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Exploring the relationship between childhood trauma history and working alliance in psychotherapy

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EXPLORING THE RELATIONSHIP BETWEEN CHILDHOOD TRAUMA HISTORY AND

WORKING ALLIANCE IN PSYCHOTHERAPY

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by

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ABSTRACT

Adults who have a history of potentially traumatic events (confrontation with actual or threatened death, serious injury, or a threat to a person's physical integrity) in childhood may be at risk for a less established and less strong early working alliance, defined as an agreement between therapist and client on therapy goals, tasks and bond. The aim of this dissertation was to examine whether a sample of adult client-participants who presented with a self-reported history of the potentially traumatic events of childhood sexual, physical and/or emotional abuse experiences (referred to as the "childhood trauma only group") reported differences in regard to their perceptions of their early working alliance with their therapists than a sample of adult psychotherapy client-participants who did not report such childhood experiences ("non childhood trauma group"). Quantitative data analyses examined archival Working Alliance Inventories completed by client-participants during initial psychotherapy sessions at a local community based clinic. Contrary to the study's hypothesis, results did not show a significant difference in working alliance scores between the "childhood trauma only group" as compared to the "non-childhood trauma group." Instead, both client groups endorsed strong early working alliance scores. These results extend existing research showing that individuals with childhood trauma histories are capable of forming strong therapeutic alliances with their therapists, which have been shown to be influential in treatment outcome.

Keywords: working alliance inventory, therapeutic alliance, childhood trauma

Introduction

Trauma has proven to be a robust and needed area of research because, according to Bonanno and Mancini (2012), most people experience at least one and usually several potentially traumatic events during their lives (Breslau, Davis, Peterson, & Schultz, 2000; Copeland, Keeler, Angold, & Costello, 2007; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Of the various types of potentially traumatic events (PTEs), this dissertation focused on sexual, physical and emotional abuse reported by adult client-participants that they themselves experienced during childhood.

When people are confronted with actual or threatened death, serious injury, or a threat to a person's physical integrity, such traumatic exposure can have a wide range of effects or trajectories. In terms of trajectories, Bonanno (2008) identified four: (a) a chronic disruption in functioning, (b) a delayed onset of distress that increases over time, (c) recovery, where there is an initial disturbance in stable functioning that decreases over time and pre-trauma functioning is recommenced, and (d) resilience in individuals who are able to maintain a relatively consistent state of functioning post trauma. Considering distress and disturbances that present in some of these trajectories, negative symptoms that may emerge following a traumatic experience include social withdrawal, sleep problems, difficulty with attention and concentration, and guilt, which are relatively generalized across cultures (Antai-Otong, 2002).

Studies on the long-term consequences of trauma have examined the relation of potentially traumatic life events to subsequent patterns of symptom development across the lifespan (Alisic et al., 2014; Carr, Martins, Stingel, Lemgruber & Juruena, 2013; Pérez-Fuentes et al., 2013). Childhood trauma has been related to behavioral and social problems in adulthood (Joseph & Linley, 2008), such as a general increase in psychopathology, decreased self-esteem,

increased interpersonal problems, sexual difficulties (Davis, Petretic-Jackson, & Ting, 2001), risky sexual behaviors (i.e., exposure to HIV, prostitution, and early sexual contact [before age 15; Sikes & Hayes, 2010]), and difficulties in emotion regulation (e.g., hostility, anger management, modulation of feeling) and interpersonal skills (e.g., reactive aggression, bullying, limited social competence; Cloitre, Miranda, Stovall-McClough, & Han, 2005). Of note, increased rates of substance dependence of approximately 50% have been observed among individuals with PTSD who experienced trauma in childhood or adulthood (Santa Ana et al., 2006).

Due to the aforementioned potential effects on childhood traumatic experiences in adulthood, this dissertation intended to extend existing research examining how self-reported childhood traumatic experiences may be related to individuals' relationships with their therapists in the beginning stage of therapy. To provide context for this goal, this introduction section includes a brief overview of the research on the therapeutic relationship and the working alliance (Appendix A provides a broader literature review, which addresses feedback discussed during the preliminary orals process). Following this brief summarized literature review, the hypothesis for this study, along with research questions that guided statistical analysis are included.

Potentially Traumatic Events and the Therapeutic Relationship

In regard to the therapeutic relationship in general, literature describes the struggle many clinicians experience with forming a therapeutic relationship with adult abuse survivors due to clients' emotional lability, relational instability and mistrust (Schwartz, 2000). Yet, once a therapeutic relationship is carefully established, it can serve as a mediating factor in clients' resilience following a traumatic event(s), according to Kohlenberg and Tsai (1991). Thus, the development of a therapeutic relationship early on in the course of the treatment of trauma

survivors appears needed. The therapeutic relationship has been defined as the "feelings and attitudes the participants hold toward one another, and the psychological connection between the therapist and patient, based on these feelings and attitudes" (Gelso & Hayes, 1998, p. 17).

Accordingly, the therapeutic relationship and its related concepts, such as the working alliance, may be helpful to measure and explore, specifically for individuals that have survived PTEs. The next subsection briefly reviews how the concept of the working alliance that develops between the client and therapist is measured, outcomes of the working alliance, and how the Working Alliance Inventory has been used with people who have experienced PTEs.

Working Alliance

There are a variety of self-report questionnaires that aim to measure clients' perspective of the therapeutic alliance. In addition to the Working Alliance Inventory (WAI; described below), the Helping Alliance questionnaire developed by Luborsky (1985), is highly correlated with the WAI (0.74; Hatcher & Barends, 1996). Also, to name a few, the California Psychotherapy Alliance Scale (Gaston & Marmar, 1993) depicts the client's assessment of the therapeutic alliance and commitment to the therapeutic process, and the Kim Alliance Scale (Kim et al., 2001) is a 30-item client self-report questionnaire that measures empowerment of the client (responsibility for making life choices), and also includes the same three dimensions as in the WAI (tasks, bond and goals; Bordin, 1979).

To assess therapeutic alliance for the purpose of this dissertation, the researcher studied and utilized the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). This measure was chosen after careful analysis and exploration of other measures of therapeutic alliance, as it is considered a commonly used measure that assesses goals, tasks, and therapeutic bond, which was shown to be useful across therapeutic disciplines, techniques and styles. A working alliance

is said to develop from a therapeutic relationship, such that it grows from an agreement between client and therapist on therapy goals and tasks (Busseri & Tyler, 2003). It also highlights the progression of a resilient relational bond between the client and therapist (Busseri & Tyler, 2003). Kivlighan (2007) stated the working alliance helps the client and therapist to work together, form a partnership and collaborate in a dyadic environment.

Accordingly, research has found that the working alliance is related to positive outcomes. For example, Horvath (2001) noted that the best predictor of positive therapeutic outcome is defined by the client's report of a strong early therapeutic rapport, and that the degree of the relationship between alliance and therapy outcome was unrelated to the therapeutic technique practiced. Further, meta-analytic studies found that a strong therapeutic relationship is correlated with better psychotherapy treatment results (e.g. Davis, Garske & Martin, 2000). An additional discussion of outcome research on the working alliance is found in Appendix A of this dissertation.

Although studies exist regarding use of the WAI with the general population (reviewed in Appendix A), more studies appear to be needed to understand how PTEs impact clients' interpersonal relationships with their therapists. In particular, only six studies were located in a review of the literature for this dissertation that indicated possible effects of PTEs on the working alliance measured with the WAI. Mixed results were found.

From four general studies that measured the WAI in study samples that experienced PTEs (not specifically in childhood; thus unlike the present dissertation sample), one study did not include WAI results (Howgego et al., 2005), and two studies found that those with PTSD symptoms rated their therapeutic relationship as high initially with stable progression (Brand, Knaevelsrud, Schulz, & Wagner, 2012; Kanninen, Punamaki &Salo, 2000). The fourth study is

the only one of the four that found that those with reported PTSD symptoms rated their alliance with their therapists as high at session four, and that the WAI improved over the course of treatment (linear growth; Knaevelsrud & Maercker, 2007).

