors, and a hierarchical model with one third-order general factor, exhibited the best data fit. The general factor, which we named *youth-perceived relationship quality*, explained a substantial amount of variance for TIS (81%) and alliance (98%). TIS and alliance effects, treated independently, explained an additional 3% and 1.4% of variance in satisfaction with care and psychological difficulties after therapy, respectively, as compared with general youth-perceived relationship quality. **Conclusions:** While therapeutic relationship factors—in clinical practice, training, and research—are often considered distinct, we found a high degree of commonality in how young people perceived the alliance and TIS. Further research is warranted on youth-perceived relationship quality as an integrated variable in youth psychotherapy.

Trial Registration: ISRCTN10460622.

Keywords: Adolescents, Therapy Alliance, therapy Relationship, Latent Construct Analysis

Clinical Impact Statement

Question. This paper investigates whether, from the perspective of young people, alliance and therapist interpersonal skills (TIS) of empathy, unconditional positive regard, and congruence are experienced as distinct or overlapping constructs. ***Findings.*** We found a high degree of commonality. ***Meaning***. Clinicians and trainers in the field of youth psychotherapy may benefit from a recognition of *relationship quality* as a general, unidimensional feature of how young people perceive the psychotherapeutic relationship. ***Next steps***. Future research should consider whether other therapy relationship variables, from the perspective of young people, also align to a general relationship quality factor.

Adolescence is a period of rapid biological, psychological, and social change, making young people particularly vulnerable to mental ill health (Blakemore, 2019). In England, the prevalence rate has risen over the past two decades with approximately one in seven 11 to 16 year-olds having a mental disorder, with higher rates for young people living in lower income households (Sadler et al., 2018). Childhood disorders often continue into adulthood and can have longstanding social and economic consequences (Chen et al., 2006).

Among the relational processes that support positive outcomes in therapy, the alliance is the most studied. The alliance can be defined as the collaborative bond between psychotherapist and patient (Karver et al., 2018). It is widely understood to comprise of three core elements: (1) the emotional bond between patient and therapist, (2) agreement on the tasks aimed at facilitating change, and (3) consensus on the goals of therapy (Bordin, 1979). Meta-analyses show that alliance quality is moderately associated with outcomes in youth populations, though the strength of the effect varies across studies (Karver et al., 2018; Murphy & Hutton, 2018).

Kazdin and McWhinney (2018) argue that, to predict the outcomes of psychotherapy with youth, "we ought to look at additional factors and perhaps accumulate these to better predict who will respond well and poorly" (p. 240). Understanding additional relationship factors may be particularly important in clinical and empirical work with children and young people, where a complex and nuanced approach is required: taking into account the patients' developmental stage, varying levels of engagement, and the involvement of caregivers in the psychotherapy process (R. Ryan et al., 2023).

Alongside the alliance, therapists' interpersonal skills (TIS) have been identified as important relational competencies. TIS can be defined as those practices that allow the therapist to attune to the therapeutic relationship (Castonguay et al., 2006; Lambert et al., 1978).

Conceptually, TIS can be distinguished from *qualities of the therapeutic relationship* (two-way relational factors, such as the alliance), *therapist clinical relational skills* (relationship-focused psychotherapist activities, such as self-disclosure and relational interpretations), and *therapist factors* (enduring and relatively stable traits of therapists that exist outside of specific therapeutic relationships) (Cooper, 2026). *Therapist alliance-building behaviors*, such as formulating meaningful goals and exploring a young person's motivation for change can be considered a subset of TIS (Creed & Kendall, 2005; Russell et al., 2008). Meta-analytic findings suggest that, overall, TIS are moderately associated with outcomes for young people (r = .37, Karver et al., 2006).

Rogers's (1957) core conditions of empathy, positive regard, and congruence are the most widely-researched (Karver et al., 2006) and -trained TIS (e.g.,
British Association for Counselling and Psychotherapy, 2022), and therefore the focus for the present study. *Empathy* can be defined as the extent to which therapists can understand and communicate their patient's experiencing, and is a moderate to strong predictor of outcomes in adults (Elliott et al., 2018) as well as youth (Cooper, Saxon, et al., 2025; Cooper, Smith, et al., 2025). *Congruence*, also termed authenticity or genuineness, refers to the therapist's capacity to be emotionally present and real in the relationship (Rogers, 1957), and is modestly associated with psychological improvement, with stronger effects in younger patients (Cooper, Saxon, et al., 2025; Kolden et al., 2018). *Unconditional positive regard*, sometimes known as warmth or acceptance, describes the therapist's attitude and ability to accept the patient as a person worthy of respect (Bozarth & Wilkins, 2001). Barrett-Lennard (1962), in his development of the most-widely used measure of Rogers's TIS, the Barrett-Lennard Relationship Inventory, distinguished between *level of regard*, akin to liking or warmth; and *unconditionality of regard*, referring to the

constancy of this level. Across qualitative and quantitative data, there is clear evidence that level of regard predicts positive outcomes in adults as well as youth, with some indications that unconditionality of regard may also be associated with positive gains for young people (Brouzos et al., 2015; Cooper, Saxon, et al., 2025; Farber et al., 2019).

TIS, as defined, are behaviors that contribute to the development of the therapeutic relationship, and research into therapist alliance-building behaviors has examined them as such (e.g., Creed & Kendall, 2005; Jungbluth & Shirk, 2009; Russell et al., 2008). This research has shown that increases in the provision of support, praise, and other responsive TIS over first sessions of cognitive behavioral therapy (CBT) are associated with improved youth-rated Session 3 alliance (Russell et al., 2008). In addition, higher levels of collaboration—and lower levels of "pushing the child to talk" and "finding common ground"—are predictive of higher youth-rated alliance (Creed & Kendall, 2005). Difficulties in establishing an alliance have been linked to problems in relational attunement (for instance, competitive responding by the psychotherapist, de la Peña et al., 2012). Qualitative research shows that psychotherapist attuning behaviors—including being caring, trustworthy, open to listening, and showing respect—constitute the process of forming an alliance (Manso et al., 2008).

