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RESEARCH ARTICLE

Therapist Interpersonal Skills and Outcomes for Young People

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Abstract

Objective: Our primary aim was to assess the associations between outcomes and therapist interpersonal skills (TIS) of empathy, congruence, regard, and unconditionality, as rated by young people. We also aimed to compare these associations against outcome–alliance associations, and to assess whether these associations were specific to a TIS-prioritizing therapeutic practice.

Methods: Our primary sample was 167 13–16-year-olds who exhibited emotional symptoms and received up to 10 weeks of school-based humanistic counseling plus pastoral care as usual (SBHC + PCAU). Young people were predominantly female (76%), with 45% Black or other minoritized identity. We measured TIS with the Barrett Lennard Relationship Inventory; and used linear regression modeling to assess TIS associations with outcomes on psychological distress, wellbeing, and satisfaction.

Results: TIS, most markedly congruence, were significantly associated with outcomes, contributing approximately 3% of change. TIS and alliance explained similar proportions of outcomes, with a model including only congruence showing the best fit on psychological distress and wellbeing. We did not find consistent evidence that the TIS–outcome association was specific to humanistic counseling.

Conclusion: Therapists and lay professionals working with young people should strive to develop their interpersonal skills—particularly congruence—within the context of other relationship skills, qualities, and characteristics.

Clinical or methodological significance of this article: Therapists and lay professionals should be mindful of their levels of congruence when working with young people. "Being real" may be an important factor that young people look to in developing trust with their therapists and is associated with improved outcomes. This highlights the importance of supervision, self-care, and other practices that support therapists to be authentic.

Adolescence is a period of rapid biological, psychological, and social change, making young people particularly vulnerable to mental ill health (Blakemore, 2019). In England, one in seven 11–16-year olds have been identified as having a mental disorder, with prevalence rates rising since 1999 (Sadler et al., 2018). Such is the scale of this problem that, in 2021, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry (AACAP), and Children's Hospital Association (CHA) (2021) jointly declared a

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"national emergency" in child and adolescent mental health.

Identifying the effective factors in psychotherapy for young people is essential in helping to improve intervention success. In the field of adult psychotherapy, the alliance has been established as one of the most consistent predictors of positive outcomes (Flückiger et al., 2018; Zilcha-Mano, 2017). However, studies examining the relationship between alliance and outcomes for young people are more limited, albeit increasing (Kazdin & McWhinney, 2018). An early meta-analysis of prospective studies (i.e., where the alliance was assessed before outcomes) on the alliance–outcomes association in youth concluded that the alliance had a small weighted mean effect on outcomes ($d = 0.14$), with the effect being greater for individual-based treatments ($d = 0.16$) compared to family-based treatments ($d = 0.05$) (McLeod, 2011). More recently, Karver et al. (2018) found a slightly larger weighted random effect size of $r = .19$ (95% CI = .13, .25) for this association in children and adolescents. A meta-analysis of 99 studies which explored both prospective and concurrent associations between alliance and outcomes for children and adolescents found a mean effect size of $r = .17$ (95% CI = 0.13, 0.21) (Roest et al., 2023). These studies indicate that levels of alliance in youth psychotherapy are associated with a modest, but consistently significant, improvement in outcomes. It should be noted, however, that a wide array of alliance measures have been used in these studies, many of which were not specifically developed for this age group.

Although alliance is the most investigated factor in process–outcomes research with young people, Kazdin and McWhinney (2018) state that, "to predict outcome, we ought to look at additional factors" (p. 240). *Therapist interpersonal skills* (TIS) are competencies that allow therapists to attune to the relationship, and can be distinguished both from "qualities of the therapeutic relationship" (such as the alliance) and "therapist clinical [relational] skills" (such as self-disclosure and relational interpretations) (Castonguay et al., 2006; Lambert et al., 1978). A meta-analysis of both prospective and concurrent studies, which investigated the relationship between TIS and the outcomes of young people, showed a weighed mean correlation of .35 (Karver et al., 2006). The most familiar TIS are Rogers's (1957) "core conditions" of empathy, congruence, and unconditional positive regard. However, research on the relationship between these TIS and outcomes for young people is limited (Hayes & Brunst, 2017). In the following paragraphs, we provide an exhaustive review of the quantitative evidence, alongside recent robustly-established qualitative findings.

Empathy can be defined as the therapist's ability and willingness to understand the client's experiences through the client's eyes (Elliott et al., 2019; Rogers, 1980). Qualitative research consistently indicates that young people value empathic understanding from their therapist (Cooper et al., 2024; Dittmann & Jensen, 2014; Fiorini et al., 2024). In a thematic analysis of qualitative interviews with 50 young people in humanistic counseling, for instance, Cooper et al. found that 86% of participants identified "understanding and empathic" as a helpful therapist activity. In addition, empathy has been shown to be moderately correlated ($r = .37$) with improved academic achievement in young people at the end of a community help intervention (Stoffer, 1968). Early ratings (session 3) of facilitator empathy have also been shown to be associated with good post-intervention outcomes in a social anxiety intervention for young people, positively correlating with changes in young persons' self-perceived likeability ($\omega^2 = .48$) (Brouzos et al., 2015). In addition, an early study of 150 young people and 50 counselors found significant correlations ($r = .34$) between student-rated counselor empathy and student reports of the effectiveness of counseling (Athay, 1973), as assessed concurrently after the end of counseling. Brent (1986), by contrast, found no association between empathy and outcomes for young people in cognitive therapy with depression, but the sample sizes for the treatment groups were very small ($n = 8$).

