The Therapy Process Observational Coding System—Alliance Scale: Measure Characteristics and Prediction of Outcome in Usual Clinical Practice

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The authors describe psychometric characteristics of the new Therapy Process Observational Coding System—Alliance scale (TPOCS–A; B. D. McLeod, 2001) and illustrate its use in the study of treatment as usual. The TPOCS–A uses session observation to assess child–therapist and parent–therapist alliance. Both child and parent forms showed acceptable interrater reliability and internal consistency; when applied to cases treated for internalizing disorders, both forms were associated with youth outcomes. Child–therapist alliance during treatment predicted reduced anxiety symptoms at the end of treatment. Parent–therapist alliance during treatment predicted reduced internalizing, anxiety, and depression symptoms at the end of treatment. The findings held up well after confounding variables were controlled, which suggests that both child–therapist and parent–therapist alliance play key (and potentially different) roles in the outcome of treatment as usual.

About 20% of children[1] suffer from diagnosable mental disorders (U.S. Department of Health & Human Services, 1999), and each year more than 6.9 million American youngsters receive treatment (Sturm, 1997). Given the large number of youths receiving treatment, obtaining a better understanding of the therapeutic processes that facilitate psychotherapy improvement for children is an important goal. Researchers and practitioners alike suggest that the client–therapist alliance is a factor that warrants empirical attention in child therapy (Durlak, Wells, Cotten, & Johnson, 1995; Kazdin, Siegel, & Bass, 1990; Shirk & Saiz, 1992; Weisz, Huey, & Weersing, 1998). However, unlike the research with adults, which shows alliance to be a rather consistent predictor of successful therapy outcome (see Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), research on child therapy has not established a conclusive link between alliance and outcome.

In an important recent meta-analysis, Shirk and Karver (2003) reported on the state of the field of alliance–outcome association in children. The studies reviewed encompassed a broad array of treatment approaches, including individual-, parent-, and family-focused treatment; prevention programs; restitution-oriented work programs; and medical treatment of chronic asthma. Fewer than half the studies used measures designed specifically to assess the alliance, and only one alliance measure was used in multiple studies (i.e., the Child's Perception of Therapeutic Relationship [CPTR]; Kendall, 1994; Kendall et al., 1997). Moreover, there were substantial study-to-study differences in which alliance dimensions were measured, how alliance was conceptualized (e.g., psychodynamic vs. pantheoretical), and whose perspective on the alliance was assessed (i.e., child, therapist, parent, observer). This variability in measurement makes comparing results across studies difficult and underscores the need for a set of psychometrically sound alliance measures for child therapy (Shirk & Karver, 2003; Weisz et al., 1998).

In developing and validating alliance measures for child therapy, it is important to pay attention to the two participants whose relationship with the therapist seems crucial (see Shirk & Karver, 2003; Weisz et al., 1998). A distinctive challenge for child psychotherapists is building an alliance with both child and parent. The child is often in therapy involuntarily, and the parent and child may not agree on the target problem or the treatment goals (Hawley & Weisz, 2003; Yeh & Weisz, 2001). Because both children and parents play prominent roles in the process, assessment of child–therapist alliance needs to be complemented by assessment of parent–therapist alliance. To date, no studies examining the alliance–outcome association in child therapy have assessed parent–therapist alliance. In fact, only a single published study has examined parent–therapist alliance, and this was done in the context of parent-focused treatment (see Kazdin & Wassell, 1999). It therefore remains an open question whether child and parent alliance are differentially associated with outcome.

[1] We use the term *children* to encompass both children and adolescents, except when distinctions need to be made between the two age groups.

Another feature needed in alliance measures for child therapy is identification of the alliance dimensions that are particularly relevant to child therapy, as opposed to therapy with adults (Shirk & Karver, 2003). The therapist's ability to develop a warm relationship and engage both the child and the parent in the therapeutic process is believed to be crucial to the success of child therapy (Diamond, Diamond, & Liddle, 2000; Shirk & Russell, 1998; Shirk & Saiz, 1992). These two alliance dimensions, termed *bond* and *task*, refer to the affective aspects of the client–therapist relationship and client participation in the activities of therapy, such as discussing feelings. These dimensions are hypothesized to be important for children, who are often in therapy involuntarily and may not acknowledge experiencing problems (Shirk & Russell, 1998), and for parents, who play a crucial role in deciding how long treatment will last (Armbruster & Kazdin, 1994; Cottrell, Hill, Walk, Dearnaley, & Lerotheou, 1988). Given the prominence of these two dimensions in the theoretical literature, it is important that an alliance measure for child therapy assess both.

A third feature that seems highly desirable in the assessment of alliance is direct observation. Most current child alliance measures have relied on self-reports from the child, parent, or therapist. Such methods have real value because they can directly assess the child's and/or parent's thoughts about the alliance relationship. However, self-report methods may also make alliance–outcome associations (or the absence of them) difficult to interpret, especially in child therapy (Shirk & Karver, 2003). Developmental factors may limit a child's ability to report on the alliance relationship (Shirk & Karver, 2003); child and parent reports may also reflect demand characteristics of the assessment or a desire to say nice (or not so nice) things about the therapist. Ratings by trained observers, by contrast, may be relatively free of such limitations and thus provide more information than self-report measures (Shirk & Karver, 2003).

Another methodological issue is important in studies of alliance–outcome relations: ruling out alternative explanations (e.g., that change in symptomatology causes positive alliance). To rule out alternative explanations, alliance researchers using correlational designs can (a) attempt to eliminate theoretically relevant third variables that may account for alliance–outcome associations (e.g., client and/or therapist characteristics hypothesized to relate to the alliance and/or the outcome) and (b) establish the temporal sequence of the variables by measuring alliance prior to outcome (Feeley, DeRubeis, & Gelfand, 1999; Judd & Kenny, 1981). However, most child studies to date have failed to either rule out spurious explanations or establish the temporal sequence (Shirk & Karver, 2003). Consequently, little clear evidence exists on the predictive association between alliance and outcome in child therapy, a gap that researchers can remedy by measuring alliance prior to outcome and ruling out plausible third-variable explanations.

The Therapy Process Observational Coding System for Child Psychotherapy—Alliance scale (TPOCS–A; McLeod, 2001) was developed to address past limitations and to examine the alliance–outcome association in child therapy. The TPOCS–A was designed to provide the field with a comprehensive coding system capable of objectively describing child and parent alliance. The TPOCS–A differs from previous research instruments in that it (a) targets each of the principal players involved in child therapy process (i.e., child and parent in relation to therapist), (b) thoroughly assesses the alliance across both bond and task dimensions, and (c) is based on observer coding of actual therapy sessions.