However, what is not clear from such research is whether, from a youth perspective, TIS are experienced as distinct from the alliance. That is, do young people experience a collaborative bonding with their psychotherapists as distinct from experiencing them as behaving in ways that develop the therapeutic relationship; or do young people experience these relationship factors as an undifferentiated whole? Developmentally, it is possible that young people may not have reached the level of formal operational thinking that would allow them to conceptualize multiple, distinct dimensions in their relationship with a psychotherapist (Huitt & Hummel, 2003; Piaget,

1972). Rather, young people may tend to collapse perceptions of the collaborative bond and the psychotherapist's interpersonal skills into a single dimension. According to Piaget (1972), a tendency towards unidimensional perceptions may be particularly likely in situations involving emotions, as well as those that are unfamiliar (Overton et al., 1987). Psychotherapy may be marked with both these qualities: an emotionally evocative encounter in a situation that may, to the young person, seem strange and unusual. Consequently, young people may be unlikely to develop multidimensional, nuanced conceptualizations of the relationship in this context.

Research with adult populations suggests that the experiencing of TIS and alliance may be highly interrelated. Meta-analysis indicates that, for patients, a large association exists between perceptions of alliance with a psychotherapist and perceptions of empathy (r = .56) and genuineness (r = .63) (Nienhuis et al., 2018). On this basis, Nienhuis et al. concluded that, "there may be reason to believe that when rated by the same person, these constructs have significant overlap and lack discreteness" (p. 593).

Empirical evidence on the interrelationship of relational factors within psychological therapy for children and young people is sparser. However, Karver et al. (2006), in their meta-analysis of therapeutic relationship variables in youth and family therapy (rated from a range of perspectives), reported that TIS were correlated .37 with other therapeutic process variables, including alliance; while alliance correlated .35 with other therapeutic process variables, including empathy. In a study conducted among adolescents undergoing substance abuse treatment, youth-perceived counselor affiliation was significantly correlated with alliance (r = .40), and particularly its bond dimension (r = .58) (Auerbach et al., 2008). Duff and Bedi (2010) found 11 of 15 youth-identified therapist behaviors were moderately to strongly correlated with alliance, with three specific behaviors—making encouraging statements, making positive

comments about the client, and greeting the client with a smile—accounting for 62% of variance in alliance scores. Qualitatively, a systematic review examining how young people conceptualized, utilized, and experienced the alliance found that perceptions of the psychotherapist as empathic, caring, and self-disclosing were integrated into the experience of the alliance (Dimic et al., 2023). For instance, Everall and Paulson (2002) found, in their interview data, that the alliance was described with phrases such as being built on "a sense of trust and respect" (p. 82). Participants invoked qualities such as genuineness, open communication, emotional availability, and feeling "heard." Conversely, alliance ruptures were often perceived as a breakdown in authentic interpersonal connection, frequently triggered by perceived disrespect, a lack of empathy, or authoritarian attitudes. Indeed, factor analytic research suggests that the alliance, itself, may not be experienced by adolescents as a three-dimensional construct, but as a single factor (Cirasola et al., 2021) or as two factors (van Benthem et al., 2024). These results suggest that, although TIS and alliance can be studied as conceptually and temporally distinct, from a youth perspective, they may be experienced as an integrated, undifferentiated whole.

The primary aim of this paper was to determine whether young people experience the alliance and Rogers's (1957) TIS as distinct and, if so, in what ways. In addition, as a related secondary aim, we aimed to assess the degree to which alliance and TIS—as experienced by young people—are independent predictors of two psychotherapy outcomes: self-reported satisfaction with psychotherapy and level of psychological difficulties. In asking such questions, we recognize that young people's perceptions are just one perspective on these relationship factors, and that our findings may not generalize to therapist-, parent-, or observer-rated perspectives. However, there are several reasons why we believe young people's

phenomenological experiencing of the relationship—and differentiations within it—is an important area of enquiry. First, as Rogers (1957) suggests, the patient's subjective perception of the therapeutic relationship is likely to influence how the relationship effects therapeutic change: from the research, we know that youth perceptions of therapist TIS and alliance predict outcomes (Cooper, Saxon, et al., 2025). Hence, understanding these perceptions is likely to have implications for clinical training and practice. Second, from a "patient and public involvement" perspective, listening to the voices of young people is an ethical imperative: acknowledging young people's expertise in their own perceptions and experiences, empowering them, and giving them a say in matters that concern their own mental health and wellbeing (Totzeck et al., 2024). Third, in terms of psychotherapy research, if alliance and TIS are experienced by young people as distinct, it gives weight to Kazdin and McWhinney's (2018) claim we should look at factors beyond the alliance to predict outcomes in youth psychotherapy. By contrast, if they are substantially overlapping, a continued focus on young people's perceptions of the alliance may be sufficient proxy for understanding how their experiencing of the therapeutic relationship relates to therapeutic change.

Although there is preliminary evidence, as indicated above, of an association between young people's perception of the alliance and TIS, this is the first study to go beyond correlational analysis and, using a cross-sectional design, structurally analyze the dimensions that may underlie alliance and Rogers's (1957) specific TIS. It is also the first study to conduct such an analysis based on a standardized, adherence-checked intervention; and with adequate power to detect well-fitted models and meaningful differences between model fit.