Congruence, also termed "authenticity" or "genuineness," can be defined as the therapist's ability to be "freely and deeply" themselves in the context of the therapeutic relationship, with access to the full range of their own experiencing of the therapy and their patient (Rogers, 1957). In a comprehensive review of the literature, Kolden et al. (2018) found, across both adults and younger clients, a weighted aggregate effect size of $r = .23$ for the relationship between therapist congruence and psychological improvement. The studies included in this meta-analysis measured the correlation between congruence and outcomes both concurrently and prospectively. Additionally, Kolden et al. found that effect sizes for the congruence–outcomes relationship were significantly higher in younger clients compared to adult clients, suggesting that it may be a more important factor for outcomes in this age group. However, the authors also noted that only three studies in their meta-analysis involved young people. They further noted that the congruence–outcome relationship is stronger in school-based settings ($r = .35$) than mixed settings ($r = .21$) or

outpatient settings ($r = .06$). Hansen et al. (1968) investigated the correlations between observer and client ratings ($N = 70$) of counselor congruence and change in young peoples' self-concept congruence. They found that client post-treatment ratings of counselor congruence, as measured using the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962), did not correlate with post-treatment changes in client-rated self-concept congruence ($r = .01$). However, they did find that mean observer ratings of counselor congruence from early, middle, and late sessions out of a total of 12 sessions did correlate significantly with client-rated changes in self-concept congruence ($r = .88$). In their qualitative interview study with young people, Cooper et al. (2024) did not find that "congruence," "genuineness," or "realness" were therapist qualities frequently identified as helpful by young people. Nevertheless, 16% of the young people indicated that the therapist being un-natural or clichéd hindered change. In addition, 80% of the young people said that trusting the counselor was a helpful factor in achieving positive outcomes—and transparency has been established as a key determinant of trust (Hancock et al., 2023). By being open, honest, and genuine, clients may develop a greater faith that their therapist will respond to their vulnerabilities in reliable, supportive, and "containing" ways.

Unconditional positive regard can be defined as the therapist's experiencing of a warm acceptance of each aspect of the client's experience (Rogers, 1957). However, Barrett-Lennard (1962), in his seminal research into Rogers's TIS as causal factors in therapeutic change, divided unconditional positive regard into two components that he considered separate. The first of these, *level of regard*: can be defined as, "the affective aspect of one person's response to another" (p. 4)—akin to liking, warmth, or appreciation. The second, *unconditionality of regard*, referred to the constancy of this level. This bifurcation of unconditional positive regard formed the basis for Barrett-Lennard's Relationship Inventory which, as "the most recognized and best validated instruments for assessing the core conditions" (Kolden et al., 2019, p. 326), means that level and unconditionality of regard may be evaluated separately the literature. Across age ranges, Farber et al. (2019) found a mean association between outcomes and unconditional positive regard indicators (combining both unconditionality and level of regard) of Hedges's $g = .028$. Focusing specifically on studies with youth, Cordaro et al. (2012) found level of regard—specifically therapist warmth and friendliness, as rated by observers—to be positively correlated with treatment completion (canonical correlation = .36). In youth samples, observer ratings of therapist warmth have also been associated with client ratings of global improvement ($r = .63$), the attainment of young people's main personal goal ($r = .58$), teacher-rated academic achievement ($r = .41$), teacher-rated classroom behavior ($r = .32$), client self-assessed likeability ($\omega^2 = .41$), and lessened client-rated negative interpretations of social situations ($\omega^2 = .39$) (Brouzos et al., 2015; Green & Herget, 1991; Stoffer, 1968). Qualitatively, too, Fiorini et al. (2024) found that children and young people in psychoanalytic psychotherapy valued a warm and genuinely caring therapist; while, in humanistic counseling, being "friendly and welcoming" (92% of participants), "non-judgmental and unconditionally accepting" (88%), and "caring" (74%) were the three most frequently-identified helpful therapist qualities by youth (Cooper et al., 2024). Together, there is clear evidence that level of regard predicts positive youth outcomes, with some indications that unconditionality of regard may also be associated with positive gains.

Whilst the literature, to date, offers some indication of a positive relationship between TIS and therapeutic outcomes for young people, there are several methodological limitations which have not yet been addressed in any single study. First, few studies have looked at the prospective relationship between TIS and outcomes and have often measured these concurrently, making it difficult to determine causal relationships. Second, those studies which have looked at the relationship prospectively (e.g., Brouzos et al., 2015; Green & Herget, 1991; Karver et al., 2018) have either had small samples ($N < 45$) and/or have utilized an idiosyncratic intervention which has not been assessed as being adherent to any particular therapeutic modality. Third, there is no evidence on how the magnitude of association between TIS and outcomes compares against the association of outcomes with other relationship factors (e.g., the alliance) or, indeed, whether TIS–outcome associations are still significant once other factors are taken into account. Closely related to this, associations between TIS and outcomes are generally reported as independent correlations, rather than taking into account the highly intercorrelated nature of TIS themselves. Fifth, there is no evidence on whether the relationship between TIS and outcomes is "theory-specific" (Crits-Christoph & Gibbons, 2021)—that is, unique to therapy approaches, such as humanistic counseling, which prioritize these practices—or a non-specific common factor across different forms of professional help. Rogers's (1957) "necessary and sufficient" conditions suggests that the relationship should be present in any form of psychological help, but other

literature has argued that these modes of relating have effects specific to person-centered, Rogerian practices (Ong et al., 2020).

Given these gaps in knowledge, the present study aims to address the following research questions (RQs). RQ1: Do youth-rated TIS predict psychological distress, wellbeing, and service satisfaction outcomes in school-based humanistic counseling? RQ2: How does the association between youth-rated TIS and outcomes compare against the association between youth-rated alliance and outcomes, in terms of the amount of variance explained? RQ3: Are any associations between youth-rated TIS and outcomes "theory-specific": that is, are they significantly stronger in a humanistic therapy intervention as compared with an alternative form of interpersonal help?