Two studies were located that investigated the relationship between a reported history of childhood trauma and the client-rated WAI. First, Paivio and Patterson (1999) used the WAI at sessions three, four, ten and termination (average of 20 total sessions; session termination range: 12-27) with a sample of 33 child trauma survivors (26 women and seven men; 91% Caucasian; 76% household income less than $39,000). Nine (27%) met DSM IV criteria for an Axis II diagnosis (Paivio & Patterson, 1999) and 70% endorsed a history of therapy experiences to address anxiety, marital distress, substance dependence or depression. Results showed that the child trauma survivors generally endorsed strong early alliances with their therapists on the WAI at session 3 ($M = 5.74$; $SD = 0.66$), and a steady increase in alliance strength throughout the course of therapy, specifically in the bond dimension (linear pattern). These findings share some similarities with a general population study that described and identified a linear growth pattern (gradually increasing WAI strength over time; Kivlighan & Shaughnessy, 2000).

Of note, however, the results varied by abuse severity (Pavio & Patterson, 1999). Specifically, early alliance struggles (lower initial ratings of the WAI, but WAI scores from this subgroup were not reported in the study) were correlated with the exposure of higher numbers of severe traumatic events as a child, such as physical or emotional trauma, or neglect, measured on the Childhood Trauma Questionnaire (CTQ, 1994) and Posttraumatic Stress Disorder Symptom Severity- Interview (PSSI). 68% of participants reported that they experienced multiple childhood traumatic events (Paivio & Patterson, 1999). Results indicated that subscales of the CTQ such as emotional/physical abuse (-0.31), emotional neglect (-0.28), and physical neglect (-

0.27) were negatively correlated with early alliance scores at the fourth session. Thus, the more severe abuse that clients experienced as a child, the lower the participants rated their initial working alliance with their therapist; moreover, they also endorsed suffering from interpersonal damage as an adult, measured by the Inventory of Interpersonal Problems (IIP), and received a personality disorder diagnosis on Axis II in the DSM-IV (Pavio & Patterson, 1999).

Paivio and Patterson (1999) subsequently compared their above mentioned study utilizing a sample of participants who endorsed a history of trauma to WAI results from two general population samples from different studies. The first comparison study, by Paivio and Bahr (1998), included 33 participants who reported symptoms of depression, anxiety and moderate employment and interpersonal functioning problems. The researchers included participants based on criteria for short-term therapy outlined by Malan (1976); the criteria included motivation for treatment, capacity to develop a therapeutic relationship, and the ability to target a current personal issue or problem. The WAI was measured at sessions three and termination (average of 12 sessions of experiential psychotherapy; session termination range: 8-16), and results showed a positive linear growth pattern, from high to higher scores, from session three (M=5.68, SD=0.68) to the termination session (M = 6.24, SD = 0.46). Thus, Paivio and Patterson (1999) found a slightly stronger initial alliance rating in those who experienced childhood trauma (M = 5.74; SD = 0.66) compared to Paivio and Bahr's general clinical sample (M = 5.68, SD = 0.68), and both studies indicated positive linear growth over time.

The additional study referred to by Pavio and Patterson was conducted by Mallinckrodt (1996), which included a sample of 34 participants in the general population who participated in a general nonabuse-focused brief therapy model (mean number of sessions = 14.96; session termination range: 8-20). Participants who had fewer than eight sessions of therapy were

excluded from the data analysis. The WAI was administered at session three, and again at the termination of therapy. Overall, Mallinckrodt (1996) study's early alliance ratings (session 3; M = 5.02; SD = 0.75) were not rated as high as Paivio and Patterson's (1999) results of early alliances (sessions three and four) in those with a history of childhood trauma (M = 5.74; SD = 0.66).

In the second study, those who experienced sexual trauma as a child and indicated strong social support on the Social Reactions Questionnaire (SRQ; Ullman, 2000) administered pretreatment showed that this support assisted them in forming a strong therapeutic bond during the start of treatment as measured by the WAI 12-item short form at the beginning of sessions two and four (Keller, Zoellner, & Feeny, 2010). These results are in line with the previous studies, wherein a childhood sexual abuse history did not indicate a poor early alliance, as predicted (Paivio & Patterson, 1999). This study included 188 participants (144 women and 44 men) between the ages of 18 and 65 who were given the primary diagnosis of chronic Post Traumatic Stress Disorder (PTSD) using the PTSD Symptom Scale (PSSI, 1993) and the Structured Clinical Interview for DSM-IV (SCID-IV, 1995). The participants were randomly assigned to a 10-week treatment of either a Psychotherapy or Pharmacotherapy treatment group (Keller et al., 2010). The psychotherapy treatment utilized prolonged exposure (PE; Foa, Hembree, & Dancu, 2002), and the Pharmacotherapy group, which included sertraline (SER) at a mean dosage at the end of treatment of 135.68 mg/day (SD = 66.80) and weekly visits to the psychiatrist to track side effects and provide support throughout (Keller et al., 2010). The results of sessions two and four indicated a mean average early working alliance of 65.37 and a standard deviation of 12.59. The difference in early therapeutic alliance was significant, as the study participants in the PE group reported a stronger early working alliance (M = 67.37, SD = 11.07)

than those in the SER group (*M* = 62.00, *SD* = 12.59).

Although the general population tends to rate their working alliances as high (e.g., Gelso & Carter, 1994; Golden & Robbins, 1990; Kivlighan & Shaughnessy, 2000; Paivio & Bahr, 1998; but see Mallinckrodt, 1996), there is some variation in WAI scores for those with PTSD symptomology (some report of high and linear scores, some high and stable). Despite many hypotheses stating that those who reported childhood abuse are unable to form solid therapeutic relationships with their therapists, existing research with participants who reported childhood history of trauma indicates that they are able to form strong working alliances with their therapists. Given these mixed findings, further exploration of the association between the dyadic working relationship and clients' experiences of adverse events in childhood appears needed in order to inform future therapeutic treatment.

Study Aim, Research Questions and Hypothesis for Investigation

The aim of this dissertation was to examine and gain a clearer picture of whether a sample of adult client-participants who presented with a self-reported history of the potentially traumatic events of childhood sexual, physical and/or emotional abuse experiences (referred to as the "childhood trauma" sample) reported differences in regard to their perceptions of their early working alliance with their therapists as compared to a sample of adult client-participants who did not report such a history in childhood. Hence, the research questions were:

- What is the mean score of early WAI strength in the "childhood trauma only" sample?

- What is the mean score of early WAI strength in the "non-childhood trauma" sample?

- What is the difference in the early WAI scores of client-participants who did not report a history of childhood emotional, physical or sexual abuse as compared to the scores of client-participants who reported such a history in childhood? Is this aforementioned difference statistically significant?

Given the aforementioned literature finding that a history of childhood trauma leads to increased interpersonal problems (Davis et al., 2001), interpersonal skill deficits in adulthood (Cloitre et al., 2005), and weak alliances with therapists when they also are found to have challenges in sustaining social relationships (Mallinckrodt, 1991; Moras & Strupp, 1982), the hypothesis of this study was that client-participants who did not report a history of childhood emotional, physical or sexual abuse/trauma would report higher and stronger early working alliance scores than client-participants who reported a history of childhood abuse/trauma.

Method

Participants

The participants included 100 individual therapy clients from two community

counseling clinics in Southern California associated with a private graduate school in Southern

California. Inclusion criteria for this dissertation included that client-participants be English

speaking, adults (18 and over) who presented for individual therapy and provided written consent

for the use of all written materials in their clinic files, including the Client Information Adult

Form, Telephone Intake Summary, Intake Evaluation Summary Form and the Treatment

Summary Form (Refer to Appendices C, D & E). In addition, inclusion criteria included the

completion of the WAI at any session from 3-7 in order to measure early working alliance

(http://wai.profhorvath.com/sites/default/files/upload/WAI-C%20s.pdf). Finally, client-

participants must have either a) met the studies' operationalized definition of PTEs of childhood

trauma, or b) have no endorsement of PTEs across their lifespan. For additional details regarding

sample selection using the inclusion criteria, please refer to Appendix H. Those that were

excluded from the study were individuals who sought child/adolescent therapy, couples therapy

and family therapy in any of the three community clinics. Additionally, files where the client and

the therapist did not both consent to use of written materials were also excluded from the study.