Method

Design

This study was a secondary analysis of data collected as part of a two-arm, individually randomized trial comparing school-based humanistic counseling plus pastoral care as usual (SBHC+PCAU) versus pastoral care as usual (PCAU) for young people (aged 13–16 years old) with emotional symptoms (Cooper et al., 2021; Stafford et al., 2018). The study was conducted in 18 "secondary" schools in England (typical age range: 11–18 years old). The study utilized data from the SBHC+PCAU intervention arm of the trial and structural equation modeling to examine the strength of associations between youth perceptions of TIS and alliance. We adopted a cross-sectional design so that we could establish levels of distinctiveness or overlap in patients' concurrent, phenomenological experiencing of their psychotherapists.

Ethical approval for the research was obtained under procedures agreed by the University Ethics Committee of the University of Roehampton, 31st August 2016. Young people and parents/carers provided informed consent/assent and advised at all stages of the study.

Participants

Eligible participants were aged 13-16 years old and experiencing moderate to severe levels of emotional symptoms (as indicated by a score ≥ 5 on the Emotional Symptoms subscale of the self-report Strengths and Difficulties Questionnaire, range = 0–10 (Goodman, 2001b)). They had an estimated English reading age of at least 13 years, wanted to participate in counseling, had a school attendance record of 85% or greater (to increase likelihood of attending testing meetings), and were not currently in receipt of another therapeutic intervention. Exclusion criteria included being incapable of providing informed consent for counseling, planning to leave the school within the academic year, and deemed at risk of serious harm to self or others.

Participants were recruited between 29th September 2016 and 8th February 2018 from 18 secondary schools in the Greater London area. The mean number of pupils per school was 900

(*SD*=226.1, range=445–1489). Seven of the schools (38.9%) were in the most deprived Index of Multiple Deprivation (IMD) quintile, with a further three (16.7%) in the second lowest quintile. The mean percentage of children from black and ethnic minorities, based on data provided by 11 of the 18 schools, was 47.0% (*SD* = 29%, range = 3.0%–89.0%).

Of the 329 participants recruited to the trial, 167 were allocated to the experimental conditions (SBHC+PCAU) and, of these, 15 (9.0%) did not complete the therapy relationship measures. This left 152 participants for our analysis: 114 female (75%), mean age 13.7 years old, 70 of a minoritized ethnicity (46%), and 86% without a disability (Supplemental Material 1). Demographically, these participants were broadly similar to the 15 SBHC+PCAU participants who did not complete the measures, as well as the 162 participants in the PCAU condition.

Measures

Barrett-Lennard Relationship Inventory: Form OS-40: T-S (Student Form, v. 3) (BLRI OS-40 T-S)

The Barrett Lennard Relationship Inventory *OS-40: T-S (Student form, v. 3)* (Barrett-Lennard, 2015), hereafter referred to as the "BLRI," was developed for students to rate their teachers' interpersonal skills (and, for the present study, their counselors, see Supplemental Material 2 for a detailed description). The BLRI has 10 items for each of its four subscales (Regard, Empathy, Congruence, Unconditionality) with item wording slightly adapted and simplified from the original BLRI. The 6-point response scale varies from -3 (*No, I definitely feel it's not true*) to -1: (*No, I think it's probably untrue*), and then from +1 (*Yes, I think it might be true*) to +3 (Yes*, I strongly feel that it is true*). No midpoint/0 response is available. The OS-40 has shown satisfactory levels of internal consistency (G. Ryan et al., 2023; Silva et al., 2016). In

the present study, Cronbach's αs were Regard = .83, Empathy = .90, Congruence = .76, and Unconditionality = .63.

Working Alliance Inventory Short Form (WAI-S)

The WAI-S is a 12-item measure, adapted from the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989). Like the WAI, the WAI-S is based on Bordin's (1979) tripartite model of the alliance, and consists of three 4-item subscales: agreement on goals (Goal subscale), collaboration on tasks (Task subscale), and the quality of the therapy relationship (Bond subscale). Responses are on a 1-7 point Likert scale, with higher scores indicative of a better alliance. The WAI-S is the most used alliance measure with young people and scores from it have demonstrated good internal consistency within youth samples (Cronbach's α = .94, Capaldi et al., 2016). In the present study, internal reliability for the WAI-S total score was a Cronbach's α of .93, with αs of Goal = .83, Task = .72, and Bond = .90.

Experience of Service Questionnaire (ESQ)

The 12-item Experience of Service Questionnaire (ESQ) is a widely used measure with young people to assess satisfaction with treatment provision (Attride-Stirling, 2003). It asks respondents to, "Please think about the appointments you have had at this service or clinic," and then to tick responses from a 2 ("Certainly true") to 0 ("Not true") scale, with the option of also ticking "?" ("Don't know"). Testers were instructed to make it clear to the young people that "service or clinic" referred to their psychotherapy. Of the 12 items, nine form a "Satisfaction with Care" main factor (Brown et al., 2014) which has been found to be robust and sensitive to clinical differences between high and low scoring respondents. Scores on this dimension range from 0 to 18, with higher scores indicating greater satisfaction. Cronbach's α for Satisfaction with Care in the present sample was .87.

Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening instruments for children and young people (Goodman, 2001b). The scale consists of 25 items divided between five subscales: (1) emotional symptoms (SDQ-ES), (2) conduct problems, (3) hyperactivity/inattention, (4) peer relationship problems, and (5) prosocial behavior. The first four subscales give a Total Difficulties score (SDQ-TD). Items are rated by the young person on a scale of *Not true* (0), *Somewhat true* (1), and *Certainly true* (2).