In this report, we describe the development and report on the psychometric properties of the TPOCS–A and then use the measure to examine two important questions regarding the alliance–outcome association in child treatment as usual (TAU) for youths with internalizing disorders (i.e., anxiety and depressive disorders). First, is child and/or parent alliance associated with outcomes in TAU for youths with internalizing disorders? We hypothesized that a strong child–therapist alliance and a strong parent–therapist alliance would be associated with a significant reduction in youth symptomatology (Shirk & Karver, 2003). Second, are child and parent alliance differentially associated with outcomes in TAU for youths with internalizing disorders? Because no prior published report has examined whether parent alliance is associated with outcome in a sample of youths with internalizing disorders, we offer no a priori hypothesis. We focus on youth internalizing disorders because these disorders are typically treated via child-focused therapy with parent participation (see Barrett, Dadds, & Rapee, 1996; Kendall, 1994), in contrast to treatments for more externalizing, disruptive disorders (e.g., attention-deficit/ hyperactivity disorder [ADHD], conduct disorder). These treatments typically involve interventions directed solely at parents or teachers (Kaslow & Thompson, 1998; Ollendick & King, 1998), which makes it difficult to assess child–therapist alliance.

Method

Participants

Child participants. Participants were drawn from five outpatient community mental health clinics in Los Angeles County, California, participating in the Youth Anxiety and Depression Study (YADS; Weisz, 2004a). For the project, as families called a clinic, they were asked to identify the problems that had led them to call. If the problems included symptoms of anxiety or depressive disorders and consent was obtained, a standardized diagnostic interview and other measures (see below) were administered. As one aspect of YADS, children who had depressive or anxiety disorders and whose parents believed that the internalizing diagnoses should be the primary focus of treatment received TAU from therapists employed in the clinic, and therapy sessions were taped. Participant inclusion was determined partly by a team of project and clinic staff, who used standardized diagnostic interviews to verify that each child met *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; *DSM–IV*; American Psychiatric Association, 1994) criteria for an anxiety or depressive disorder (described below), and partly by parents, who judged whether the internalizing disorders should be the primary treatment focus. Children with mental retardation or psychotic symptoms were excluded.

The 22 children (9 boys and 13 girls) in this study averaged 10.30 years of age ($SD = 1.83$, range = 8–14). Reflecting the diversity of Los Angeles (58.0% ethnic minority; U.S. Census Bureau, 1999), 41.0% were Caucasian, 36.0% were Latino, 18.0% were African American, and 5.0% were of other ethnicities (e.g., Native American). Annual income was under $15,000 for 46.0% of the families, $15,000 to $30,000 for 23.0%, and over $30,000 for 31.0%.

Therapist participants. The 20 therapists (30.0% social workers and 70.0% psychologists; mean age = 31.70, $SD = 6.19$, range = 25–50) participating in the study were 35.0% Caucasian, 35.0% Latino, 10.0% Asian and Pacific Islander, 10.0% mixed race (e.g., Caucasian and Latino), and 5.0% African American. The therapists averaged 7.42 ($SD = 2.91$) years of experience (i.e., number of years spent in training and as a professional therapist). The professional and demographic characteristics

of the therapists are comparable to previous TAU samples (see Weersing, Weisz, & Donenberg, 2002).

Coders. The coding team consisted of 2 clinical psychology graduate students and a licensed clinical psychologist (2 men and 1 woman). Coders ranged in age from 30 years to 32 years ($M = 30.67$, $SD = 1.15$) and included 2 Caucasians and 1 Latina. Each coder had previous coding experience, though none had coded therapy process. The coders each had at least 5 years of clinical experience, and all had been trained in individual talk, family, group, and play therapy with children. In addition, each coder had been trained to use behavioral, cognitive–behavioral, psychodynamic, family systems, and client-centered treatment approaches.

Development of the TPOCS–A

The TPOCS–A (McLeod, 2001)[2] is a nine-item measure consisting of a child and parent form designed to provide the field with a comprehensive coding system capable of objectively describing child–therapist and parent–therapist alliance. The TPOCS–A was developed via a five-step process.

Step 1: Scale focus. First, we identified the alliance dimensions relevant to child therapy that became the TPOCS–A subscales. We used the two dimensions emphasized in the literature as TPOCS–A subscales (Shirk & Russell, 1998; Shirk & Saiz, 1992)—that is, bond (i.e., affective aspects of the client–therapist relationship) and task (i.e., client participation in the activities of therapy, e.g., play or discussion of feelings and cognitions). These dimensions are believed to be crucial to the success of child therapy and relevant for both child–therapist and parent–therapist alliance (Diamond et al., 2000; Shirk & Russell, 1998; Shirk & Saiz, 1992).

Step 2: Subscale and item development. The second step was to create items for the subscales. In accord with accepted psychometric practice, we sampled multiple sources when drafting the items to establish their preliminary face and content validity (see Lambert & Hill, 1994): the CPTR (Kendall, 1994; Kendall et al., 1997), the Child Psychotherapy Process Scales (CPPS; Estrada & Russell, 1999), the Revised Vanderbilt Therapy Alliance Scales (RVTAS; Diamond, Liddle, Hogue, & Dakof, 1999), and the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992). The 33-item CPPS and the 32-item RVTAS primarily assess the task and goal alliance dimensions. The 10-item CPTR and the 8-item TASC are self-report measures that primarily assess the bond alliance dimension. As none of the measures thoroughly assessed both the bond and the task dimension, we combined the measures. CPTR and TASC items that could be defined in terms of observable behavior (5 CPTR items, 8 TASC items) were retained. In addition, items from all measures that mapped onto the bond and task dimensions (5 CPTR items, 14 CPPS items, 8 RVTAS items, and 8 TASC items) were kept, and redundant items were combined. The resulting item pool (5 Bond scale items and 6 Task scale items) was reviewed by clinical University of California, Los Angeles, psychology faculty and practicing clinicians, who were asked to classify each item as falling on either the bond or the task dimension. Items that were not classified correctly or identified as unclear were revised. On the basis of feedback, three additional items were generated for the Bond subscale (i.e., "Share his or her experience with the therapist," "Appear uncomfortable when interacting with the therapist," and "Maintain a professional working relationship"). The final version of the TPOCS–A consisted of the Bond (8 items) and Task subscales (6 items).