The total sample was separated into two groups (50 "childhood trauma only," 50 "non-

childhood trauma") for the purpose of this study. In terms of demographic information, the total

study sample (n = 100) consisted of 67 females (67%) and 33 males (33%). Participants in the

total sample identified with the following ethnic groups: 5 Middle-Eastern (5%), 4 Asian (4%), 7

African American (7%), 53 Caucasian (53%), 15 Latino/Latina (15%), 1 Pacific Islander (1%)

and 15 as other (15%). In terms of years of education, this total sample ranged from receiving 11

years of education to 24 years ($M = 15.22$, $SD = 2.37$). Age of total sample ranged from 18-73 ($M = 34.39$, $SD = 11.88$).

As shown in Table 1, the "childhood trauma only" sample group consisted of 50 participants, including 17 males (34.0%) and 33 females (66.0). Participants in this sample identified with the following ethnic groups: 3 Middle-Eastern (6%), 3 Asian (6%), 6 African American (12%), 23 Caucasian (46%), 7 Latino/Latina (14%) and 8 as other (16%). Participant age range in the "childhood trauma only" sample spanned 18 to 73 years of age ($M = 35.62$, $SD = 12.93$). Years of education spanned from 11 to 24 years ($M = 15.16$, $SD = 2.56$ All research files that met criteria for a PTE within the participant's childhood (as well as the required WAI measures to measure early alliance from session 3-7) were selected for the study.

Table 1 also includes participant demographics of the "non-childhood trauma" group, comprised of participant files that contained a completed WAI from sessions 3-7. This sample consisted of 50 participants, which included 16 males (32%) and 34 females (68%). Participants in the non-trauma sample identified with the following ethnic groups: 2 Middle Eastern (4%), 1 Asian (2%), 1 African American (2%), 30 Caucasian (60%), 8 Latino/Latina (16%), 7 other (14%), and 1 Pacific Islander (2%). Participant age range in the "non-childhood trauma" sample spanned 19 to 63 years of age ($M = 33.16$, $SD = 10.71$). Years of education ranged from 11 to 21 years ($M = 15.28$, $SD = 2.20$).

Measure

The Working Alliance Inventory-Short Form (WAI-S; Tracey & Kokotovic, 1989) is a self-report measure that contains 12 items intended to assess the construct of working alliance. Researchers created the WAI in order to analyze aspects of the therapeutic relationship within multiple different therapeutic orientations and modalities (Knaevelsrud & Maercker, 2007).

Developed from Bordin's (1979) operationalization of the working alliance within three

subscales, the WAI measures goals (the degree to which the client and therapist agree on the

therapeutic intervention), tasks (how much the client and therapist agree on the process of the

therapeutic course of treatment), and bond ([the amount of "mutual trust, acceptance, and

confidence" (p. 224) the client and therapist have for one another] Horvath, 1989).

The items are scored on a 7-point Likert-type scale, ranging from 1 (never) to 7 (always).

Higher scores on the WAI-S client form signify a more positive rating of one's perceived

working alliance with his or her therapist. Examples of the items include: "We agree on what is

important for me to work on (tasks)", "_____ and I have different ideas on what my problems are

(goals)", and "I am confident in _____'s ability to help me (bond)." Scores on the WAI-S

Total Scale range from 12-84 (Horvath & Greenberg, 1989). According to A.O. Horvath, the

WAI is considered to be ipsative, meaning the measure was "not standardized on a homogeneous

population." Therefore, researchers are encouraged to utilize group means of their study samples

in order to categorize results as "high" or "low" (A.O. Horvath, personal communication, March

7, 2017).

In terms of the development of this self-report measure and its psychometric properties,

the WAI-S was normed on 124 sampled dyads that completed WAI self-report forms. More

specifically, out of the 124 sampled dyads, completed data was obtained after the first therapy

session from 15 therapists who identified with diverse theoretical orientations and rated 123

clients, as well as 84 clients (31 men and 53 women with an age range of 17 to 34 years). Using

this data, researchers selected the items most suggestive of the three factors (goals, task, and

bond) to construct the 12-item WAI-S using a confirmatory factor analysis. Internal consistency

for all three subscale scores the sample of 124 pairs of clients and therapists were .90 to .92 for

the client version, and .83 to .91 for the therapist version. Total score internal consistency measures at .98 for the client version, and .95 for the therapist version (Tracey & Kokotovic, 1989). According to Horvath and Greenberg (1986), the original 36-item WAI has high internal consistency, with the construct validity measuring at 0.93 on the composite score. The construct also has high reliability, with means from .72 to .97 (Davis et al., 2000; Hanson, Curry, & Bandalos, 2002). Research findings highlight that the factor structure for the WAI-S is fairly similar to the original 36-item WAI (Tracey & Kokotovik, 1989).

In reference to completed confirmatory and exploratory factor analysis, the total score (composite) is regarded as the most important and meaningful measurement of the working alliance, versus measurement of the three independent subscales (Barends & Hatcher, 1996; Cook & Doyle, 2002; Kokotovik & Tracey, 1989). For this reason, the dissertation only analyzed total scores.

Overall, researchers have favored utilization of the working alliance for the past 20 years, with regard to many diverse populations, along with efforts to conceptualize the therapeutic relationship between client and therapist within the therapeutic space (Bachelor & Horvath, 1999). Orlinsky, Grawe, and Parks (1994) found that research on the WAI, in general, provided the strongest evidence correlating the therapeutic process to therapy outcome.

With regard to the analysis of early alliance, not specifically defined in the literature, it has been associated with the time in which the therapist and client develop and facilitate a collaborative dynamic, which fosters confidence in one another (Ardito & Rabellino, 2011). Although the alliance between a client and therapist has been said to establish in the first five sessions of therapy and peaks at the third session (Saltzman et al., 1976), recent research has not been located that addresses this issue. Furthermore, we found that there was no clear rationale

given nor pattern of early sessions found in the studies reviewed above that analyzed WAI scores with samples that endorsed a history of traumatic experiences in childhood (as addressed in the literature review/addendum), although session three was commonly chosen. To review, Paivio and Patterson (1999) utilized WAI scores at sessions three, four, ten and termination (average of 20 total sessions; session termination range: 12-27). Mallinckrodt (1996) analyzed WAI scores at session three and again at termination (mean number of sessions = 14.96; session termination range: 8-20). Keller et al. (2010) measured WAI scores at sessions two and four. Finally, Smith et al. (2012)'s study utilized the WAI scores solely at session three. Given the range found in the extant literature as well as our database limitations, this dissertation used a broad time frame of sessions 3-7 to indicate early psychotherapy sessions.

Procedures and Analysis

All methods of this experimental, between-subjects study were approved by the Institutional Review Board of Pepperdine University's Graduate School of Education and Psychology. After receiving full IRB approval, the researcher created an electronic database that included study participant data. The participant data was obtained from a larger research project that collected large amounts of archival, de-identified, clinical research data from a private graduate school's community counseling clinics in Southern California. Client-participants and therapists both consented to release certain contents of client files for research purposes, including client demographic information, recorded therapy sessions, intake reports, termination reports, and questionnaires. The therapists were doctoral and master's students who conducted therapy under licensed mental health professionals. The client-participants were members of the community seeking therapy for various presenting problems. As stated above, participants for the "childhood trauma only" group were selected from the large, hard copy master database, and

included those that endorsed experiencing a PTE in childhood and completed the WAI from

sessions 3-7. For the "non childhood trauma" group, participants were selected based on an

absence of endorsed traumatic lifetime history, and completion of the WAI from sessions 3-7.

For more information on sample selection, please refer to Appendix H.