For the purposes of this study, we used scores on the SDQ-ES scale of the self-completed 11–17 year old SDQ to screen for eligibility. Internal consistency for scores on the youth-rated SDQ-ES have been established as $\alpha = .66$, and $\alpha = .80$ for SDQ-TD (Goodman, 2001a). For the present sample the internal consistencies were $\alpha = .70$ and $\alpha = .78$ respectively.

Procedure

Recruitment and Allocation

Recruitment was through the schools' pastoral care teams. The teams were briefed on the trial and, as a pre-screening stage, asked to identify potentially eligible young people. If young people expressed interest, their parents or carers were asked to provide written consent by a member of the pastoral care team. An assessor then met with the young person, formally assessed their eligibility, and (if eligible) invited the young person to provide written assent. Young people were then randomly assigned (1:1) to the two conditions.

Intervention

SBHC is a manualized form of humanistic therapy based on evidence-based competences for humanistic counseling with young people aged 11-18 years
(British Association for Counselling and Psychotherapy, 2019). SBHC assumes that distressed

young people have the capacity to address their difficulties if they can explore them with an empathic, supportive, and trustworthy counselor. SBHC therapists use a range of techniques, including active listening, empathic reflections, and inviting young people to express underlying emotions and needs. SBHC also included weekly use of the Outcomes Rating Scale (Miller et al., 2003). Sessions were delivered on an individual, face-to-face basis, and lasted 45-60 minutes. They were scheduled weekly over a period of up to 10 school weeks, with young people able to terminate counselling prior to this time point.

SBHC was delivered by a pool of 19 counselors. Sixteen of the counselors were female with a mean age of 45.0 years old (*SD* = 9.0). Fourteen of the counselors were of White British ethnicity and five were of Black Caribbean or African ethnicity. All counselors were qualified to diploma level (at least a two-year, part time training) and had been qualified for an average of 7.2 years (*SD* = 6.6). The mean number of pupils per counselor was 8 (SD = 3.43), minimum was 2 and maximum was 14.

The counselors received, at minimum, four days of group training in SBHC, and were supervised by an experienced clinician throughout the trial. Adherence to SBHC was assessed by two independent auditors using a young person's adapted version of the Person Centred and Experiential Psychotherapy Rating Scale (PCEPS-YP) (Freire et al., 2014; Ryan et al., 2021). All counselors exceeded the pre-defined adherence cut-point.

Participants in the present sample had full access to their school's usual pastoral care: the schools' pre-existing services for supporting the emotional health and wellbeing of young people. Pastoral care varied substantially across schools and pupils. Typically, it involved time with school staff, such as pastoral care managers. In some instances, the service could also involve referral to community-based specialists, such as social workers or police liaison officers.

Amount of support could vary considerably, from single, one-off meetings of five minutes or less, to one day or more of ongoing help (e.g., with a learning support mentor). Although, for ethical and pragmatic reasons, we did not attempt to standardize the standard care schools were offering, pastoral care staff were asked to log all support provided (Cooper et al., 2021; Stafford et al., 2018).

Outcome Measurement

The BLRI and WAI-S were completed by young people at 6-weeks post-randomization. At 12-weeks post-randomization, participants were also asked to complete the ESQ and SDQ. Measures were administered by a tester who was independent to the counseling process.

Analysis

To test whether TIS and alliance were experienced as distinct aspects of the therapeutic relationship we performed several analyses within structural equation modelling (SEM) approach. Using confirmatory factor analysis (CFA) we focused on testing the hypothesis that common variance between youth perceptions of alliance and TIS was explained by one, higher-order latent factor of youth-perceived relationship quality. To approach this goal we checked whether this model (Figure 1) was supported by data, and whether it fitted the data better than models which excluded the existence of the third-order factor. The initial alternative model postulated that there were no second-order constructs (such as alliance and TIS), there were only various aspects of the therapeutic relationship correlated to each other (Figure 2). The next alternative model postulated one general factor explaining all aspects of therapeutic relationship but also assumed that there were no independent constructs such as alliance and TIS (Figure 3). The last of the alternative models postulated the existence of two independent but correlated second-order constructs—alliance and TIS—which explained the variability of specific aspects

of the therapeutic relationship (Figure 4). Comparing the models in terms of goodness of fit and the parsimony rule allowed us to verify the hypothesis about the existence of a general, third-order factor explaining two constructs: alliance and TIS.