Method

Design

This study was a secondary analysis of data collected as part of a two-arm, individually randomized trial (1:1) 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). The study was conducted in 18 "secondary" schools in England (typical age range: 11–18 years old).

The present study utilized regression modeling to examine the strength of associations between TIS and subsequent improvements in mental health outcomes (RQ1), and compared these with the strength of associations between the young people's working alliance scores and outcomes (RQ2). For RQ3, we drew on data from both arms of the trial to assess the differential effects of TIS on outcomes across counseling and non-counseling conditions.

Ethical approval for the trial was obtained under procedures agreed by the University Ethics Committee of the University of Roehampton (Reference Psych 16/227), 31st August 2016. Young people and parents/carers advised at all stages of the study.

Table I. Participant characteristics at baseline.

	SBHC + PCAU (n = 167)	PCAU (n = 162)	All (n = 329)
Gender			
Female	127 (76%)	129 (80%)	256 (78%)
Male	37 (22%)	32 (20%)	69 (21%)
Other	3 (2%)	1 (<1%)	4 (1%)
Age (years)	13.7 (0.8)	13.8 (0.8)	13.8 (0.8)
School Year			
Year 8	28 (17%)	27 (17%)	55 (17%)
Year 9	79 (47%)	71 (44%)	150 (46%)
Year 10	53 (32%)	52 (32%)	105 (32%)
Year 11	7 (4%)	12 (7%)	19 (6%)
Ethnicity			
White	90 (54%)	88 (54%)	178 (54%)
Asian/Asian British	16 (10%)	15 (9%)	31 (9%)
Africa/Caribbean/ Black British	27 (16%)	30 (19%)	57 (17%)
Mixed	29 (17%)	23 (14%)	52 (16%)
Other	4 (2%)	5 (3%)	9 (3%)
Missing	1 (<1%)	1 (<1%)	2 (<1%)
Disability			
No disability	142 (85%)	136 (84%)	278 (85%)
Has a disability	23 (14%)	22 (14%)	45 (14%)
Missing	2 (1%)	4 (3%)	6 (2%)

Participants

Eligible participants were aged 13–16 years old and experiencing moderate to severe levels of emotional symptoms (as indicated by a score of 5 or more on the Emotional Symptoms subscale of the self-report Strengths and Difficulties Questionnaire, SDQ-ES, range = 0–10 (Goodman, 2001)). Participants 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, and were not currently in receipt of another therapeutic intervention. Exclusion criteria were 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 (N = 329) were recruited between 29th September 2016 and 8th February 2018 from 18 secondary schools in the Greater London area, with seven schools (38.9%) being in the most deprived Index of Multiple Deprivation quintile. The mean percentage of children from black and minoritized ethnic groups, based on data provided by 11 of the 18 schools, was 47.0% (SD = 29%, range = 3.0%–89.0%).

Of the 329 participants, 167 were randomized to school-based humanistic counseling plus pastoral care as usual (SBHC + PCAU) and 162 to pastoral care as usual alone (PCAU). Retention rates at 6, 12, and 24-weeks, across groups, were 97.6% (n = 321), 95.7% (n = 315), and 93.0% (n = 306), respectively. On average, young people in the SBHC + PCAU condition attended 7.80 sessions (SD = 2.70, range: 0–11).

Table I gives baseline characteristics of the full sample for the trial, overall and in each treatment arm. Across conditions, 78% of the participants were female, with a mean age of 13.8 years old;

54% of participants were of a White ethnicity, 17% African/Caribbean/Black British, 16% of mixed ethnicity, and 9% Asian/Asian British. Demographically, the two treatment arms were broadly similar.

Measures

Barrett Lennard relationship inventory form: OS-40: T-S (student form) (version 3) (BLRI: OS-40: T-S). The Barrett-Lennard Relationship Inventory is a family of measures based on Rogers's (1957) theory of the necessary and sufficient conditions for therapeutic personality change, with unconditional positive regard divided into *level of regard* and *unconditionality of regard*. This gives four subscales to measures in the Barrett-Lennard Relationship Inventory family: *Empathy*, *Congruence*, *Regard*, and *Unconditionality*.

For this study we used the Barrett Lennard Relationship Inventory *OS-40: T-S (Student form) (v3)* version (Barrett-Lennard, 2015), hereafter referred to as the "BLRI," which was developed for students to rate their teachers' interpersonal skills. It has 10 items (five positive, five negative) for each of the subscales—with item wording slightly adapted from the original BLRI. Example items are, "I feel that she is genuine—talks to me (to us) straight" (Congruence, positive item). 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 from +1 (*Yes, I think it might be true*) to +3 (Yes, *I strongly feel that it is true*). No midpoint response is available.

SBHC + PCAU participants were instructed to complete the BLRI in relation to their therapist while PCAU participants completed it in relation to their "main" pastoral care teacher: "the person in school who has helped you the most with any problems you may have been having recently." The BLRI version used has shown satisfactory levels of internal consistency in a sample of Portuguese nursing students (Silva et al., 2016). In our full sample, the Regard and Empathy subscales yielded internal reliability with Cronbach's αs of .85 and .88, respectively, while Congruence had an α of .72, and Unconditionality an α of .66.