      First, after data input of the two groups in SPSS, the data analyses was conducted in three

steps: demographic analysis, descriptive analyses and main analysis. The demographic analyses

demonstrated the age, gender, education and ethnicity of the total population sample (and each

group), along with providing information on the presence of multicollinearity. Next, to answer

the descriptive questions regarding the average WAI strength from early sessions 3-7 in the

"childhood trauma" and the "non-childhood trauma" groups, an analysis was run to identify the

mean, median, and mode of early WAI-S total scores. Subsequently, to address the main

hypothesis, a quantitative, between-subjects ANCOVA design was used to investigate the

similarities or differences in the therapeutic relationship, as rated using the WAI-S, between

those who reported experiencing childhood trauma, as compared to those who did not report

childhood trauma. Using an ANCOVA, the researchers had the ability to control the variables of

gender and age to increase the chance of more accurate results, with less chance for error, while

comparing the two sample groups.

Results

Descriptive Statistics

To address the research questions of the study, descriptive statistics were performed to identify the most commonly endorsed early WAI score for the total and both sample groups. In the total sample, early WAI scores ranged from 40-84 ($M = 78$, $SD = 9.16$). As seen in Table 2, the average early WAI score for the "childhood trauma only" group was 78.24 ($SD = 8.23$), and for the " non-childhood trauma" group was 78.46 ($SD = 10.09$). The mode for both groups was 84 (See Figures 1 and 2). This study considered the ipsative interpretation of composite scores, which emphasizes consideration for the study means and range of scores (40-84; A.O. Horvath, personal communication, March 11, 2017). Thus, scores were interpreted in reference to themselves. Both groups placed in the strong/high/positive level of early working alliance for this study, as their means are near the top of the WAI-S scale (12-84).

As shown in the histograms provided in Figures 1 and 2, the "childhood trauma only" group's early WAI scores exhibited a skewness of -1.15 and kurtosis of .029, while the "non-childhood trauma" group showed a skewness of -2.51 and kurtosis of 6.53. These results indicate that early WAI scores, especially for the "non-childhood trauma" group, tended to clump toward the positive direction, and that the data was not normally distributed, with a small ceiling effect. A high skew can make the use of parametric tests more difficult.

Hence, an additional non-parametric t –test, appropriate for non-normal data, was utilized in order determine if there was a significant difference in WAI scores between the two groups in question. This Mann-Whitney U test (Figure 3 and Table 3) was not significant, showing that there was no significant difference between the groups on WAI scores, despite the skewness mentioned in the "non-childhood trauma" group.

Overall, it was important to this study to run statistical tests to ensure the demographics (i.e., education, age, gender, and ethnicity) did not significantly influence WAI scores, before the main statistical analysis was completed. Thus, following the demographic analysis (as described above), a statistical regression, was run in order to determine if multicollinearity was found in the original correlational matrix of demographic information. Tolerance was found to be 0.98, which suggests non-multicollinearity (a score of 1 indicates perfect non-multicollinearity). Furthermore, if any demographic variables were found to impact WAI scores significantly, they could be identified as covariates. It was determined whether there was correlation between early WAI scores and education, as well as early WAI scores and age. Education and WAI scores were not significantly correlated, $r(100) = -.10$; $p = .32$; nor was age and WAI scores, $r(100) = -.02$; $p = .85$. Additionally, an ANOVA indicated that there was no significant difference in early WAI scores related to ethnicity at the $p < .05$ level ($F [6, 93] = 0.67$, $p = .67$).

Regarding gender, a two-tailed independent sample t-test was utilized in order to determine if there was a significant difference between male and female early WAI scores. The results indicated a significant difference between male ($M = 80.76$, $SD = 7.1$) and female ($M = 77.16$, $SD = 9.9$) early WAI scores; $t (84.55) = 2.08$, $p = .04$, with males generally rating their early WAI 3.6 points higher than females (mean difference). Thus, this study followed through on the original plan to control for gender, and it also conservatively included age, even though there was no correlation identified between age and WAI.

Relationship between Working Alliance Scores, Childhood Trauma Only Compared to Non-Childhood Trauma Groups

To test the hypothesis of this study that client-participants who did not report a history of childhood emotional, physical or sexual abuse/trauma would report higher and stronger early

working alliance scores than client-participants who reported a history of childhood abuse/trauma, this researcher conducted a one-way analysis of covariance (ANCOVA), controlling for the variables of gender and age. This method allowed researchers to understand if there was a statistically significant difference between the client-rated WAI-S of a group of client-participants that did not endorse a history of PTEs at the early phase of treatment (M = 78.46, SD = 10.09) versus the group of client-participants with a history of childhood abuse (M = 78.24; SD = 8.23). As shown in Table 4, results found there was no significant difference between the two sample groups ("childhood trauma only" and "non trauma" after controlling for age and gender (F [1, 96] = .014, p = .91); therefore, the study's hypothesis was not supported. Additionally, 0% of the variability in working alliance scores was accounted for by group.

Discussion

The client-therapist relationship is considered an integral part of the foundation of psychotherapy with adult survivors of child abuse (Paivio & Patterson, 1999). The nature of this relationship is sometimes described and studied using the WAI, which is a part of research regarding treatment with adult clients who have been exposed to traumatic experiences as children. The WAI is considered an efficient tool in measuring a client's emotional bond and his or her level of agreement with the tasks and goals of therapy using a Likert-type scale; higher scores indicate more positive ratings (Gullo, Lo, & Gelso, 2012). Given past literature supporting the idea that those with childhood PTE histories experience interpersonal difficulties (e.g., family and social life; Zlotnick et al., 1996), researchers commonly hypothesize that these individuals likely struggle to form a strong/positive therapeutic relationship with their therapists (Keller et al., 2010). Because the WAI has been utilized with psychotherapy clients that have experienced childhood PTEs in only two studies located in the literature review for this study (i.e., Keller et al., 2010; Pavio & Patterson, 1999), more research appears needed in order to understand how these stressful experiences in childhood may impact clients' interpersonal relationships with their therapists in adulthood.

More specifically, considering the emerging research on therapeutic alliance with this study's population of interest, the need remained to further investigate the working alliance among adults that reported a history of childhood trauma (emotional, physical or sexual abuse) with an adult population that did not report a history of childhood trauma/abuse, regardless of the treatment modality, in order to possibly inform future therapeutic treatment. Accordingly, this study was the third of its kind that aimed to utilize the WAI with adults who reported childhood sexual and/or physical and emotional trauma, and second of its kind that aimed to compare a

general population sample to a group with self-reported history of PTEs.

Regarding this study's descriptive results, its findings are consistent with earlier studies that indicated child trauma survivors generally endorsed strong and high early alliances with their therapists in adulthood (Keller et al., 2010; Paivio & Bahr, 1998; Paivio & Patterson, 1999). Interestingly, all aforementioned previously conducted studies (including the present study) hypothesized that those who reported childhood abuse would be unable to form solid therapeutic relationships with their therapists. These hypotheses appear consistent with the early clinical belief that the development of a therapeutic alliance can be challenging with trauma survivors (Herman, 1992; Olio & Cornell, 1993). Given this history of disconfirmed hypotheses with our particular population, it is suggested that researchers consider revising this impression of individuals with PTE histories. Such an approach would be consistent with findings that WAI scores are typically high with general population samples (Gelso & Carter, 1994; Golden & Robbins, 1990). Alternatively, one might consider the fact that the WAI might not measure the therapeutic relationship in a way that captures difficulties in relating to others that those with PTE histories might experience. Additionally, given the ipsative nature of WAI scoring, and the related difficulties with comparing results of various study findings with each other due to scoring differences, this idea might be even more difficult to examine with this measure.

In regard to the main hypothesis of this study, that client-participants who did not report a history of childhood emotional, physical or sexual abuse/trauma would report higher and stronger early working alliance scores than client-participants who reported a history of childhood abuse/trauma, statistical analysis determined that early WAI-S scores were not significantly different between the two study groups ("childhood trauma only" and "non-childhood trauma"). Similarly, Pavio and Patterson (1999) did not find clinically significant

differences in WAI scores between the two groups in question (childhood trauma group compared to general population group). Again, alliance ratings were similarly high for both groups. Similarly, Keller et al. (2010) found that average WAI-S from the beginning of sessions two and four was 62-67, indicating strong working alliance ratings.