Step 3: Scoring strategy. With the items finalized, the next step was to determine the scoring strategy. For the ratings, we used the RVTAS 6-point Likert-type scale with the following anchors: $0 = $ *not at all* and $5 = $ *great deal*. The scoring strategy therefore involves (a) ratings on a 6-point Likert-type scale, (b) ratings of the entire therapy sessions, and (c) ratings of both child–therapist and parent–therapist alliance (i.e., the TPOCS–A consists of identical child and parent forms).

Step 4: Pilot coding. The finalized measure was then used to code 25 therapy sessions. Interrater reliability of each item was assessed, and those

items that demonstrated low reliability (intraclass correlation [ICC] below .40; Cicchetti & Sparrow, 1981) were refined. During the piloting phase, coders provided feedback on item content and definitions, which was used to refine the TPOCS–A items.

Step 5: Research applications. For the present study, the TPOCS–A was used to code child and parent alliance in 87 and 49 therapy sessions, respectively. Following the completion of coding, the interrater reliability of each item was assessed (see below), and those items that did not demonstrate adequate reliability (i.e., ICC below .40; Cicchetti & Sparrow, 1981) on the child and parent form were dropped. With items dropped, the final TPOCS–A child and parent forms consisted of nine items: "experience therapist as supportive"; "act hostile toward therapist"; "demonstrate positive affect toward therapist"; "share experience with therapist"; "uncomfortable interacting with the therapist"; "degree to which client and therapist have difficult interacting"; "use skills learned in therapy to make changes outside of therapy"; "not comply with tasks"; and "work together equally on tasks."

TPOCS–A Scoring and Session Sampling Procedures

To ensure that coders were properly trained and to minimize rater drift, we used the following procedures to generate scores on the TPOCS–A items.

Sampling of therapy sessions. Contact was maintained with the therapists over the course of treatment, and the therapists informed project staff when each case terminated (i.e., therapists and/or clients decided to stop). At termination, four sessions from each case were selected for scoring. To sample different phases of therapy, we separated each case into beginning, middle, and end stages by dividing the total number of sessions by three. One session was randomly selected from the beginning (excluding the first session) and end (excluding the last session) stages, and two sessions were selected from the middle (see Patterson & Chamberlain, 1994). We followed this sampling procedure except when there were multiple therapists (three cases had two therapists because of therapist turnover). For these cases, we randomly selected two middle session tapes from each therapist.

Coder training. Coders trained over a 2-month period to reach adequate prestudy reliability (ICC > .60; Cicchetti & Sparrow, 1981). Bryce D. McLeod trained the coders. Training consisted of reading the scoring manual, reviewing specific session segments, and practicing scoring sessions. Once scoring commenced, tapes were randomly assigned to coders, and regular reliability assessments were performed. The results of these assessments were discussed in weekly meetings to prevent rater drift (Margolin et al., 1998). Coders were blind to treatment outcome.

Scoring of therapy sessions. Coders scored entire therapy sessions, which ranged in length from 30 to 63 min ($M = 44.98$, $SD = 8.53$). Each therapy session was double coded: One coder scored all sessions, and the other coders scored 47 and 41 sessions, respectively. For process analyses, a mean score for the scoring pairs on each item was used. Mean scores were used, as opposed to scores produced by one coder, because they reduce measurement error by removing differences among coders (Lambert & Hill, 1994).

Assessment Procedure

Children and their parents were interviewed on two occasions: (a) a pretreatment interview conducted shortly after the clinic intake, and (b) a

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[2] The Therapy Process Observational Coding System for Child Psychotherapy (TPOCS; McLeod, 2001) consists of two broad scales: (a) The Strategies scale (TPOCS–S), and (b) the TPOCS–A. Because the focus of the present study is on alliance–outcome relations in TAU for youths with internalizing disorders, the TPOCS–S was not used extensively in the present study.

posttreatment interview conducted approximately 15 months after the pretreatment interview. Each interview lasted approximately 3 hr, and families received payment of $50 as an honorarium. At the pretreatment assessment, parents and children provided written consent (including consent to have therapy sessions taped) and demographic information and separately completed symptom measures. Posttreatment procedures closely followed those previously outlined for the pretreatment interview, except that families were paid $75 for participating.

Symptom and Diagnostic Measures

Diagnostic Interview Schedule for Children (DISC). The DISC (Version 4.0; Shaffer, Fisher, Dulcan, & Davies, 1996) is a structured clinical interview administered to parents and children (DISC-C) that generates an array of *DSM–IV* diagnoses and symptom counts. An earlier version (Version 2.3) generated a rich body of reliability and validity data (e.g., Rubio-Stipec et al., 1996); the DISC team continues to assess the DISC 4.0 psychometric characteristics (e.g., Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000). Because the length of DISC interviews was a significant problem for children, we only used the DISC-C for diagnostic domains for which children seemed to be particularly appropriate informants—that is, anxiety disorders, depressive disorders, and conduct disorder. Child diagnoses were obtained through combined parent and child report, except for ADHD and oppositional defiant disorder, which were based solely on parent report. We focused analyses for the present study on anxiety and depression symptoms, combining parent and child reports.

Child Behavior Checklist (CBCL). Parents completed the CBCL (Achenbach, 1991), a widely used and psychometrically sound measure. The 118 items assess symptoms across a broad range of clinical significance (e.g., from shyness to suicide attempts). CBCL raw scores are converted to *T* scores for three broadband scales (e.g., Internalizing) and eight narrow-band subscales (e.g., Somatic Complaints). In the current investigation, four CBCL scales were used: Total, Internalizing, Externalizing, and Anxious–Depressed. *T* scores above 70 are considered clinically significant, and scores between 65 and 69 are considered borderline significant. The CBCL has been used with acceptable levels of reliability to measure behavior problems of children aged 4–16 years in a variety of cultural settings (Achenbach, 1991; Achenbach et al., 1990).

State–Trait Anxiety Inventory for Children (STAIC). The STAIC (Spielberger, 1973) is a 20-item measure that assesses general and enduring anxiety symptoms. Extensive reliability and validity data are available (e.g., Kirisci, Clark, & Moss, 1996), and the measure demonstrated adequate internal consistency at pre- ($\alpha = .87$) and posttreatment ($\alpha = .87$) in the present sample.