Figure 1

One Third-Order General Factor Model

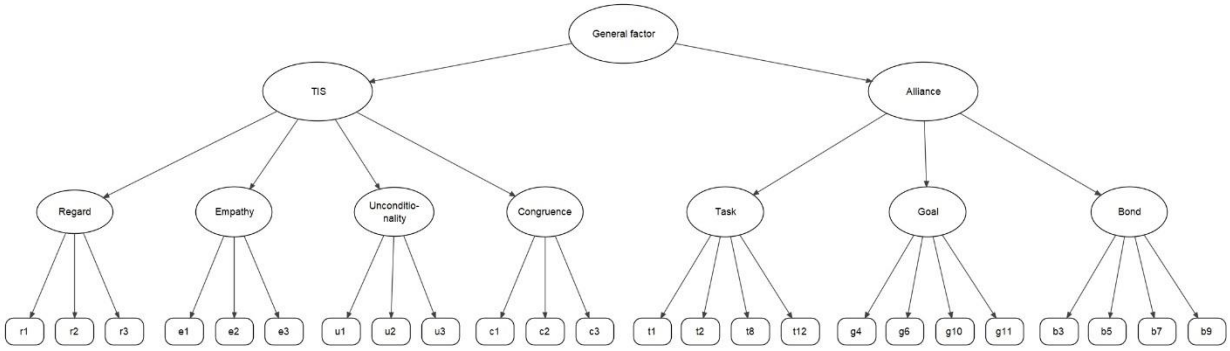


Figure 2

Correlated First-Order Factors Model

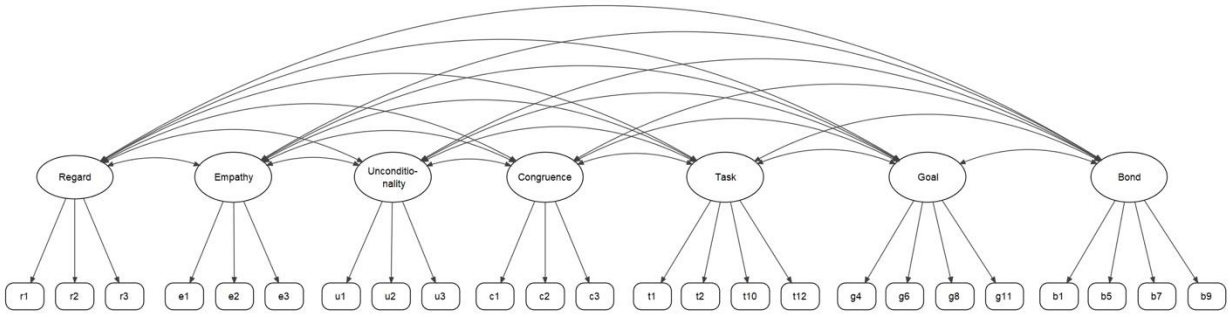


Figure 3

One General Second-Order Factor Model

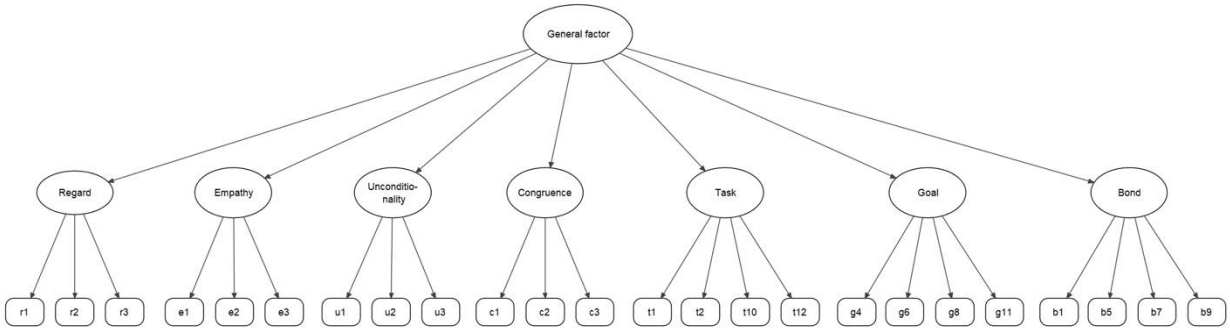
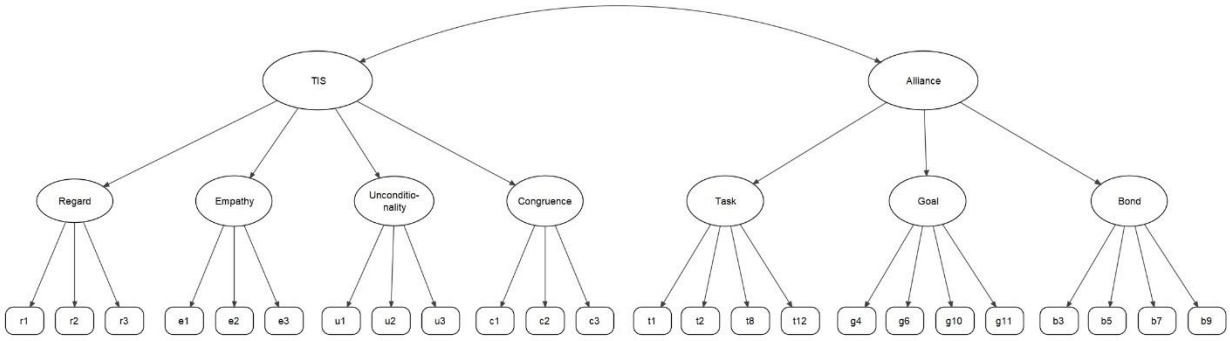


Figure 4

Two Correlated Second-Order Factors Model



Additionally, we tested whether both alliance and TIS have significant and independent effects on variables conditioned on the therapy results, i.e. satisfaction with psychotherapy (measured by ESQ) and level of psychological difficulties after psychotherapy (measured by SDQ-TD). For this criterion variable analysis, we hypothesized that variance shared by the alliance and TIS completely explained effects of these predictors on the dependent variables. In other words, we expected that there were no independent effects of alliance and TIS on satisfaction with therapy and total difficulties after therapy; rather we expected that latent variable representing variance shared by alliance and TIS explained both dependent variables. To test these hypotheses we performed structural equation analyses—for the two dependent variables separately—and within each of these analyses we compared two models: one with two

independent latent variables of alliance and TIS, and a second with the latent variable of youth-perceived relationship quality representing common variance between alliance and TIS (Figure 5). We checked which of the models was better fitted and gave more information about the dependent variable.