To potentially help resolve questions about WAI scoring methods used in studies similar to this dissertation, efforts were made to contact the authors of these studies (i.e., Howgego et al., 2005; Kanninen et al., 2000; Keller et al., 2010; Kivlighan & Shaughnessy, 2000; Knaevelsrud & Maercker, 2007; Pavio & Patterson, 1999; Wagner et al., 2012) that included use of the WAI, but failed to mention the WAI version (short form versus traditional form and the method of scoring). Since the current study did not receive responses from the aforementioned authors, the researchers were unfortunately unable to resolve the questions and compare WAI means with previous studies (e.g., comparison of high/low categorization). Even if information had been shared with this researcher, the ipsative nature of the WAI would make it difficult to make comparisons. As mentioned in the methods section, per this aforementioned interpretation of scores, the two groups included in the current study are considered to have highly rated/positive WAI-S scores, as their means are near the top of the WAI-S scale. The current study found that there was a significant difference between male and female early WAI scores, with males generally rating their early WAI 3.6 points higher than females (mean difference). Therefore, there was an increase in curiosity as to whether or not literature investigated gender differences with regard to the WAI. It appears that gender was found to be unrelated to WAI ratings in this previously reviewed study with a trauma population (Knaevelsrud & Maercker, 2007), and unmentioned in others (Keller et al., 2010; Kanninen et al., 2000; Paivio & Patterson, 1999; Wagner et al., 2012).

Contrary to this study's findings, Hersoug, Hoglend, Havik, Von Der Lippe, and Monson (2009) discovered that female clients (out of a general sample of 270 outpatient participants, with exclusion criteria of psychosis, history of psychiatric hospitalization, and major cognitive impairments) scored their early alliances as higher than males; however, later in treatment this difference in alliance scores diminished. It appears that the literature has not often explored the relationship between the establishment of the working alliance and gender across populations (Menaker, 2010).

Although the findings of this study are consistent with earlier studies utilizing the WAI, there may be circumstances within the study that led to these non-findings within the comparison of these two groups, such as construct measurement issues. Methodological issues are discussed next in the limitations section.

Limitations

In terms of this study, there were several methodological limitations. This subsection reviews limitations regarding study characteristics, measurement of the working alliance and trauma, and data analyses.

Characteristics of the study sample. This researcher initially considered that a limitation would be a small sample size, which may have affected the capacity to ascertain statistical significance. Upon additional research, however, it should be noted that this study's "childhood trauma only" group of 50 participants is considered larger than the 33 included in the study of Paivio and Patterson (1999). Further, this study's total sample of 100 participants is larger than the average study included in the meta-analysis by Hanson, Curry, and Bandalos (2002); studies' typical sample size was a mean of 56 clients (73% female, 27% male; 83% European American, 17% unknown ethnicity; unknown presenting problem[s]). This information

suggests that the present dissertation can potentially contribute to the current related literature. Additionally, this study did not utilize random sampling in participant selection. Given the possibility of selection bias by the researchers, the samples utilized may less accurately represent the investigated larger population of focus.

Certain characteristics have been connected theoretically to the working alliance, such as: client age, client and therapist ethnicity, client and therapist gender homogeneity, type of treatment, session of WAI administration, therapist educational level/years of clinical experience, referral source and type of client (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Martin et al., 2000). Although some of the aforementioned variables were included in the present study, some were not; both areas are considered here.

In terms of age, this study utilized a sample of participants who were aged 18 and older. Although study results indicated no significant differences in the relationship between age and client-rated WAI score, this adult study unfortunately cannot be generalized to adolescents and children. Furthermore, the total sample consisted of individuals with a mean education level of some college ($M = 15.22$) and who are voluntarily seeking treatment. Further, the majority of the sample included female participants (67%) as compared to males (33%). These statistics are similar to previous studies that utilized a study sample with majority women participants. Keller et al., (2010) included 188 study participants, 76.6% female and 23.4% male, and a total of 33 participants (26 female, 7 male) were included in Paivio and Patterson (1999)'s study. Given the significant difference in WAI scores rated by males versus females, and relatively small male sample sizes in the aforementioned studies (and current study), the ability to generalize results to the male population is limited.

This dissertation also included ethnicity in the descriptive statistics. Although this study found that ethnicity did not significantly influence WAI scores, it would have been interesting to compare means of WAI by ethnicity, as the working alliance between clients of color and their therapists may likely present unique considerations. Ethnic minority populations are known to underutilize therapeutic services and display high therapy dropout rates (Casas, Vasquez, & Ruiz de Esparza, 2002; Center for Mental Health Services, 1998; U.S. Department of Health and Human Services, 1998). Reasons for this finding include miscommunication and cultural misunderstandings between clients and their therapists within the therapeutic context (American Psychological Association [APA], 2003). Only one study was located in a review of the literature for this dissertation that included the investigation of the relationship between WAI scores and ethnicity. While studying a sample group of 107 male intimate partner violence perpetrators (50% Caucasian and 50% racial and ethnic minority [e.g., African American, Asian American, Hispanic, and American Indian]), Walling, Suvak, Howard, Taft, and Murphy (2012) found that Caucasian participants' client-rated WAI scores increased over time (linear progression), whereas a consistent pattern of change was not found for the racial and ethnic minority group (Walling et al., 2012). Given this information, it might be helpful to consider the role of therapist cultural competency and further explore not only differences between Caucasian clients and racial and ethnic minority clients, but also differences in WAI scores within the racial and ethnic minority subgroups and over time.

With regard to variables theoretically linked to WAI not explored in the present study, this study did not explore the type of client. More specifically, this study did not investigate the client's potential relational issues and possible correlation to the client-rated working alliance. Research showed that clients viewed by their therapists to have unsatisfactory social

relationships had a greater amount of difficulty in forming a working alliance with their

therapists (Kokotovik & Tracey, 1990). Given the fact that those who have an endorsed history

of childhood trauma report increased interpersonal problems (Davis et al., 2001), and difficulties

in the development of interpersonal skills (e.g., reactive aggression, bullying, limited social

competence (Cloitre, Miranda, Stovall-McClough, & Han, 2005), research in the area of

relational issues and possible correlation to the working alliance may be warranted.

Along with further exploration of the relationship between WAI and variables such as

ethnicity and type of client, there were other variables that the current study did not include in

analyses that could have relevance to the constructs investigated. For instance, this study did not

plan to control for the referral source (e.g., work mandated, family member, friend or self-

referred) of client-participants. Because this variable could have implications for client

motivation for change, this variable could contribute to differences in client-participants'

willingness to develop a therapeutic relationship. Research suggests that therapy clients that feel

responsible for their progress and work in therapy (e.g., self-referred) are more likely to facilitate

a strong working alliance with their therapists than those who feel less responsible (e.g., outside

referral; Tokar, Hardin, Adams & Brandel, 1996). Additionally, this study did not control for

therapeutic modality. Keller et al. (2010) found that following control for therapy treatment

modality (prolonged exposure or pharmacotherapy), early alliance was minimally associated

with number of sessions achieved in therapy ($r = .17$, $p = .05$).

Next, although some previous studies included the WAI during a particular empirically

supported therapy with a sample of therapists with more than one year of experience, the

proposed study's database included treatment as usual and did not have the means to identify use

of specific empirically supported treatments or the therapeutic orientation of the therapists-in-

training at a community clinic. Although the WAI was essentially designed to measure the therapeutic relationship without a bias toward any individual theoretical orientation (Horvath & Greenberg, 1986; Horvath & Greenberg, 1989), utilizing similar methods to previous studies could offer more insight into this instrument's utility with a specific therapeutic modality or treatment.

WAI and trauma measurement. The next set of limitations concerns measurement of the working alliance. First, due to the fact that only the total score of the WAI was utilized for the purpose of the current study, some curiosity exists as to whether or not the inclusion of subscale scores could have been helpful in understanding the relationship between WAI and the study samples of investigation ("childhood trauma only" and "non-childhood trauma"). With reference to the research of Paivio and Patterson (1999), the total scores and all three subscales were studied independently of one another at sessions 3,4,10 and therapy termination. Results indicated that the bond scale steadily increased throughout the course of psychotherapy. Further, Knaevelsrud and Maercker (2007) found that the bond subscale of the WAI was particularly high, even early in treatment (session 4) for adult participants with PTSD. Thus, there was some question as to whether or not study of the bond scale independently of the total score would significantly change interpretation of results or generate thought provoking findings. However, as previously mentioned in the method section, exploratory and confirmatory factor analysis indicated that the total score (composite) is considered the most important and meaningful measurement of the working alliance, versus measurement of the three independent subscales (Cook & Doyle, 2002; Hatcher & Barends, 1996; Tracey & Kokotovik, 1989). Thus, this study did not include an independent analysis of the bond scale for the two sample groups in question.