Children's Depression Inventory (CDI). The CDI (Kovacs, 1992) is a 27-item measure of childhood depression backed by extensive reliability and validity data (e.g., Kovacs, 1992). Items assess a wide range of depression symptoms, including suicidality, anhedonia, and disturbances in sleep, appetite, and cognitive functioning. In the present sample, the measure demonstrated adequate internal consistency at pre- ($\alpha = .89$) and posttreatment ($\alpha = .72$).

Therapist Background Questionnaire. The Therapist Background Questionnaire (Weisz, 1997), obtained at pretreatment, consists of 21 questions regarding the therapist's personal characteristics (e.g., age), educational background (e.g., degree), primary theoretical orientation, clinical training, and experience.

Therapeutic Alliance Scale for Children (TASC). The TASC (Shirk & Saiz, 1992) is an eight-item self-report measure that assesses child and parent affect toward the therapist (seven items) and child and parent perceived agreement with the therapist regarding tasks of therapy (one item). The TASC was chosen because it has demonstrated excellent reliability and validity (see Shirk & Saiz, 1992) and because its brevity and simple language make it easy to comprehend and administer across the range of ages included in this study (8 years to adult). In this study, the

TASC demonstrated excellent internal consistency for the parent ($\alpha = .89$) and child report ($\alpha = .93$).

Results

We adopted a six-step approach to data analysis. First, we assessed the clinical characteristics of the sample. Second, we characterized the treatment procedures used in TAU. Third, we assessed the degree of pretreatment–posttreatment symptom change. Fourth, we investigated the psychometric properties of the TPOCS–A. Fifth, we examined alliance–outcome associations for children and parents. Sixth, we controlled for a series of alternative explanations that might explain the observed alliance–outcome associations.

TAU: Sample Characteristics, Treatment Procedures, and Treatment Outcome

Clinical characteristics. As is typical of community clinic samples (see Weersing & Weisz, 2002), the youths showed substantial comorbidity; the mean number of *DSM–IV* diagnoses was 3.32 (*SD* = 1.43, range = 1–6), and significant numbers of externalizing disorders were combined with the internalizing disorders. Child participants met criteria for the following diagnoses at pretreatment: generalized anxiety disorder (23.0%), separation anxiety disorder (46.0%), social phobia (46.0%), specific phobia (64.0%), major depressive disorder (23.0%), minor depressive disorder (23.0%), dysthymia (9.0%), ADHD (46.0%), oppositional defiant disorder (41.0%), and conduct disorder (14.0%). The mean CBCL Total score was 68.32 (*SD* = 8.19), the mean CBCL Internalizing score was 69.14 (*SD* = 8.62), the mean CBCL Anxious–Depressed score was 69.68 (*SD* = 8.93), and the mean CBCL Externalizing score was 64.23 (*SD* = 10.54).

Treatment procedures. TAU therapists were instructed to use the treatment procedures they believe in and use regularly in their clinic practice, and no effort was made to manipulate TAU in any fashion. Because there is no clearly accepted way to define completion of treatment in TAU, we focused on the end of treatment, the point at which no further sessions were held. The average number of sessions for the 22 cases was 17.76 (*SD* = 13.27, *Mdn* = 14.00, range = 6–62), and 14% had ended therapy in fewer than 8 sessions.

We expected that treatment would be primarily child-focused with parental participation. Session attendance was consistent with this prediction. All of the children (i.e., identified patients) participated in treatment, attending 87 of the 88 coded sessions (96.6%): On average, the child attended 74 (84.1%) complete sessions and 13 (12.5%) half sessions. Twenty of the primary caregivers (i.e., individuals who attended pre- and posttreatment assessments) attended at least 1 session, and 16 attended at least 2. Overall, caregivers attended 51 of the 88 coded sessions (58%): 34 (38.6%) complete sessions, 15 (17.0%) half sessions, and 2 (2.3%) quarter sessions.

Because TAU therapists were free to do whatever they chose, unguided by any manual or protocol, we expected that they would use an eclectic blend of therapeutic strategies (Weersing et al., 2002). In a separate study (see McLeod & Weisz, 2003), we explored this possibility using the TPOCS–S (McLeod, 2001), a therapy process measure designed to identify the therapeutic strat-

egies used by therapists in TAU. We did find that TAU therapists implemented an eclectic blend of treatment strategies drawn from multiple theoretical orientations, although they generally favored nonbehavioral strategies, such as psychodynamic and client-centered therapy, over behavioral strategies, such cognitive and behavioral therapy.

Treatment outcome. Table 1 shows pretreatment–post-treatment scores on the outcome measures. Paired comparisons revealed a significant reduction in CBCL Internalizing scores, $t(20) = 4.30$, $p < .01$; DISC anxiety symptoms, $t(19) = 10.07$, $p < .01$; and DISC depressive symptoms, $t(19) = 5.45$, $p < .01$. However, there was not a significant reduction in STAIC scores, $t(20) = 1.21$; and the reduction in CDI scores was a marginal effect, $t(19) = 1.77$, $p < .10$.

We next assessed the effectiveness of TAU by comparing our findings with an empirically supported treatment (EST) for youth anxiety disorders (i.e., Kendall et al., 1997). Kendall et al. randomly assigned 94 children to one of two conditions: a 16–20 session cognitive–behavioral treatment (CBT) or an 8-week control wait-list condition. Because our sample included youths with anxiety and depressive disorders, we limited our comparisons to broad internalizing symptoms (i.e., CBCL Internalizing). At pretreatment, the three conditions had similar CBCL Internalizing scores (i.e., borderline or clinical range; TAU: $M = 69.14$, $SD = 8.62$; CBT: $M = 72.07$, $SD = 6.87$; wait-list control: $M = 70.91$, $SD = 8.68$). However, at posttreatment the TAU ($M = 60.00$, $SD = 12.16$) and CBT ($M = 61.81$, $SD = 10.30$) conditions had similar scores that fell in the normal range, whereas the wait-list condition remained higher and fell in the borderline clinical range ($M = 68.73$, $SD = 8.44$). These findings indicate that the TAU and CBT conditions evidenced similar amounts of change in broad internalizing symptoms.[3]