Figure 5

TIS and Alliance as (A) Two Second-Order Factors, and (B) A General Third-Order Factor (Youth-Perceived Relationship Quality) Predicting Satisfaction with Care

We utilized the lavaan R package (Rosseel, 2012) to estimate all hypothesized models. To address missing data, we applied the full information maximum likelihood estimation method. As our data exhibited deviations from the multivariate normal distribution (Mardia's skewness test = 9287.19, $p < .001$; Mardia's kurtosis test = 13.95, $p < .001$), we applied the Satorra-Bentler scaled chi-square statistic and standard errors (Satorra & Bentler, 1988). To evaluate model fit, we employed common indices: Tucker and Lewis Index (TLI), Comparative Fit Index (CFI), Root Mean Square Error of Approximation (RMSEA), and Standardized Root Mean Square Residual (SRMR). Adequate model fit was determined by TLI and CFI values greater than .90 (Bentler, 1990), RMSEA values lower than .08 (Browne & Cudeck, 1993), and SRMR values lower than .08 (Hu & Bentler, 1999). For comparing non-nested models, we used

the Bayesian Information Criterion (BIC), where smaller BIC values indicated better model fit compared to alternative models (Burnham & Anderson, 2004).

Because our hypotheses referred to the question of whether the postulated models were fitted to data, we computed two kinds of a priori power analyses to check if we had sufficient power to detect (1) the well-fitted models, taken into account several parameters such as degrees of freedom (the smallest *df* in our models is 229), alpha level = .05, beta level = .20, and conservative RMSEA effect size = 0.05; and to detect (2) significant differences between models' fit (in terms of ΔRMSEA = 0.005). Both power analyses were computed with semPower package in R (Moshagen & Bader, 2024). The first power analysis suggested that to detect RMSEA = 0.05 with the probability of .80 we need at least $N = 104$ observations if our model had at least $df = 229$. The second analysis showed that to detect subtle but significant difference of ΔRMSEA = .005 (RMSEA1 = 0.045 and RMSEA2 = 0.050) between two models with $df1 = 244$ and $df2 = 229$, we needed at least $N = 130$ observations. Hence, both analyses confirmed that we have enough power to detect the well-fitted models with degrees of freedom equal at least 229 and differences between RMSEAs for models with $\Delta df =$ at least 15.

Results

Preliminary Analyses

On average, young people attended for 7.80 sessions of counseling (SD = 2.70, range: 0–11).

Before examining complex structural models, we initially confirmed the latent structure of the four measures (BLRI, WAI, ESQ, and SDQ-TD) separately (see Supplemental Material 3 for detailed analysis). Based on CFA we found that BLRI items variability was explained best by the hierarchical model with one second-order factor and four first-order factors (i.e. regard,

empathy, unconditionality, and congruence): $\chi^2(50) = 75.61$, $p = .011$, CFI = .97, TLI = .96, RMSEA = .058 (95%CI: .031, .082), SRMR = .048. The structure of the alliance was described best by the model with the general second-order factor explaining three first-order factors (i.e., tasks, goals, and bonds): $\chi^2(51) = 85.59$, $p < .001$, CFI = .96, TLI = .95, RMSEA = .067 (95%CI: .044, .088), SRMR = .042. One general factor model with covariances between three pairs of items provided good fit for the ESQ: $\chi^2(24) = 26.62$, $p = .32$, CFI = .99, TLI = .99, RMSEA = .029 (95%CI: .001, .072), SRMR = .049. Finally, four first-order factors model with covariances between three pairs of items had acceptable fit for the SDQ-TD: $\chi^2(161) = 224.666$, $p < .001$, CFI = .87, TLI = .85, RMSEA = .053 (95%CI: .036, .068), SRMR = .080.

Correlations within the four BLRI subscales ranged from .52 to .78 (*Mdn* = .60), within the three WAI-S subscales ranged from .74 to .85 (*Mdn* = .76), and between the BLRI subscales and the WAI-S subscales from .38 to .80 (*Mdn* = .69) (Supplemental Materials 4).

Main Analyses

Each model demonstrated adequate fit (Table 2), however both the two correlated second-order factors (Figure 4) and the one third-order general factor model (Figure 1) exhibited better data fit (BIC = 14540.77) than correlated first-order factors (BIC = 14562.25; Figure 2) and one general second-order factor (BIC = 14585.62; Figure 3). Although the correlated second-order factor model (Figure 4) demonstrated equivalent fit indices, the hierarchical, third-order model (Figure 1) is theoretically more parsimonious. This model explains the covariance between second-order factors through a single, overarching construct, rather than relying on freely estimated correlations among them. Thus, it provides a more economical and integrative conceptual account of the relationships between constructs.

Table 2

Confirmatory Factor Analysis (CFA) for Factor Structures of the WAI and BLRI

Model	χ^2	*df*	*CFI*	*RMSEA*	*SRMR*	*AIC*	*BIC*
One third-order factor (Fig. 1)	385.72	244	.93	.062	.063	14371.43	14540.77
Correlated first-order factors (Fig. 2)	339.88	229	.94	.056	.060	14347.56	14562.25
One second-order factor (Fig. 3)	420.82	245	.91	.069	.065	14419.30	14585.62
Two second-order factors (Fig. 4)	385.72	244	.93	.062	.063	14371.43	14540.77

Further examination of the estimated parameters in the hypothesized superordinate factor model (Figure 1) revealed that the general factor explained a substantial amount of variance for TIS (81%) and alliance (98%). This suggests both constructs have significant commonality and can be considered good indicators of a higher-order construct, which we termed *youth-perceived relationship quality*. All factor loadings for the third-order general factor model are presented in Supplemental Materials 5 and 6. We note that one item, G10, had a low factor loading on the Goals subscale of the WAI-S.