Working alliance inventory short form (WAI-S). The WAI-S is based on Bordin's (1979) tripartite model of the working alliance, and comprises three 4-item subscales: agreement on the goals of the therapeutic relationship (Goal subscale), collaboration on the tasks needed to achieve these goals (Task subscale), and the quality of the therapeutic relationship (Bond subscale) (Tracey & Kokotovic, 1989). Whilst the WAI-S was developed for adult clients, it is one of the most commonly used alliances measures with young people (Cirasola et al., 2021). An example item on the WAI-S is: "I feel that _____ appreciates me" (Bond subscale). Responses are rated on a 1–7 point Likert scale, with higher scores indicating a better therapeutic alliance. The WAI-S has 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 .83 for the Goal subscale, .72 for the Task subscale, and .90 for the Bond subscale. However, there is limited evidence that the three factor bond–task–alliance structure exists when the WAI-S is rated by young people, with some studies reporting a single-factor, or bi-factor, model (Cirasola et al., 2021; van Benthem et al., 2024).

Young person's clinical outcomes in routine evaluation (YP-CORE). The YP-CORE is a self-report measure of psychological distress in young people (Twigg et al., 2009, 2016) and comprises 10 items using a five-point scale (0-4), giving a total score between 0 and 40, with higher scores indicating greater levels of distress. The YP-CORE measure has good evidence of internal consistency (Cronbach's α = .85; Twigg et al., 2009), retest stability (Pearson's r = .76; Twigg et al., 2016) and a differentiation between means for clinical and non-clinical samples (19.0 [SD = 7.5] and 9.4 [SD = 7.3], respectively, Twigg et al., 2016). Internal reliability for the YP-CORE, across both conditions, for our study was .77.

Warwick-Edinburgh mental well-being scale (WEMWBS). The WEMWBS is a 14-item self-report measure validated for young people aged 13 years and above (Clarke et al., 2011; Tennant et al., 2007). An example item is: "I've been feeling useful" with respondents asked to select if they have experienced this "none of the time," "rarely," "some of the time," "often," or "all of the time" over the last two weeks. The measure is psychometrically sound for use with younger clients (Clarke et al., 2011; Tennant et al., 2007), with retest stability over a 6-week period reported to be between $r = .56$–$.63$ in 13–16 year olds (Duncan et al., 2023). Internal reliability for the WEMWBS, across both conditions, for our study was Cronbach's α = .87.

Experience of service questionnaire (ESQ). The 12-item Experience of Service Questionnaire (ESQ) assesses 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"). An example item is "I feel that the people who saw me listened to me." Testers were instructed to make it clear to the young people that, if they were in the SBHC + PCAU condition, "service or clinic" referred to their counseling; and, if they were in the PCAU condition, it referred to "any pastoral care that they have had over the past three months, including contact with their pastoral care teacher." Of the 12 items, nine have been found to form a "Satisfaction with Care" main factor (Brown et al., 2014). Scores on this dimension range from 0 to 18, with higher scores indicating greater satisfaction. Internal reliability for satisfaction with care, across both conditions, for our study was Cronbach's $\alpha = .87$.

Strengths and difficulties questionnaire (SDQ). The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening instruments for children and young people (Goodman, 2001). For the purposes of this study, we used scores on the emotional symptoms subscale (SDQ-ES) of the self-completed 11–17 year old SDQ to screen for eligibility. The SDQ-ES consists of five items assessing emotional and psychosomatic problems, such as "Many fears, easily scared." Items are rated by the young person on a scale of *Not true* (0), *Somewhat true* (1), and *Certainly true* (2). Internal consistency for the SDQ-ES has been established as Cronbach's $\alpha = .66$ (Goodman, 2001).

Procedure

Recruitment and assessment. Recruitment for the trial was through the schools' pastoral care teams, which were briefed on the study 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 them to provide written assent. Once baseline measures were taken, young people were then randomized to either the SBHC + PCAU or PCAU condition.

Interventions. SBHC is a manualized form of humanistic therapy (Kirkbride, 2016) 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. Sessions were delivered on an individual, face-to-face basis, and lasted 45–60 min. They were scheduled weekly over a period of up to 10 school weeks.

SBHC was delivered by a pool of 19 counselors, 16 of whom were female with a mean age of 45.0 years old ($SD = 9.0$). Fourteen 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 ($SD = 6.6$). They received, at minimum, four days of group training in SBHC, and were subsequently 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., 2023). All counselors exceeded the pre-defined adherence cut-point.

Participants in the SBHC + PCAU group also had full access to their school's usual pastoral care: the schools' pre-existing services for supporting the emotional health and well-being 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. The amount of support could vary considerably, from single, one-off meetings of 5 mins or less, to 1 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 .

The PCAU group comprised access to the school's usual pastoral care support alone (i.e., without SBHC). The "main" pastoral care teachers that PCAU participants rated on the BLRI would not have been delivering the SBHC intervention and, to the best of our knowledge, did not have specialist training in TIS.

Outcome measurement. The YP-CORE and WEMWBS outcome forms were completed by all young people at baseline assessment/randomization, and at 6 and 12 weeks post-randomization. At 12 weeks post-randomization, participants were also

asked to complete the ESQ. The BLRI was completed by all young people at six-weeks post-randomization. For each of these tests, testers were blinded to the young person's allocation to minimize the likelihood of inadvertently biasing the young people's responses. Following completion of the BLRI, testers were unblinded and young people in the SBHC + PCAU condition were asked to also complete the WAI-S. Young people in the PCAU arm were not asked to complete the WAI-S at 6 weeks post-randomization because, unlike the BLRI, the WAI-S is specific to a psychotherapeutic relationship.

Analyses

The analyses to address RQ1 used the SBHC + PCAU arm data only, assessing the associations between the BLRI subscales and outcomes (12 weeks post-randomization) on YP-CORE, WEMWBS, and ESQ. The second set of analyses (RQ2), also using the SBHC + PCAU arm data, compared the subscales of the BLRI with those of WAI-S in their associations with outcomes. The third set of analyses (RQ3) used the full sample to test the significance of the BLRI–treatment arm interaction in its association with outcomes.