TPOCS–A Psychometric Properties

Interrater reliability. We calculated interrater reliability for the TPOCS–A child and parent forms using ICCs (Shrout & Fleiss, 1979) and on the basis of the full sample of tapes. The reliability coefficients represent the model ICC(1, 3), on the basis of a one-way random effects model. The ICC provides an estimate of

the ratio of the true score variance to the total variance. These correlations therefore provide a reliability estimate of the mean scores of all coders considered as a whole and allow for generalizability of the results to other samples. Interrater reliability was acceptable (i.e., at least .40; see Cicchetti & Sparrow, 1981) for the child items ($M = 0.59$, $SD = 0.10$): "experience therapist as supportive" (ICC = .65; $M = 2.96$, $SD = 0.81$), "act hostile toward therapist" (ICC = .40; $M = 4.49$, $SD = 0.56$), "demonstrate positive affect toward therapist" (ICC = .56; $M = 2.54$, $SD = 0.73$), "share experience with therapist" (ICC = .75; $M = 3.08$, $SD = 0.89$), "uncomfortable interacting with the therapist" (ICC = .62; $M = 4.25$, $SD = 0.65$), "degree to which client and therapist have difficulty interacting" (ICC = .66; $M = 4.31$, $SD = 0.70$), "use skills learned in therapy to make changes outside of therapy" (ICC = .49; $M = 0.85$, $SD = 0.74$), "not comply with tasks" (ICC = .54; $M = 4.49$, $SD = 0.78$), and "work together equally on tasks" (ICC = .61; $M = 2.87$, $SD = 0.78$). Interrater reliability was also acceptable for the parent items ($M = 0.61$, $SD = 0.10$): "experience therapist as supportive" (ICC = .60; $M = 3.39$, $SD = 0.63$), "act hostile toward therapist" (ICC = .56; $M = 4.71$, $SD = 0.45$), "demonstrate positive affect toward therapist" (ICC = .49; $M = 2.89$, $SD = 0.75$), "share experience with therapist" (ICC = .54; $M = 3.54$, $SD = 0.52$), "uncomfortable interacting with the therapist" (ICC = .50; $M = 4.85$, $SD = 0.20$), "degree to which client and therapist have difficulty interacting" (ICC = .61; $M = 4.65$, $SD = 0.44$), "use skills learned in therapy to make changes outside of therapy" (ICC = .64; $M = 0.79$, $SD = 0.98$), "not comply with tasks" (ICC = .62; $M = 4.89$, $SD = 0.27$), and "work together equally on tasks" (ICC = .56; $M = 3.31$, $SD = 0.59$).

Subscale interdependence. Theoretical and empirical work thus far has not clarified whether the component alliance dimensions are independent or interdependent (see Bordin, 1979; Horvath & Greenberg, 1989; Shirk & Saiz, 1992). We therefore examined the degree of overlap between the Bond and Task subscales for the child and parent forms. We produced subscale scores by calculating the mean score for all tapes (i.e., tapes from the beginning, middle, and end therapy stages) of sessions that the client attended (i.e., child or parent) from each case on the nine TPOCS–A items, then averaging together items on each subscale. The Bond and Task subscales evidenced considerable overlap on both the child ($r = .58$, $p < .01$) and the parent ($r = .71$, $p < .01$) forms. Because of the substantial overlap and the fact that past research has suggested that the bond and task dimensions may not be distinct constructs in child therapy (see Shirk & Saiz, 1992), we combined the subscales for all subsequent analyses. Finally, we assessed the degree of overlap between the TPOCS–A child and parent forms. The correlation between the child and parent forms was $-.03$ ($n = 19$, *ns*), suggesting that child and parent alliance were independent.

Table 1
Means and Standard Deviations for Outcome Measures

	Pretreatment		Posttreatment		
Outcome domain	*M*	*SD*	*M*	*SD*	*p <*
Internalizing					
CBCL Internalizing score	69.14	8.62	60.00	12.16	.01
Anxiety					
DISC symptoms	34.90	12.07	17.19	11.46	.01
STAIC	33.29	7.52	30.43	8.24	*ns*
Depression					
DISC symptoms	17.81	7.95	9.24	6.33	.01
CDI	9.00	8.08	5.10	7.72	.10

Note. Significant differences reflect *t* tests comparing pre- and posttreatment scores. CBCL = Child Behavior Checklist; DISC = Diagnostic Interview Schedule for Children; STAIC = State–Trait Anxiety Inventory for Children; CDI = Children's Depression Inventory.

[3] We intended to assess the effectiveness of TAU by comparing our findings with previous findings on an EST for youth anxiety disorders and on an EST for youth depressive disorders; however, we were unable to identify a study using an EST for youth depressive disorders that included a measure of broad internalizing symptoms (i.e., CBCL Internalizing or Anxious–Depressed Scale). Thus, we only included a comparison involving an EST for youth anxiety disorders.

Internal consistency. Internal consistency of the child form was acceptable for the full sample ($\alpha = .95$), early alliance (i.e., average of first two sessions; $\alpha = .93$), and late alliance (i.e., average of last two sessions; $\alpha = .91$). The child form evidenced moderate stability over the course of therapy: The correlation between early and late alliance was .54 ($n = 22$, $p < .01$). With regard to the parent form, internal consistency was acceptable for the full sample ($\alpha = .89$), early alliance ($\alpha = .87$), and late alliance ($\alpha = .79$). The parent form evidenced high stability over the course of therapy: The correlation between early and late alliance was .88 ($n = 11$, $p < .01$).

Validity. A strong relation between a target measure and a separate measure examining the same construct provides evidence of convergent validity (Campbell & Fiske, 1959; Horvath & Greenberg, 1989). To examine the convergent validity of the TPOCS–A, we assessed the extent to which the child and parent forms overlapped with a self-report alliance measure, the TASC (Shirk & Saiz, 1992). For child alliance, the correlation (a) between the TPOCS–A child form and the TASC measuring child–therapist alliance was .53 ($n = 21$; $p < .02$), (b) between the TPOCS–A and TASC bond items was .51 ($n = 21$; $p < .02$), and (c) between the TPOCS–A and TASC task items was .66 ($n = 21$; $p < .01$). For parent alliance, the correlation (a) between the TPOCS–A parent form and the TASC measuring parent–therapist alliance was .29 ($n = 19$; ns), (b) between the TPOCS–A and TASC bond items was .24 ($n = 19$; ns), and (c) between the TPOCS–A and TASC task items was .45 ($n = 19$; $p < .05$). These findings indicate that both the TPOCS–A child and parent forms converged with the self-report TASC, though the parent form converged to a lesser degree.