Criterion Variable Analysis

Satisfaction with Care

An initial correlational model for pairwise correlations between the three latent constructs demonstrated acceptable fit: $\chi^2(482) = 662.65$, $p < .001$, CFI = .91, TLI = .90, RMSEA = .053 (95%CI: .044, .062), SRMR = .068. High correlations were found between all latent variables: $r = .90$ for the relationship between alliance and TIS, $r = .79$ for the relationship between alliance and satisfaction with care, and $r = .73$ for the relationship between TIS and satisfaction with care (all correlations were significant with $p < .001$). As the correlational model and the model with TIS and alliance as independent predictors of satisfaction with care (Figure 5A) are equivalent,

the latter model had identical fit indices. The superordinate factor model (Figure 5B) also exhibited satisfactory fit: $\chi^2(483) = 673.06$, $p < .001$, CFI = .90, TLI = .90, RMSEA = .055 (95%CI: .046, .063), SRMR = .071. However, BIC values suggested the independent latent predictors model (Figure 5A) fitted better compared to the superordinate factor model (Figure 5B), BIC = 14030.15 and BIC = 14036.51, respectively.

Further examination revealed that TIS and alliance effects, treated independently (Figure 5A), explained 63% of the variance in satisfaction with care, while the superordinate factor of youth-perceived relationship quality (Figure 5B) explained 60% of the dependent variable variance. Youth perceived relationship quality significantly predicted satisfaction with care ($\beta = .77$, $p < .001$). The alliance also significantly predicted satisfaction with care ($\beta = .71$, $p = .012$), but the independent effect of TIS was not significant ($\beta = .09$, $p = .75$). Given the very high correlations between alliance and TIS ($r = .90$), most of the common variance between TIS and satisfaction with care is probably explained by alliance. Considering both variables as independent predictors of satisfaction with care added minimal value compared to using one predictor representing common variance between them.

Total Difficulties

A model including pair-wise correlations between three latent variables demonstrated good fit to data: $\chi^2(340) = 502.37$, $p < .001$, CFI = .93, TLI = .92, RMSEA = .067 (95%CI: .047, .057), SRMR = .067. Total difficulties correlated weakly but significantly with alliance, $r = -.24$, $p = .02$, while a correlation between difficulties and TIS was non-significant, $r = -.20$, $p = .09$. The model with the TIS and alliance as latent predictors of total difficulties, being equivalent to the correlational model, was fitted to data the same as the latter. The model with a superordinate factor representing youth-perceived relationship quality exhibited acceptable fit too: $\chi^2(341) =$

501.77, $p < .001$, CFI = .93, TLI = .92, RMSEA = .057 (95%CI: .047, .066), SRMR = .068. In this case, BIC values suggested the superordinate factor model fitted slightly better compared to the independent latent predictors model, BIC = 16,386.20 and BIC = 16,390.30, respectively.

TIS and alliance explained 5.9% of total difficulties variance, while the general latent factor explained 4.5% of this variance. Youth-perceived relationship quality, as a superordinate latent factor, significantly predicted total difficulties, $\beta = -.21$, $p = .026$. However, although variance explained by alliance and TIS modeled as independent predictors was comparable to the variance explained by the superordinate factor, none of the independent predictors had significant effect on total difficulties: $\beta = -.32$, $p = .330$, $\beta = .09$, $p = .784$ (for alliance and TIS, respectively). Taking all the results together (i.e., high correlation between alliance and TIS, significant pair-wise correlation between alliance and total difficulties, non-significant effects of both predictors modeled together, and significant effect of superordinate factor), we can repeat the previous conclusions: treating alliance and TIS as independent predictors of total difficulties adds very little value compared to using one predictor: youth-perceived relationship quality.

Discussion

This study investigated the extent to which the alliance and the TIS of empathy, unconditional positive regard, and congruence are perceived by young people as distinct or overlapping dimensions. We found considerable commonality between experiences of alliance and TIS, such that these dimensions may be considered indicators of a higher-order construct that we have called *youth-perceived relationship quality*. Taken independently, youth-perceived TIS and alliance explained slightly more of the variance in satisfaction with care and total difficulties than this overarching relationship quality. However, including both variables as independent predictors added minimal explanatory value compared to using a single predictor of

relationship quality (3% and 1.4%, respectively). Notably, introducing youth-perceived TIS into our modeling of youth satisfaction and level of difficulties did not add significantly to alliance.

Previously, Cirasola et al. (2021) have shown that, from a youth perspective, the alliance is best conceptualized as a one (or, possibly, two) dimensional construct, rather than having three distinct components. Our research builds on this finding and, consistent with previous qualitative research (Dimic et al., 2023; Manso et al., 2008), suggests that young people's perceptions of the therapist's interpersonal skills may also be aligned to this one dimension.

One explanation for the lack of distinction between these relationship factors, as perceived by young people, is the way that alliance and TIS variables are measured, where there is a high degree of overlap across scale items. For instance, while the WAI-S has an item "I feel really understood," the BLRI empathy subscale has an item "_____ understands me". However, the subscales of these measures reflect systematic, nuanced, and well-informed attempts to operationalize these constructs, with score interpretations that have shown validity and reliability through subsequent enquiry. It is possible, then, that alliance and TIS variables could be operationalized in ways that emphasize, more clearly, their distinctiveness; but such operationalizations may deviate from how these constructs are typically and traditionally understood.

Alternatively, it may be that young people do not have the formal operational abilities to conceptualize multiple, distinct dimensions in their relationship with a psychotherapist, as hypothesized in our Introduction (Huitt & Hummel, 2003; Piaget, 1972). Hence, young people may perceive only one main dimension of relationship quality, along a good–bad axis. If this is the case, it is also possible that one construct, or a small handful of constructs—far less than theoretically hypothesized—underpin all young people's perceptions of the therapy relationship:

inclusive, for instance, of such factors as the real relationship, treatment credibility, and managing countertransference.