Next, using self-report alliance measures, like the WAI, may generate other potential limitations. One is that accuracy cannot be verified through other sources of information about client-participants' beliefs about their therapists (e.g., reports from family members or other treatment providers; interviews) because other ways to measure these constructs were not available in the database. Further, use of specific self-report measures (the WAI in this case) may also restrict the nature of information collected from participants, conceivably disregarding other aspects of the participants' experience they may have wanted to disclose about the therapeutic relationship. Other measures as mentioned in the introduction (e.g., the Helping Alliance questionnaire developed by Luborsky (1985), the California Psychotherapy Alliance Scale (Gaston & Marmar, 1993) or the Kim Alliance Scale [Kim et al., 2001]), or methods, such as qualitative analysis of participant interviews, could be used to operationalize the individual experience of the therapeutic alliance for the client. Langhoff, Baer, Zubraegel, and Linden (2008) provided a helpful conceptualization of the therapeutic alliance, in which they suggested that different constructs that measure the therapeutic alliance likely provide different perspectives, as they are not identical to one another. Similarly, a review by Elvins and Green (2008) makes clear the diversity of concepts and measures available to address treatment alliance; and, their research suggests that there is no one current measure of alliance that meets all the predefined criteria in either adult or child populations. Accordingly, Langhoff et al. (2008) posited that each construct might relate to the outcome and progress during therapy very differently, which helps to encourage researchers to pursue the use of more than one measurement of therapeutic alliance, and to refrain from utilizing solely their own perspectives of the therapeutic alliance quality).

Similarly, another limitation concerns how the specific types of potentially traumatic events were identified in this study. While the preponderance of trauma literature used a diagnostic construct to define PTEs, trauma and negative outcomes, this study utilized participant self-report to identify certain potentially traumatic events. This approach to participant selection impacted the ability to directly compare this sample with those used in other studies that utilized PTSD diagnostic criteria or clinical levels of impairment and distress or empirically supported diagnostic measures (e.g., SCID-I (Structured Clinical Interview for DSM Disorders; First, Spitzer, Gibbon, Williams, 2002); CAPS [Clinician Administered PTSD Scale for DSM-5; Weathers et al., 2013]). Of further note, the proposed study examined the relationship between different traumatic experiences and early working alliances; however, this study did not explore the impact that different diagnoses may or may not have on the development of the working alliance.

Analysis limitations. The final set of limitations involves analyses made and considered in this dissertation. Results of this study (and with reference to the histograms provided in figures 1 and 2) indicated that early WAI scores tended to clump toward the positive direction and hover around the highest score possible, 84. Subsequently this data was not considered normally distributed, and a bit of a ceiling effect was shown, especially for the "non-childhood trauma" group. It is possible that participants may have endorsed a stronger therapeutic alliance than actually experienced to appear like a "good client" or due to fear that providing a negative evaluation of the alliance will cause an adverse reaction from the therapist. Also, given that clients' impression of their therapists' expertise has been was positively correlated with clients' satisfaction in therapy (Heppner & Heesacker, 1983), it could be that client-participants in this study may have viewed their graduate student therapists as competent, and consequently, rated

their working alliances as strong.

Moreover, a one-time point analysis, as utilized in this study, does not allow for predictive analyses. Without analysis across multiple time points, it is not possible to analyze progress, change, or lack thereof. Paivio and Patterson (1999) investigated study differences in WAI at different time points for a childhood trauma group (e.g., Sessions three and therapy termination [average of 12 sessions of experiential psychotherapy; session termination range: 8-16]). Results of this study showed a positive linear growth pattern, from high to higher scores, from session three ($M = 5.68$, $SD = 0.68$) to the termination session ($M = 6.24$, $SD = 0.46$).

Subsequently, there is a possibility that individuals who interpreted their working alliances as weak may consequently not have completed the measures in this study and/or be the same individuals who dropped out early in the course of therapy. Thus, data from those who did not complete measures due to these or any other reason (e.g., fatigue; therapist error) was not available to be analyzed in this study. Also, early termination was not analyzed.

Regarding data analysis, an ANCOVA utilizes linear regression to calculate effect size using covariate information. Limitations of an ANCOVA include the use of a large number of covariates. Fortunately, this study attempted to decrease the level of error by identifying covariates that were independent of the study variables. As the number of covariates increases, the degree of statistical error also increases. Given this information, the current study limited the number of covariates to two (gender and age). However, only gender was shown to have a significant influence on WAI scores. Age was not determined to impact WAI scores; thus, this study did not particularly benefit from controlling for it (but kept it in to be consistent with preliminary oral plans).

Additionally, given the state of the literature at this point (e.g., only [Pavio and Patterson, 1999] researched severity of trauma and the relationship to the WAI), the current study did not investigate single versus multiple traumatic events and their relationship to the WAI (although attempts were made to capture this information for the current study after the preliminary orals). There are benefits to exploring whether participants reported multiple experiences of childhood trauma, as this data would be helpful in ascertaining if there was a significant difference in WAI scores between those who reported multiple histories of trauma in childhood versus those who reported a single incident in childhood. Of note, as stated in the introduction, Pavio and Patterson (1999) found that early alliance struggles at session four (lower initial ratings of the WAI) were correlated with the exposure of higher numbers of severe traumatic events as a child, such as physical or emotional trauma, or neglect, measured on the CTQ and PSSI. Thus, the more severe abuse that clients experienced as a child, the lower the participants rated their initial working alliance with their therapist (Pavio & Patterson, 1999). Accordingly, this dissertation study attempted to ascertain whether the participants in the "childhood trauma only" group also experienced PTEs in adulthood. Because the database utilized did not provide clear information on these details, it was not possible to determine whether the group of participants with reported traumatic experiences in childhood interpreted their working alliance to be different or similar to the group of participants with reported traumatic experiences in childhood and adulthood.

Future Research

Characteristics of study samples. In the future, it is recommended that researchers utilize larger randomized sample sizes when exploring the WAI with participants who endorsed a history of childhood trauma as compared to participants who have not endorsed such a history, even though typical WAI studies use an average of 56 clients (Hanson, Curry, & Bandalos,

2002). Potential moderators that could be examined in (or controlled for) a future study with larger samples include client ethnicity, academic achievement level, socioeconomic status, and presenting problem of the client (Hanson et al., 2002).

With respect to culture and ethnicity, it might be helpful to note that future studies may want to study its relationship with the working alliance to aid in assisting therapists to facilitate much stronger alliances with clients of color. From a multicultural perspective of treatment, Comas-Días (2006) suggested that therapists focus on understanding the client's cultural voice, the establishment of trust and credibility, and particular demonstration of cultural empathy in the therapeutic space. Further, it is suggested that future researchers study the client's social interaction style and the relationship with the WAI, given research that stated that those who have an endorsed history of childhood trauma report increased interpersonal problems (Davis et al., & Ting, 2001. Literature that examined the relationship between client interpersonal problems and strength of alliance scores highlighted (with consistency) that an "overly friendly" style of relating correlated to a higher quality of alliance (Beretta et al., 2005; Crawford, Muran, Samstag & Segal, 1994; Nevo, 2002; Bauer, Horowitz, Kordy, & Puschner, 2005). Additionally, a hostile and/or dominant style of relating correlated with low alliance quality (Paivio & Bahr, 1998; Puschner et al., 2005; Saunders, 2001). Overall, it is quite possible that with more information in this area, therapists could consider more thoughtfully how to adapt their own interpersonal style of relating in order to facilitate a stronger working alliance early in treatment with clients who are experiencing interpersonal distress.