Predicting Treatment Outcome From Child and Parent Alliance

We next examined relations between the TPOCS–A child ($M = 3.31$, $SD = 0.61$) and parent ($M = 3.65$, $SD = 0.41$) forms and outcome in a series of regressions predicting outcome measures from the TPOCS–A, shown in Table 2. We produced alliance scores for the child and parent form by calculating the mean score for tapes of sessions that the child or parent attended across treatment from each case on the relevant TPOCS–A items, then averaging items together. For each regression analysis, we entered two covariates prior to the TPOCS–A child or parent score: baseline measurement (to control for initial severity) and weeks between pre- and posttreatment assessments (to control for symptom change due to the passage of time).

Internalizing symptomatology. To examine whether child–therapist or parent–therapist alliance was associated with change in

Table 2
Regression Analyses Examining Child and Parent Alliance Predicting Treatment Outcome

Outcome variable	Child alliance					Parent alliance				
	β	$p <$	R^2	ΔR^2	$p <$	β	$p <$	R^2	ΔR^2	$p <$
CBCL Internalizing scale										
Step 1										
Baseline measurement	.68	.01				.17	ns			
Time	−.24	ns	.44	.44	.01	−.19	ns	.04	.04	ns
Step 2										
Alliance	−.15	ns	.46	.02	.02	−.48	.05	.27	.23	ns
STAIC										
Step 1										
Baseline measurement	.22	ns				.37	ns			
Time	.16	ns	.17	.17	ns	.18	ns	.15	.15	ns
Step 2										
Alliance	−.58	.01	.44	.27	.02	−.63	.01	.51	.36	.02
DISC anxiety symptoms										
Step 1										
Baseline measurement	.80	.01				.89	.01			
Time	−.01	ns	.63	.63	.01	−.10	ns	.55	.55	.01
Step 2										
Alliance	−.09	ns	.64	.01	.01	−.49	.01	.76	.21	.01
CDI										
Step 1										
Baseline measurement	.52	.04				.54	.02			
Time	−.20	ns	.23	.23	ns	−.28	ns	.26	.26	ns
Step 2										
Alliance	−.19	ns	.25	.03	ns	−.52	.03	.51	.25	.03
DISC depression symptoms										
Step 1										
Baseline measurement	.63	.01				.74	.01			
Time	.01	ns	.38	.38	.02	−.02	ns	.52	.52	.01
Step 2										
Alliance	−.19	ns	.41	.03	.04	−.42	.03	.61	.17	.01

Note. CBCL = Child Behavior Checklist; STAIC = State–Trait Anxiety Inventory for Children; DISC = Diagnostic Interview Schedule for Children; CDI = Children's Depression Inventory.

internalizing symptomatology, broadly construed, we assessed associations between the TPOCS–A child and parent forms and a general measure of internalizing symptomatology: the CBCL broadband Internalizing scale. We found no significant alliance–outcome association for the TPOCS–A child form but a significant association for the TPOCS–A parent form ($\beta = -.48$, $p < .05$). A positive parent–therapist alliance assessed during treatment was associated with a reduction in total internalizing symptomatology following treatment.

Anxiety symptomatology. Next, we examined the alliance–outcome association between the TPOCS–A child and parent forms and two anxiety-specific measures: STAIC and DISC anxiety symptoms. We first examined child–therapist alliance and found that the TPOCS–A child form was associated with a reduction in anxiety symptoms on the STAIC ($\beta = -.58$, $p < .01$). The TPOCS–A parent form was associated with a reduction in anxiety symptoms on both anxiety measures: the STAIC ($\beta = -.63$, $p < .02$), and DISC anxiety symptoms ($\beta = -.49$, $p < .01$). Thus, a close child–therapist and parent–therapist alliance assessed during treatment was associated with a reduction in anxiety symptomatology at the end of treatment.

Depressive symptomatology. We next examined relations between the TPOCS–A child and parent forms and two measures of depressive symptomatology: CDI and DISC depression symptoms. We found no significant alliance–outcome relations for the TPOCS–A child form but a significant association for the TPOCS–A parent form. The TPOCS–A parent form was associated with a reduction in depression symptoms on (a) CDI ($\beta = -.52$, $p < .03$) and (b) DISC depressive symptoms ($\beta = -.42$, $p < .03$). Thus, a positive parent–therapist alliance assessed during treatment was associated with a reduction in depressive symptomatology posttreatment.

Examining Alternative Explanations

Our findings thus far indicate that both child–therapist and parent–therapist alliance are associated with youth outcomes. On the basis of these findings, one might conclude that child and parent alliance are associated with reduced youth symptomatology. However, such a conclusion is not warranted unless plausible alternative explanations can be ruled out. As we have discussed, researchers can take steps to help establish the predictive association between alliance and outcome (Feeley et al., 1999; Shirk & Karver, 2003). We have thus far taken one of these steps—that is, we measured alliance prior to outcome—but have not yet ruled out alternative explanations.[4]

To do so, we examined whether a series of treatment, client, or case characteristics acted as third variables. The treatment characteristics were (a) therapist experience, which may be systematically related to alliance because previous research has demonstrated that therapist training is related to outcome (Weisz, Weiss, Han, Granger, & Morton, 1995), and (b) CBT. Therapist use of CBT strategies may account for significant alliance–outcome associations, as CBT strategies represent the most common ESTs for internalizing disorders (Kaslow & Thompson, 1998; Ollendick & King, 1998; Weisz, 2004b). To measure CBT strategy use, we used the TPOCS–S CB subscale (McLeod, 2001; see McLeod & Weisz, 2003), which consists of 10 items: "cognitive education," "cognitive distortions," "coping skills," "functional analysis of

behavior," "respondent strategies," "relaxation strategies," "operant strategies," "modeling," "homework," and "role playing." The client characteristics were (a) age (the formation of the alliance may be more difficult for adolescents because, compared with children, it is developmentally appropriate for them to express autonomy from adults; DiGiuseppe, Linscott, & Jilton, 1996), (b) gender (child gender may act as a third variable because past research has suggested that girls derive a greater benefit from therapy; Weisz, Weiss, et al., 1995), and (c) minority status (differences in treatment goals and expectations among ethnic groups may hinder the formation of the alliance for particular ethnic groups; Sue & Zane, 1987; Yeh, Eastman, & Cheung, 1994). Finally, the case characteristics were (a) severity (as measured by the CBCL Total score and total DISC symptoms; problem severity can negatively impact multiple areas of child functioning; Kazdin, 2000; including the ability to form interpersonal relationships, and may therefore hinder alliance formation) and (b) presence of conduct disorder (children diagnosed with conduct disorder typically have problems with authority figures, which may make it more difficult for them to form an alliance; DiGiuseppe et al., 1996; Shirk & Karver, 2003).