Client-level data were nested within counselors and schools. However, multilevel analysis indicated no significant or reliable higher-level effects, likely due to sample size limitations. Therefore, single-level linear regression modeling was used to identify those BLRI and/or WAI-S subscales significantly associated with each outcome (at the .05 level). Preliminary descriptives indicated high positive correlations between a number of the BLRI subscales, and WAI-S subscales (using one-tailed Spearman's rho as only Congruence was normally distributed). For the SBHC + PCAU sample (RQ1 and RQ2) all subscales of the BLRI were found to be positively correlated (all p-values < 0.001). The weakest correlations were between Unconditionality and the three other subscales, with rho values of .54, .56, and .59 for Congruence, Empathy, and Regard, respectively. Other correlations exceeded .7: Congruence and Empathy (rho = .80), Congruence and Regard (rho = .74) and Regard and Empathy (rho = .78). The WAI-S subscales correlated with each other with all rho values greater than .7. Between the BLRI and WAI-S subscales, the correlations of Congruence with WAI-S Task, Bond, and Goal subscales were .69, .71, and .69, respectively; for Regard they were .65, .78, and .65; for Empathy they were .72, .76, and .72; and, for Unconditionality they were .39, .51 and .53, respectively.

For the full sample (RQ3) only Congruence was normally distributed and all the BLRI subscales correlated significantly (all p-values $< .001$). Unconditionality correlated with the other three other subscales with rho values of .55, .63, and .63 for Congruence, Empathy, and Regard, respectively. Congruence and Empathy (rho = .70), Congruence and Regard (rho = .67), and Regard and Empathy (rho = .77) were stronger correlations.

To avoid problems of multicollinearity in the regression models due to high correlations, an iterative procedure was used, ensuring no two variables in the final models had a correlation coefficient greater than .7. For each model, after inclusion of the outcome measure baseline, and baseline to 6-week post-randomization change scores (where appropriate), each subscale was included individually to assess its association to outcome in terms of statistical significance and change in adjusted R^2 (R^2_{adj}). Change scores were included in our models to control for improvement prior to application of the BLRI and WAI-S tests. This allowed us to establish, more clearly, prospective associations from therapeutic relationship variables to subsequent clinical outcomes.

If highly correlated subscales were individually associated with outcome they were entered together in a revised model and removed individually based on their partial correlation coefficient. The smallest was removed first and the model was re-run. This process was repeated until only one of the highly correlated subscale variables, significantly associated with outcome, remained in the model. Any other variables not highly correlated were then re-entered and retained if statistically significant and interactions between variables in the models were included if significant. For RQ3, the interactions between treatment arm and BLRI subscales were included in the model and assessed in terms of statistical significance and R^2_{adj}. Plots were produced to visually represent any differences between treatment arms in the relationships between the BLRI subscales and outcomes.

Standardized betas are reported in the models and model accuracy (fit) was assessed using the root mean squared error of approximation (RMSE), with a smaller RMSE indicating better "fit." Model residuals were plotted to assess normality and all analyses were conducted using SPSS (v.26) and Stata (v15.1; StataCorp, 2017).

Results

The results are presented for each of the three outcome measures (YP-CORE, WEMWBS, and

ESQ at 12 weeks post-randomization) within each of the research questions (RQ1, RQ2, and RQ3). Key regression models and charts are reported below, while other models and charts are presented in Supplemental Materials.

Therapist Interpersonal Skills and Outcomes in Counseling (RQ1)

Psychological distress (YP-CORE). Following the procedure outlined above, baseline score on YP-CORE and baseline to six weeks change in YP-CORE were entered in the model first and both were statistically significant ($p < .001$) and the model had a R^2_{adj} of .37. Entering the four BLRI subscales individually found Regard ($p = .015$, $R^2_{adj} = .38$), Empathy ($p = .037$, $R^2_{adj} = .37$), and Congruence ($p = .002$, $R^2_{adj} = .40$) to each be associated with outcome. Unconditionality ($p = .316$, $R^2_{adj} = .36$) was not associated with outcome. Entering Regard, Empathy, and Congruence together found only Congruence to be significant ($p = .049$). Including all of the subscales and removing them individually based on the smallest partial correlation coefficients resulted in Congruence being identified as the subscale most strongly associated with the YP-CORE outcome. No interactions were significant in the model and the R^2_{adj} of .40 for Congruence alone did not increase with the inclusion of other variables or interactions. The smallest RMSE (.764) was also found when Congruence was entered alone, reduced from .781 when no subscales were included, indicating that the model including Congruence produced the best model fit.

Table II shows the variables included in the final model. Greater severity at baseline/randomization was associated with a higher outcome score (poorer outcome at 12 weeks), while greater change between baseline and six weeks was associated with a better outcome. Greater Congruence was also associated with a better YP-CORE outcome ($b^* = -.18$, $SE = .06$, $p = .002$). The final model explained 40% of the outcome variance and had the best model fit ($R^2_{adj} = .40$). Inclusion of Congruence increased R^2_{adj} from .37 when only baseline and change scores were included, therefore Congruence was associated with approximately 3% of YP-CORE outcome variance (F Change = 9.84, $p = .002$).