Additionally, as mentioned, this study did not control for referral source. Given findings indicating that self-referred therapy clients are more likely to facilitate a strong working alliance with their therapists than those individuals who are not self-referred (Tokar et al., 1996), more

studies that compare WAI scores between a group of self-referred clients with a group of clients referred by a family, friend or court are needed to confirm this finding. Furthermore, due to the significant difference in WAI scores between male and female client-participants in the present study, increasing the number of male participants in future studies may assist in supporting or disconfirming the current findings.

Data analysis suggestions. As mentioned above in the limitations subsection, the present study attempted to capture frequency of traumatic events in childhood and adulthood; however, this researcher was unsuccessful in this endeavor. Future research, therefore, could compare three groups: one group that endorsed one childhood traumatic experience, another group that endorsed multiple PTEs in childhood, and a comparison general population group. Researchers could pursue the use of an ANOVA in order to compare the three group means, and to evaluate if group means are significantly different from one another.

In terms of other analyses that might be helpful in ascertaining the relationship between history of childhood trauma and the working alliance as compared to a study group that did not report such a history, the research is mixed as to whether to investigate the WAI at one time point versus multiple time points across the therapeutic process. As mentioned in the introduction, results of Paivio and Patterson (1999)'s study showed that the child trauma survivors generally endorsed strong early alliances with their therapists on the WAI at session three and a steady increase in alliance strength throughout the course of therapy, specifically in the bond dimension (linear pattern). Although not clear in the article, the authors alluded to conducting multiple one-tailed tests of significance in their correlational analyses to measure the means of WAI scores at sessions three, four, ten, and termination. The findings of Paivio and Patterson (1999) shared some similarities with a general population study that described and

identified a linear growth pattern (gradually increasing WAI strength over time [Kivlighan &

Shaughnessy, 2000]). In reference to studies that included participants that experienced PTEs

(not specifically in childhood), two found that those with PTSD symptoms rated their therapeutic

relationship as high initially with stable progression (Wagner et al., 2012; Kanninen et al., 2000).

One study found that those with reported PTSD symptoms rated their alliance with their

therapists as high at session four, and that the WAI improved over the course of treatment (linear

growth; Knaevelsrud & Maercker, 2007). This aforementioned brief review of studies that

measured working alliance suggest that it might be helpful for researchers to investigate the WAI

at more than one time point. Therefore, time series analyses may be considered in order to study

client-rated working alliance scores at more than one time point. Another way to accomplish this

would be to pursue the use of multiple ANOVAs in order to compare group means at different

time points throughout the therapeutic process.

Further, given that the current study did not analyze client-rated WAI scores, along with

consideration for other instruments of analysis, it is suggested that a multivariate analysis of

covariance is utilized in the future. A MANCOVA allows researchers to capture the difference in

means with several dependent variables, while controlling for any covariates the researchers see

fit. For example, Kivlighan and Shaughnessy (2000), referenced in the literature review

(Appendix A), used a three series MANCOVA in order to study if a curvilinear pattern of

alliance development would be positively associated with therapy outcome. The average working

alliance scores were identified as the covariate, and the Battery of Interpersonal Capabilities

(Paulhus & Martin, 1987) and the Inventory of interpersonal Problems (Horowitz, Rosenberg,

Baer, Urefio, & Villasefior, 1988) were identified as the dependent variables, so that researchers

could understand the relationship between patterns of working alliance development.

Along with the literature suggesting the need for exploring the WAI over time, this study also found what may be considered contradictory literature to suggest that one time point analyses may better account for the studying the working alliance. To this point, Martin et al. (2000) meta-analytic review found that therapist and observer evaluations of the working alliance are predicted to change over time, but client rated alliance scores tend to remain steady over time. Additionally, much earlier in the research, Horvath and Symonds (1991) calculated the average of alliance scores over the course of therapy and found that early alliance scores were interpreted as stable over the course of psychotherapy.

Overall, not only is the research mixed on whether to conduct a one time point analysis versus multiple, curiosity also continues with the identified population of interest (history of reported childhood trauma). Therefore, researchers are encouraged to pursue a multiple time point analysis. That way, if researchers find WAI scores tend to be steady over time, as some literature argues, one time point analyses can be used in the future. On the contrary, if curvilinear or linear progressions are found in the results, researchers will then elicit more confidence in studying the working alliance process over the course of therapy.

In addition to the discrepancy between a one time point analysis versus multiple, the question remains as to what session is most indicative and accurate in the identification of early working alliance from the client perspective. Literature suggests that therapeutic outcomes can be readily determined based on early alliance scores (Salvio, Beutler, Wood, & Engle, 1992). More specifically, Horvath and Bedi (2002) found that third session alliance ratings appear to be consistent in their prediction of psychotherapy outcome. With their review of the research in this area, Cook and Doyle (2002) suggested that the majority of the alliance research utilized the third session of therapy to administer alliance measurements. To further investigate this concept,

it is suggested that researchers study the validation of the third session alliance findings or explore evidence that may propose a different early session as the most related to therapy outcome (e.g., session one, two, four, or five).

      Measurement of the therapeutic alliance. The current study utilized a self-report measure in order to identify participants that endorsed a childhood history of PTEs. To obtain more accurate results in regard to trauma history, one might consider a more detailed structured interview, such as the Childhood Trauma Interview (Fink, Bernstein, Hanelsman, Foote, & Lovejoy, 1995). Also, in order to address the limitation of only utilizing one self-report measure in order to study the working alliance, future research could consider including multiple measures of working alliance/therapeutic alliance, such as the inclusion of the Vanderbilt Therapeutic Alliance Scales, which utilize observer data only (VTAS; Hartley & Strupp, 1983), and the California Psychotherapy Alliance Scales, which include patient and therapist versions of therapeutic alliance measurement (CALPAS; Marmar, Weiss & Gaston, 1989) in addition to the WAI. The WAI and the VTAS have received the most detailed and comprehensive construct validation (Elvins & Green, 2008). Overall, studies that have included the use of the VTAS, CALPAS, and WAI, exhibited a strong relationship between alliance and outcome in various client sample groups and across diverse array of therapeutic treatments (Horvath, 1994; Raue, Castonguay, & Goldfried, 1993; Zuroff & Blatt, 2006). Of note, the meta-analysis of working alliance measures by Elvins and Green (2008) did not find evidence that using multiple measures of therapeutic alliance was more beneficial than one. Finally, if researchers would like to refrain from using self-report measures, methods such as qualitative analysis of interviews (e.g., client, therapist, observer, and/or family and friends) could be helpful in order to understand the experience of the therapeutic alliance from one or multiple perspectives. Another option would

be to consider mixed methods, in order to include both questionnaires, integrated with a qualitative approach.

Finally, to obtain a wider outlook on how therapeutic alliance is operationalized, researchers are encouraged to seek more than one perspective of the working alliance. Because this study did not address therapists' interpretation of the working alliance through the therapist-rated WAI version, future researchers are encouraged to include therapist-rated WAI scores. Some studies convey the idea that therapists generally rate their working alliance as significantly lower than their clients' ratings (Mallinckrodt & Nelson, 1991; Wei & Heppner, 2005). On the contrary, Knaevelsrud and Maercker (2007) found that adult participants with PTSD ($M = 6.3$) and their therapists ($M = 5.8$) generally rated their WAI as high at the end of therapy (Session 10). Although the literature suggests that the strongest indicator of therapy outcome is correlated with the client rated WAI (Horvath & Symonds, 1991; Safran & Wallner, 1991; Tichenor & Hill, 1989), more research that includes both client and therapist rated WAIs could be helpful in determining whether or not therapists' rating of the therapeutic relationship is comparable to client-rated alliance scores with clients that have experienced PTEs.

Further, researchers could also consider orientation of therapy/therapeutic modality utilized by the therapists and its relationship to the strength of the WAI. However, it is uncertain whether or not this is needed, based on the fact that the WAI was created to avoid theoretical bias and to encourage application across different theoretical orientations (Horvath & Greenberg, 1986; 1989).