To examine whether any of these factors acted as third variables, we first assessed whether they were associated with scores on the TPOCS–A child or parent forms. If we found a significant association, we reran significant alliance–outcome relations with the characteristic entered as a covariate to determine whether the relation remained significant after the effect of the characteristic was controlled. In the TPOCS–A child form, only one characteristic, CBT strategies, was related to child alliance. The use of CBT strategies was positively associated with child–therapist alliance ($\beta = .58$), $F(1, 20) = 10.01$, $p < .01$ ($R^2 = .33$). When we reexamined the significant alliance–outcome association with CBT strategies entered as a covariate, the association remained significant. We next turned to the TPOCS–A parent form. Only one characteristic, child age, was systematically related to parent alliance. Child age was negatively associated with the parent form ($\beta = -.65$), $F(1, 17) = 12.41$, $p < .01$ ($R^2 = .42$), which indicates that the parents of younger children had better relationships with their child's therapist than did parents of older children. When we reexamined significant alliance–outcome associations with child age entered as a covariate, all associations remained significant. These findings thus suggest that the child and parent alliance–outcome associations previously noted are not likely to be explained by confounding factors.

Because alliance measured toward the end of treatment may be positively biased by earlier symptom change (Klein et al., 2003), we assessed whether early (i.e., average of the first two sessions) and late (i.e., average of the last two sessions) alliance differentially predicted youth outcomes. For child alliance, early and late alliance were not differentially associated with youth outcomes (all ps $< .05$). For parent alliance, all alliance–outcome associations remained significant, except for one: Early alliance was not associated with a reduction in CBCL Internalizing scores ($\beta = -.30$; $\Delta R^2 = .08$, ns), $F(3, 14) = 3.15$, $p < .10$ ($R^2 = .39$). Taken together, these findings suggest that the inclusion of late alliance

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[4] It is important to note that the small sample size may limit our ability to rule out alternative explanations.

ratings did not produce spurious associations between alliance and outcome in our previous analyses.

Comparing the Present Findings With Meta-Analytic Findings

To compare the present findings with past meta-analytic findings (Martin et al., 2000; Shirk & Karver, 2003), we produced effect size (ES) estimates for alliance–outcome associations for both children and parents. We did so by averaging together all alliance–outcome product–moment correlation coefficients for all child and parent alliance–outcome analyses. The ES was .21 ($SD = .22$, range $= .01$–.59) for child alliance and .29 ($SD = .21$, range $= .07$–.60) for parent alliance. These effects are comparable to those reported in previous research with children ($r = .24$; Shirk & Karver, 2003) and adults (weighted $r = .22$; Martin et al., 2000).

Discussion

In the present study we have presented a new alliance measure for child therapy, the TPOCS–A, and demonstrated its potential contribution to the field by exploring child–therapist and parent–therapist alliance–outcome relations in TAU. The TPOCS–A was designed to provide a thorough and objective description of child–therapist and parent–therapist alliance, and its development may help address an instrumentation gap in the field. The psychometric data presented herein suggest that the TPOCS–A items show acceptable interrater reliability and the forms demonstrate good internal consistency, although the evidence for the convergent validity of the forms is mixed. The TPOCS–A thus appears to be a reliable instrument capable of advancing understanding of how child–therapist and parent–therapist alliance relate to youth outcomes.

The psychometric data suggest that the TPOCS has several strengths. Coders were able to reliably characterize both child–therapist and parent–therapist alliance across alliance dimensions, and the individual items were related in conceptually appropriate ways—that is, at the item level, interrater reliability was acceptable, and the internal consistency of each form was acceptable. Validity analyses, however, provided mixed results. The child form converged with the self-report measure on the bond and task dimensions, whereas the parent scales only converged on the task dimension. Possible reasons for the divergence are that there is limited overlap between observer and parent report or that the divergence is due to the wording of TASC items. Parent and child TASC items are identical and were originally designed to capture child–therapist alliance; as a result, the items may not adequately assess parent–therapist alliance. Future psychometric work is required to clarify whether the parent TASC and TPOCS–A parent form adequately assess the bond alliance dimension; such work may help propel the field forward by generating evidence on whether child and parent alliance have a similar structure.

With regard to research applications of the TPOCS–A forms, our findings for child–therapist and parent–therapist alliance illustrate the potential of the TPOCS–A for research on alliance–outcome relations in child therapy in traditional service settings. Both child–therapist and parent–therapist alliance were associated with youth outcomes, although parent–therapist alliance was associated with symptom improvement across a wider range of youth

measures. A strong observer-rated child–therapist alliance was associated with improvement in child-reported anxiety symptoms, whereas a strong parent–therapist alliance was associated with improvement in anxiety and depressive symptoms. These findings have both clinical and methodological implications.

Clinically, our findings suggest the possibility that a close child–therapist alliance may help promote positive youth outcomes, at least from the child's perspective. Given the involuntary status of many child clients and the fact that children rarely acknowledge having clinical problems (Armbruster & Kazdin, 1994), it seems quite plausible that a strong child–therapist alliance might be needed to maximize youth response to treatment. That is, a strong child–therapist alliance that provides a supportive, validating experience may maximize youth response by providing a corrective emotional experience or by increasing the effectiveness of therapeutic strategies through increased engagement of youths in therapeutic activities (Shirk & Saiz, 1992). However, a rather mixed picture of the alliance–outcome association for youths with internalizing disorders emerges when our findings ($r = .21$) are compared with past published reports (weighted $r = .00$; Kendall, 1994; weighted $r = .12$; Kendall et al., 1997; see Shirk & Karver, 2003). Method differences (e.g., self-report vs. observer-report alliance measures), sample differences (e.g., research vs. TAU sample; see Weisz, Donenberg, Han, & Weiss, 1995), or another factor may account for these mixed findings. Clearly, more research is needed to untangle these mixed findings and provide a more accurate estimate of the alliance–outcome association for youths with internalizing problems.

Regarding the findings for parent–therapist alliance, this study is evidently the first to bring evidence to bear on whether the parent–therapist alliance is associated with treatment outcomes for youths with internalizing disorders. We found that a strong parent–therapist alliance was associated with improvement on both parent-report and child-report outcome measures. Given the important role parents often play in both therapy engagement (e.g., they are responsible for getting the child to therapy) and the therapeutic process (e.g., therapists may ask parents to modify their parenting style), it is not surprising that the parent–therapist alliance was related to youth outcomes. In the only other study to examine parent–therapist alliance, Kazdin and Wassell (1999) found that it was associated with youth outcomes in parent-focused treatment for youths with externalizing problems. It is interesting that the strength of the alliance–outcome association in the present study ($r = .29$) was comparable to Kazdin and Wassell's findings (weighted $r = .31$; see Shirk & Karver, 2003). Therefore, the existing evidence indicates that the parent–therapist alliance may help promote positive youth outcomes and suggests that this relation warrants further empirical attention.