Our research findings also raise the possibility that there may be a single latent dimension—or a very small number of latent dimensions—that underlie therapist, parent, and observer perceptions of the youth psychotherapy relationship. This has some support from previous research, suggesting that therapist in-session behavior and interactions styles—as assessed from a range of perspectives—are closely associated to ratings of alliance (R. Ryan et al., 2023). These underlying dimensions may be consistent or, potentially, could vary in nature and number across perspectives. Hence, while previous research has analyzed TIS (as rated by observers) as predictors of subsequent alliance quality (as rated by young people) (e.g., Russell et al., 2008), it may be helpful, first, to establish the particular relationship dimensions that are, empirically, distinct within and across perspectives. Our findings also raise the question of whether—for adult patients as well as youth—there is a greater degree of overlap in our relationship constructs than psychotherapy researchers have assumed (e.g., Norcross & Lambert, 2019).

In terms of limitations, our study investigated the alliance–TIS association in one form of therapy, in one setting. It is possible that, in other therapies, across different therapies, or in different settings, the degree to which relationship dimensions are distinct could vary. However, the diversity of psychotherapies in Dimic et al.'s (2023) qualitative review—including psychodynamic, CBT, and eclectic approaches—suggests that an integrative experiencing of relationship factors by youth may be common across orientations. We also focused on just one subset of TIS (albeit the most prominent), and it is possible that, with other TIS (for instance, therapist alliance-building behaviors), different results would have been attained. We also

investigated ratings relatively early on in a psychotherapy process: 6-weeks post-randomization. It is possible that, with more time, young people might develop more nuanced perceptions of the relationship with their therapist, with a greater distinctiveness between TIS and alliance. However, it is also possible that even greater convergence between these variables may occur over time. By analyzing TIS and alliance at just one point in time, we also did not allow for the possibility that perceptions of the alliance may fluctuate over the course of psychotherapy (Lin et al., 2023; Zilcha-Mano & Errázuriz, 2017) contrasting, potentially, with more stable perceptions of psychotherapists' competences. In addition, such analysis does not allow for the possibility that TIS may help with alliance formation in the very early stages of psychotherapy but that, once alliance is formed, the two constructs may be largely overlapping. Hence, temporally-related nuances and complexities in youth perceptions of alliance and TIS may have been missed. One of our items, G10, loaded poorly onto its goal subscale. Cirasola et al. (2021) also found low inter-item correlations and poor factor loading for this particular item, suggesting that some further revision of the WAI-S may be needed for adolescent use. Young people who assent to take part in trials, and whose parents or carers consent to this participation, may not be representative of the population of potential patients. Caution must be taken, therefore, in generalizing the present findings outwards. Caution is also required because a general, sample-wide finding of indistinctness does not mean that these dimensions will be indistinct to each individual client.

For trainers and clinicians in the field of youth psychotherapy, our findings suggest that there may be value in orienting towards relationship quality as a general, holistic feature of the psychotherapeutic work, as compared with a compartmentalized focus on discrete relationship elements. Rogers's (1957) TIS remain a widely-used framework for psychotherapy training,

particularly person-centered and humanistic approaches (Di Malta et al., 2024). In the UK, competences for work with children and young people have distinct sets of competences for alliance, empathy, acceptance, and genuineness—each, themselves, containing dozens of specific competence statements and sub-statements
(British Association for Counselling and Psychotherapy, 2022). These psychotherapist competences can help to build up, in young people, a perception of relationship quality. However, our results suggest that it may also be important to include, in training and in competence frameworks, metacompetences regarding psychotherapists' abilities to "mentalize" youth perceptions of the psychotherapy relationship as an integrated, unidimensional whole. Closely related to this, our findings suggest that—as clinicians, researchers, or theoreticians—we may have tended to over-complicate concepts, or over-emphasized model-specific relationship elements at the expense of common factors (Wampold & Imel, 2015). If young people's perceptions of such relationship factors are relatively indistinct, we may be more helpful focusing on strategies, across orientations, that can help to improve young people's experiences of the therapeutic relationship as a whole.

A principal focus for future research should involve investigating the level to which our findings can be generalized: what degree of commonality exists across other youth-perceived relationship factors, and does it exist from other rater perspectives? As with Nienhuis et al. (2018), multiple datasets currently exist that may allow for such analyses. It would also be useful to develop studies with repeated measurements for each variable over the course of psychotherapy and cross-lagged analyses, to test the type, and development, of associations over time. Multilevel structural equation modelling would allow correlations between specific

experiences of a single session to be observed, as well as more general relationships at the level of overall trends.

In summary, our research has conclusively demonstrated that very little distinction exists in how young people perceive the collaborative bond with their psychotherapist and that psychotherapist's levels of empathy, genuineness, and unconditional positive regard. Focusing on youth-perceived relationship quality overall, rather than on distinct and separable elements of the psychotherapy relationship, may provide a helpful way forward for clinical practice, training, and research.

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Young People's Perceptions of Therapist Interpersonal Skills and Alliance: How Distinct are They?

Structured Clinical Impact Statement

Question. This paper investigates whether, from the perspective of adolescent patients, alliance and therapist interpersonal skills (TIS) of empathy, unconditional positive regard, and congruence are experienced as distinct or overlapping constructs. ***Findings.*** We found a high degree of commonality. ***Meaning***. Clinicians and trainers in the field of youth psychotherapy may benefit from a recognition of "relationship quality" as a general, unidimensional feature of how young people perceive the psychotherapeutic relationship. ***Next steps***. Future research should consider whether other therapy relationship variables, from the perspective of young people, also align to a general relationship quality factor.