Table II. Final model for YP-CORE (12 weeks post-randomization): therapist interpersonal skills and outcomes for counseling.

	b*	SE	t	*p*
YP-CORE Baseline	.61	.07	8.78	< .001
YP-CORE Change (Baseline to 6 weeks)	−.50	.07	−6.99	< .001
Congruence (BLRI)	−.18	.06	−3.14	.002
Constant	−.02	.06	−.26	.796

Wellbeing (WEMWBS). The results for wellbeing (WEMWBS) were similar to those for psychological distress (YP-CORE). Baseline WEMWBS and baseline to six weeks change on WEMWBS were both strongly associated with outcome (p-values < .001, $R^2_{adj} = .43$); while individually Regard ($p = .006$, $R^2_{adj} = .45$), Empathy ($p = .027$, $R^2_{adj} = .44$), and Congruence ($p = .002$, $R^2_{adj} = .46$) were each associated with outcome. Again, Unconditionality ($p = .356$, $R^2_{adj} = .42$) was non-significant. Entering Regard, Empathy, and Congruence together, none were statistically significant with p-values of .289, .478 and .082 respectively. Following the procedures outlined above, including Congruence alone ($b^* = .18$, $SE = .06$, $p = .002$) produced the best fitting model ($R^2_{adj} = .46$) with the smallest RMSE (.742). Compared to the model including baseline and change score, R^2_{adj} increased from .43 to .46 (F change = 9.93; $p = .002$), indicating an approximately 3% increase in explanatory power, while RMSE reduced from .757 to .742.

Satisfaction with care (ESQ). ESQ was only collected at 12 weeks therefore there were no baseline or change scores. Entering the BLRI subscales individually found each to be significantly associated with ESQ; Regard ($p < .001$, $R^2_{adj} = .35$), Empathy ($p < .001$, $R^2_{adj} = .35$), Congruence ($p < .001$, $R^2_{adj} = .34$), and Unconditionality ($p = .001$, $R^2_{adj} = .08$). Entering all four subscales together found Regard ($p = .007$) and Congruence ($p = .009$) to be significantly associated with outcome. As they had a correlation > .7, both Regard ($p = .007$) and Congruence ($p < .001$) were entered in a model together and partial correlation coefficients considered. This identified Regard as the single subscale associated with outcome ($p < .001$, $R^2_{adj} = .35$) and produced the best fitting model (RMSE = .754). The RMSE for a model including Congruence alone was .763.

Therapist Interpersonal Skills, Working Alliance, and Outcomes for Counseling (RQ2)

Psychological distress (YP-CORE). Of the WAI-S subscales, Task ($p = .008$, $R^2_{adj} = .40$) and Bond ($p = .006$, $R^2_{adj} = .39$) were individually associated with outcome, while Goal was not significantly associated ($p = .09$, $R^2_{adj} = .37$). Entered together, without BLRI subscales, none of the WAI-S subscales were found to be significant (all p-values

> .285). Using partial correlation coefficients to exclude subscales showed Bond to be the best fitting WAI-S subscale.

When all of the BLRI and WAI-S subscales were entered together none were significant with *p*-values ranging from .09 (for Congruence) to .743 (for Task). Excluding subscales based on partial correlation coefficients indicated that Congruence produced the best fitting model and there were no significant interactions. Therefore, the best fitting model was the same as for RQ1 (Table II). The best fitting model for the WAI-S subscales, which only included Bond, is presented in the Supplemental files. The RMSE for this model was .784, a poorer fit than for the BLRI Congruence model (RMSE = .718).

Wellbeing (WEMWBS). Of the WAI-S subscales, Task ($p = .003$, $R^2_{adj} = .45$) and Bond ($p = .004$, $R^2_{adj} = .45$) were individually associated with WEMWBS outcome, while Goal was not significantly associated ($p = .09$, $R^2_{adj} = .43$). Using partial correlation coefficients found that Task produced the best fitting model. No individual subscale was significant when all of the WAI-S subscales, or all WAI-S plus BLRI subscales, were entered together and following the removal procedure and testing of interactions, Congruence alone again produced the best fitting model (RMSE = .734) which compares to a RMSE of .740 for a model including Task. (Models for Congruence and Task are presented in Supplemental files).

Satisfaction with care (ESQ). The individual WAI-S subscales: Task ($p < .001$, $R^2_{adj} = .45$), Bond ($p < .001$, $R^2_{adj} = .46$), and Goal ($p < .001$, $R^2_{adj} = .34$), were all associated with outcome, and entering all three subscales found both Bond ($p = .005$) and Task ($p = .02$) to be significant. The removal procedure identified Bond as producing the best fitting model. Entering all of the WAI-S and BLRI subscales together found Bond ($p = .04$) to be the only significant subscale and following the removal procedure Bond produced the best fitting model of satisfaction with care with no significant interactions (see Supplemental files).

Table III. Final model for YP-CORE (12 Weeks): therapist interpersonal skills and outcomes in SBHC + PCAU versus PCAU.

	b*	SE	T	*p*
YP-CORE Baseline	.61	.05	11.90	< .001
YP-CORE Change (Baseline to 6 weeks)	−.51	.05	−9.86	< .001
Condition (SBHC + PCAU vs PCAU)	−.05	.05	−.99	.322
Regard (BLRI)	−.07	.05	−1.48	.141
Condition * Regard	.10	.05	−2.10	.036
Constant	.03	.05	.72	.474

Therapist Interpersonal Skills and Outcomes in Counseling Versus Pastoral Care as Usual (RQ3)

Psychological distress (YP-CORE). For the YP-CORE outcome, the interaction between BLRI subscales and condition was only significant for BLRI Regard ($b^* = -.10$, SE 0.05, $p = .036$). Including the interaction increased R^2_{adj} slightly from .376 to .383 (approximately 1%) and reduced the RMSE from .788 to .784. Neither Regard nor condition were significant, either before or after adding the interaction. However, the interaction indicates that, compared to PCAU, higher Regard scores in SBHC + PCAU were associated with greater improvement in YP-CORE score (Table III).