Altogether, our findings indicate that the alliance plays an important role in the outcome of child therapy. However, even though our findings help establish that alliance and outcome covary, they do not identify any particular process through which alliance affects youth outcomes. That is, whereas alliance was associated with youth outcomes, we could not determine whether these changes were produced through some curative mechanism inherent in the alliance relationship (Rogers, 1951; Strupp, 1989), through increased therapy engagement that allowed the therapeutic strategies to be effective (Shirk & Saiz, 1992), via the interplay between treatment procedures and alliance, or through some other

mechanism. Future research needs to clarify the paths through which the child–therapist and parent–therapist alliance relationships may influence youth outcomes. For example, one potentially useful question to address is the extent to which variations in treatment procedures (e.g., the extent to which exposure therapy is used) might influence the relation between alliance and outcome.

Learning more about the alliance–outcome association and identifying the change mechanisms through which the alliance relationship influences youth outcomes may be especially important to researchers interested in improving mental health services in traditional service settings (Addis, Wade, & Hatgis, 1999; Kazdin et al., 1990). To the best of our knowledge, this is the first study to examine the alliance–outcome association in outpatient settings for youths with internalizing disorders. Given that past effectiveness studies have suggested that TAU produces little or no effect (see Weisz, Donenberg, et al., 1995), it is notable that we found significant process–outcome relations. Practitioners assert that the alliance represents a key process ingredient responsible for outcomes because the characteristics of clinic-referred clients (e.g., symptom severity, comorbidity) necessitate that they focus on relationship building over therapeutic strategies to get the clients engaged in the therapeutic process (Addis et al., 1999; Kazdin et al., 1990; Shirk, 2001; Shirk & Russell, 1996; Shirk & Saiz, 1992). Our findings do not address the question of whether clinic-referred clients differ from those in research trials, but they do suggest that alliance may be an important ingredient of successful therapy in traditional service settings.

Although our findings illustrate the potential of the TPOCS–A for studying alliance in child therapy, a few limitations of the study warrant attention. First, although measuring alliance prior to outcome does help establish the temporal sequence of the alliance and outcome variables, doing so does not completely rule out the possibility that change in symptomatology causes alliance (Feeley et al., 1999). Second, the array of procedures used in TAU is not well understood or characterized in research to date and likely varies from setting to setting. As a result, the generalizability of the present findings to treatment in other service settings may be limited. Third, because effectiveness studies have shown that TAU produces little effect, it is possible that alliance does not account for clinically significant symptom change. Fourth, as our sample is composed mostly of children, our findings may not generalize to adolescents. Fifth, observational methods, although useful, do not provide direct access to child or parent thoughts about alliance (which may be more directly assessed through questionnaires and interviews). Sixth, the small sample combined with the number of analyses increases the probability of chance findings, so our results should be replicated with a larger internalizing sample. Finally, because the present sample is composed of youths with internalizing disorders, the generalizability to treatment for youths with externalizing disorders may be limited. To address these limitations, future research needs to assess whether the present findings generalize to larger, more demographically and clinically diverse samples.

Our findings illustrate the usefulness of the TPOCS–A for the description and study of alliance in child therapy. In developing the TPOCS–A, we sought to improve on past research in an effort to reconcile contradictory alliance–outcome findings. First, we defined the alliance in terms of the bonds and tasks of therapy, the alliance dimensions posited to be particularly important to child

therapy (see Shirk & Saiz, 1992). Second, we assessed two important perspectives on the alliance relationship (i.e., child and parent) to determine whether the two perspectives were differentially associated with outcome (Weisz et al., 1998). Third, we established the temporal sequence of our alliance and outcome variable by assessing alliance across treatment sessions prior to outcome assessment, and we attempted to rule out plausible third variable explanations (Feeley et al., 1999). Finally, we used observers to rate alliance, thus providing an objective, nonreactive assessment of the client–therapist relationship. By taking these steps to address the limitations that have made interpreting past findings difficult, we both highlight the importance of the alliance relationship in child therapy and provide the field with a new tool capable of quantifying this construct.

Taken together, the psychometric and empirical findings presented here suggest two broad conclusions. First, the TPOCS–A has characteristics, both procedural and psychometric, that give it the potential to fill a significant instrumentation gap in the field. Second, both child–therapist and parent–therapist alliance may play important (and potentially different) roles in the outcome of child therapy in traditional service settings.

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Journal of Consulting and Clinical Psychology Call for Papers: Special Section on Benefit Finding or Growth Following Highly Stressful or Traumatic Life Events

The *Journal of Consulting and Clinical Psychology* is requesting submissions of empirical papers that focus on the positive effects of highly stressful or traumatic events—or what has been referred to in the literature as *benefit finding, posttraumatic growth,* or *stress-related growth.* The papers must be empirical rather than theoretical in nature and should address one or more of the following topics:

1. Antecedents to benefit finding (i.e., Who engages in benefit finding?),
2. Measurement issues (i.e., What is benefit finding? How should it be measured?),
3. Mechanisms (i.e., How is benefit finding brought about? How do responses to stress and trauma sometimes result in positive changes?),
4. Validity issues (i.e., Is benefit finding real or is it an illusion/cognitive distortion?), and
5. Links to well-being (i.e., What are effects of benefit finding on well-being?).

If the fifth topic is the focus of the paper, studies must be either longitudinal or experimental. Because children, adolescents, and families have been neglected by past research, papers that examine these populations are especially encouraged. The goal of this special section is to have a set of papers that represent the life span.

The deadline for submissions of manuscripts is June 1, 2005. Final editorial decisions will be made by early 2006, with an anticipated publication date of mid- to late 2006. All submissions should be entered through the main submission portal for the journal (www.apa.org/journals/ccp.html). Authors should indicate in their accompanying cover letter that the paper is to be considered for the special section.

Questions or inquiries regarding the special section should be directed to the section coeditors, Vicki Helgeson (vh2e@andrew.cmu.edu) and Crystal Park (clpark@uconnvm.uconn.edu).