To illustrate the relationship, Figure 1 shows the plot of YP-CORE against BLRI Regard scores, adjusted for YP-CORE baseline and 0–6 week change scores and showing the lines of best fit for each condition. It shows higher scores for Regard to have minimal effect on the outcome for PCAU, but some improvement to the outcome for SBHC + PCAU. Excluding the outlier (taken as scores below 10 on Regard) made little difference to the model or the regression lines. Plots for other BLRI subscales are presented in supplemental material.

Wellbeing (WEMWBS). Similarly, for WEMWBS outcomes, the interaction between Regard and condition was significant ($p = .012$) but not for Empathy, Congruence, or Unconditionality. However, inclusion of the interaction term only made a small improvement to the model, increasing R^2_{adj} from .44 to .45 (approximately 1%), with RMSE reducing from .734 to .727. The model and plots are presented in supplemental material.

Satisfaction with care (ESQ). For ESQ, the BLRI*Condition interaction was not significant for any BLRI subscales.

Discussion

To summarize, the aim of our study was to investigate the relationship between TIS, as rated by young people, and their therapeutic outcomes. Our first analysis showed that TIS, most strongly

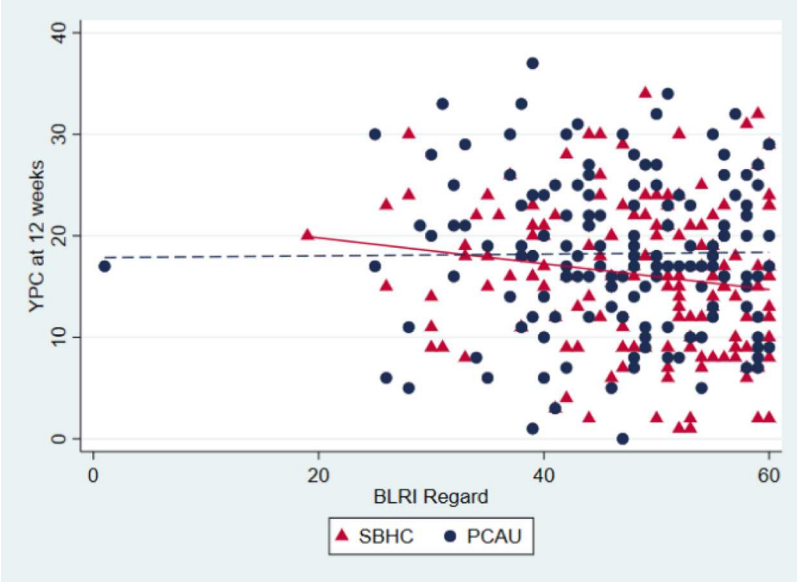

Figure 1. Relationships between BLRI Regard and psychological distress (YP-CORE at 12 weeks) with lines of best fit for SBHC + PCAU and PCAU.

congruence, were significantly associated with therapeutic outcomes, contributing approximately 3% of change. TIS overlapped with dimensions of the working alliance, and both explained similar levels of variance in outcome. In some instances, TIS, particularly congruence, made small additional contributions to model fit. There was some evidence to suggest that the association between the TIS of regard and outcomes may be theory-specific—with stronger associations in humanistic counseling as compared with an alternative approach—but the magnitude of this interaction, where present, was small (approximately 1% of variance explained).

Congruence had the strongest relationship to outcomes, explaining variance in wellbeing outcomes at a level slightly enhanced to the bond dimension of the working alliance. This suggests that congruence is an important relationship factor to consider in youth psychotherapy—above and beyond the alliance. Our finding is consistent with evidence that the congruence–outcome association is significantly higher for young people than for adults (Kolden et al., 2018) and that, for young people, trust in the therapist may be a central component of therapeutic change (Cooper et al., 2024).

Developmentally, trust may be a particularly important issue for young people. As they develop new executive skills (Griffith & Larson, 2016), along with new levels of independence, the question of whether or not another can be relied upon may become particularly salient. With the emergence of abstract thinking and identity-development processes, the issue of "realness" may also come to the fore. Erikson's (1950) theory of psychosocial development highlights adolescence as a critical period for identity formation, where individuals grapple with questions of "Who am I?" and "What is real or authentic?" This cognitive development may cause young people to scrutinize the behavior and intentions of those around them, including their therapists, as they seek "realness" or authenticity in relationships to build trust and support their evolving sense of self. Pearce and Sewell (2014) argue that counseling work with young people is often characterized by *tenuous contact*, where the relationship is fragile and easily disrupted if the young person perceives the counselor as disingenuous or "fake." Here, a young person's lack of *relational capital* means that the counselor must consistently demonstrate authenticity in their work. Relational capital refers to the trust, emotional connection, and shared experiences that facilitate meaningful relationships. In the context of therapy with young people, it is the foundational trust that may allow a therapist–client relationship to thrive, and which the young person may not have experienced in previous relationships with adults or authority figures.

The magnitude of association for TIS established in our study, about 3% of variance, is substantially lower than the 12.3% reported in Karver et al.'s (2006) meta-analysis. Possible reasons are that our study was predictive rather than concurrent, and effect sizes here tend to be lower (Karver et al., 2018). In addition, we measured TIS particularly late into therapy—six of 12 weeks—and, by controlling for change up to this point, discounted the effects

of TIS in the first half of therapy. In addition, the rigor of our method, including the use of blind independent testers and a clear temporal gap from relationship measurement to outcome measurement, may have suppressed the magnitude of association. This is consistent with findings from previous reviews, which suggest that the alliance–outcome correlation is significantly lower in RCTs (Karver et al., 2018).

We found TIS to explain a similar amount of variance in outcomes to the alliance. The TIS–outcome association was also of a similar magnitude to that found in previous studies of the alliance–outcome association, where an *r* of .19 translates into approximately 3.6% of variance explained (Karver et al., 2018). However, our study produced mixed findings on whether studying TIS and their association to outcomes adds value to studying the alliance, alone. On the one hand, Congruence did emerge as the best predictor of outcomes on psychological distress and wellbeing—over and above the three WAI-S subscales—and, from the qualitative literature, the trustworthiness of the therapist seems to be of distinctive importance. However, quantitatively, the gains in predicting outcomes over alliance alone were marginal. An important factor here is the high degree of intercorrelation between all our relational variables. Aside from Unconditionality, correlations ranged from .67 to .94 across all BLRI and WAI subscales, with a median of .75 (56% of overlap in variance). This finding is consistent with Roest et al. (2016), as well as Cirasola et al.'s (2021) confirmatory factor analysis, which failed to replicate the WAI Bond–Task–Goal structure and only found support for a general, one-factor model. Our findings suggest that this unidimensionality may be even broader, encompassing not just young people's ratings of the alliance but also TIS. However, when weighing up the relative value of unidimensional versus multidimensional models of the therapy relationship, it is also important to consider the implications for training. Teaching clinical trainees skills in TIS, such as congruence, may add value to training in alliance-building skills. In addition, that young people may not discriminate across different alliance dimensions does not mean that these dimensions are undifferentiated from a therapist or observer perspective.

With respect to the specificity of the effects of TIS to theory-consistent practices, our findings were generally more consistent with a "common factors" interpretation than a "theory-specific" one. Interactions between TIS and condition were only significant for Regard with YP-CORE and WEMWBS outcomes (two of 12 potential interactions), and the inclusion of these interaction, where significant, only made minimal improvement to model fit (approximately 1%). Previous research also supports the commonality of these factor effects across orientations, at least for the TIS of empathic understanding and level of regard. As discussed in our introduction, for instance, Fiorini et al. (2024) found that a warm and genuinely caring therapeutic relationship was also valued by young people in psychoanalytic psychotherapy—an approach that tends to place more emphasis on a "neutral" therapist stance and the cultivation of "negative transference." In trauma-focused CBT too, children and young people describe the importance of feeling validated, supported, and understood (Neelakantan et al., 2019)—with dropout in instances where the young people felt unheard or pressurized to talk (Dittmann & Jensen, 2014). Most likely, as our results suggest, there may be some small degree of theory-specificity for Rogers's (1957) TIS: if an approach, like SBHC, is wholly based on these practices, they may play a more important role than in a practice, like PCAU, where they are just one of several elements. Still, their ubiquity and embeddedness in all forms of interpersonal helping—as well as their centrality to clients' experiences of being helped—mean that differences across practices may remain small.

In terms of study limitations, it would have been preferable if the specific BLRI form that we used had had stronger prior evidence of reliability and validity with young people. And, indeed, the internal reliability of our Unconditionality subscale—as has been found in other studies (Barrett-Lennard, 1986)—was of marginal acceptability. We did not correct for multiple testing. It is also possible that the main pastoral care teachers rated by PCAU participants had some degree of training in humanistic therapy/TIS. If so, our comparative group for RQ3 would be somewhat compromised. Ideally, we would have recorded pastoral care staff's training experiences to control for this. Nevertheless, we are confident that only a very small minority of these teachers—if any—would have had formal training in TIS; and certainly not at a level of our therapists. A final limitation is that the ESQ satisfaction with care form for PCAU participants differed from the focus for their BLRI (a specific member of pastoral care), as well as from the SBHC + PCAU group, who were assessing their therapist throughout.

Our findings suggest that it may be important for both therapists and lay professionals to monitor their levels of genuineness, authenticity, and trustworthiness with young people—within the context of a collaborative, warm, and understanding therapeutic relationship. "Being real" may be an important factor that young people look to in developing trust with their therapists and supporting their

pastoral care. This also highlights a need for therapists and pastoral care staff to focus on what supports them to "be real." This might include good support, supervision, and self-care.

Future research should focus on factor analytic studies—using a range of relational measures (including the BLRI and WAI)—to establish the particular dimensions along which young people construct the relationship. In addition, session-by-session recording of process and outcome indicators, as employed by Labouliere et al. (2017) in the adolescent psychotherapy field, would help to establish clearer indications of causal relationships. Such longitudinal studies could also be used to explore whether relationship–outcome associations are more a consequence of client dispositional factors (as indicated, for instance, by baseline ratings of the relationship factor) or therapist-specific skills (as indicated, for instance, by increased ratings of the relationship factor over time). Understanding what congruence and trust mean to young people may also be an important area for qualitative research.

Declarations and Ethics Statements

Ethical approval for the trial was obtained under procedures agreed by the University Ethics Committee of the University of Roehampton, Reference (PSYC 16/227) , 31st August 2016.

Parents/carers provided informed consent for all young people participating in the study. In addition, all young people who participated in the study were provided with details of the trial and provided written assent.

Trial registration: Controlled Trials International Standard Randomised Controlled Trial Number (ISRCTN) Registry, ID: ISRCTN10460622. Registered on 11 May 2016.

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MC, MB, PB, KC, CD, and PP designed the study and were responsible for its conduct. MC was Chief Investigator and oversaw all aspects of the study. MRS and KC managed the delivery of the trial. PP was Clinical Lead for the study. DS performed the analysis. MC wrote the original draft of the paper; with all authors contributing to the writing, reviewing, and editing of the final draft.

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Supplemental data

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