Relatedly, with regard to gender and culture, one might explore the relationship between therapists' self-acceptance (gender specific), flexibility, presence and working alliance. These suggestions are based on the few studies located that examined the relationship between gender

or gender-related variables and working alliance. In a study with licensed Professional Clinical Counselors from a Midwestern state (120 women and 41 men; age range 27-73; number of years as licensed practitioners 2-35), Anderson and Levitt (2015) found that therapist gender self-acceptance was positively correlated with therapist working alliance ratings. In regard to investigation of the client-therapist relationship from the client perspective, Kivlighan, Clements, Blake, Arnzen and Brady (1993) found a significant relationship between working alliance as rated by the client and counselor flexibility, but not counselor androgyny. The researchers defined counselor flexibility as the therapists' flexibility in use of intentions (measured in standard deviation; Kivlighan et al., 1993) and androgynous counselor concept as when the therapist has the ability to be both masculine and feminine, convey emotionality, and a style that combines an open-ended approach with directiveness (based on Petry & Thomas, 1986). Overall, although research has been conducted on therapist variables impacting WAI scores and clinical outcomes, future paired data research is needed in order to study both client and therapists' influence on client-rated and therapist-rated WAI in study samples with clients that endorsed history of childhood trauma, as compared to a sample that did not endorse such a history.

Conclusion

With the relatively high prevalence rates of trauma presented within therapeutic environments, psychologists and other mental health service professionals will benefit from research that provides information on how to effectively treat survivors of trauma in a clinical setting. This study focused on the relationship between psychotherapy client self-reported trauma experiences and the development of therapeutic relationships.

To highlight its potential contributions to the literature, this study represents the second investigation of the relationship between WAI scores of psychotherapy client-participants who

endorsed PTEs in childhood and WAI scores as rated by client-participants with an absence of self-reported PTEs across a lifetime. Although this study's primary hypothesis was not supported, results were similar to the limited previous studies with this population, in that both client groups endorsed a strong early working alliance with their therapists. Based on the findings of this study, clinicians may be more cognizant of the importance of a routine assessment of the working alliance in the beginning of therapy and throughout the therapeutic process in order to examine any beliefs held about the ability of certain clients to develop strong working alliances, as well as to identify weaker alliances. Again, these results extend emerging research showing that individuals with childhood trauma histories are in fact capable of forming strong initial therapeutic alliances.

Given that such findings contradict clinical impressions expecting difficulties forming working alliances with clients who have experienced childhood trauma, future research is needed to address the potential influence of culture, motivation for treatment, therapist clinical experience, and frequency of PTEs have on early WAI scores. In summary, current literature in this field of study (including the current study) is still mixed, four studies showing high initial WAI scores, and two that did not show high initial WAI scores. When weaker alliances are found, clinicians are encouraged to address them promptly in order to support potential progress and therapeutic growth. Additional research may inform clinicians' beliefs and approaches with adult clients who have experienced childhood trauma as well as suggest the need to refine measurement of a meaningful therapeutic construct, which has been shown to impact treatment outcome.

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Table 1.

Participant Demographics

Variable		Childhood Trauma Only	Non-Childhood Trauma	Total Sample
		n = 50	*n* = 50	*n* = 100
Average Age	(± SD)	35.62 (± 12.93)	33.16 (± 10.71)	34.39 (± 11.88)
Gender	(%)			
	Female	33 (66%)	34 (68%)	67 (67%)
	Male	17 (34.0%)	16 (32%)	33 (33%)
Education	(± SD)	15.16 (± 2.56)	15.28 (± 2.20)	15.22 (± 2.37)
Ethnicity	(%)			
	Middle Eastern	3 (6%)	2 (4%)	5 (5%)
	Asian	3 (6%)	1 (2%)	4 (4%)
	African American	6 (12%)	1 (2%)	7 (7%)
	Caucasian	23 (46%)	30 (60%)	53 (53%)
	Latino/Latina	7 (14%)	8 (16%)	15 (15%)
	Other	8 (16%)	7 (14.0%)	15 (15%)
	Pacific Islander	0	1 (2%)	1 (1%)

Table 2.

WAI Descriptive Statistics

WAI Score			Childhood Trauma Only	Non-Childhood Trauma
			n = 50	n = 50
Mean	(± Std. Error)		78.24 (± 1.164)	78.46 (± 1.427)
95% Confidence	Interval for	Mean		
Lower Bound			75.9	75.59
Upper Bound			80.58	81.33
5% Trimmed Mean			79.01	80.07
Median			84	84
Variance			67.737	101.845
Std. Deviation			8.23	10.092
Minimum			57	40
Maximum			84	84
Range			27	44
Interquartile Range			14	9
Skewness	(± Std. Error)		−1.154 (± 0.337)	−2.505 (± 0.337)
Kurtosis	(± Std. Error)		−.029 (± .662)	6.531(± .662)

Table 3.

Independent Samples Mann-Whitney U Test

Variable		Total Sample
		$n = 100$
Mann-Whitney U		1215.5
Wilcoxon W		2490.5
Test Statistic		1215.5
Standard Error		133.794
Standardized Test	Statistic	-0.258
Asymptotic Sig.	(2-sided test)	0.797

Table 4.

ANCOVA, Tests of Between-Subjects Effects

Dependent Variable: WAI Score

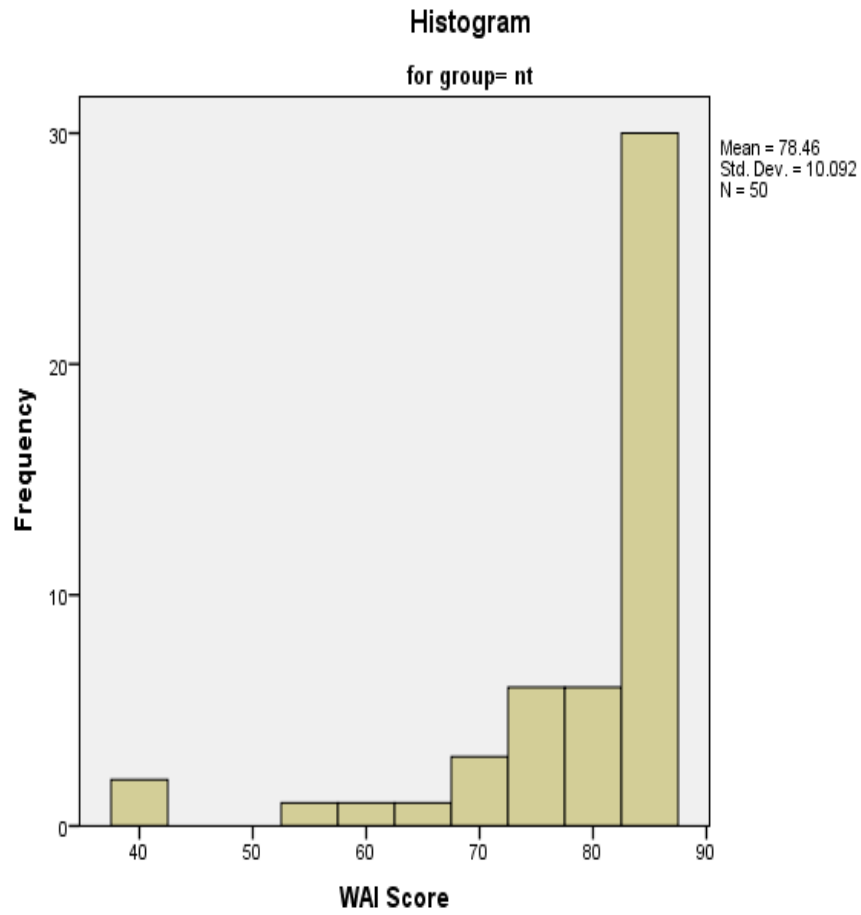| Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	302.159[a]	3	100.720	1.207	.311	.036
Intercept	29064.431	1	29064.431	348.399	.000	.784
Age	14.533	1	14.533	.174	.677	.002
Gender	298.360	1	298.360	3.576	.062	.036
Group	1.129	1	1.129	.014	.908	.000
Error	8008.591	96	83.423			
Total	622183.000	100				
Corrected Total	8310.750	99				

Figure 1. WAI scores, non-childhood trauma
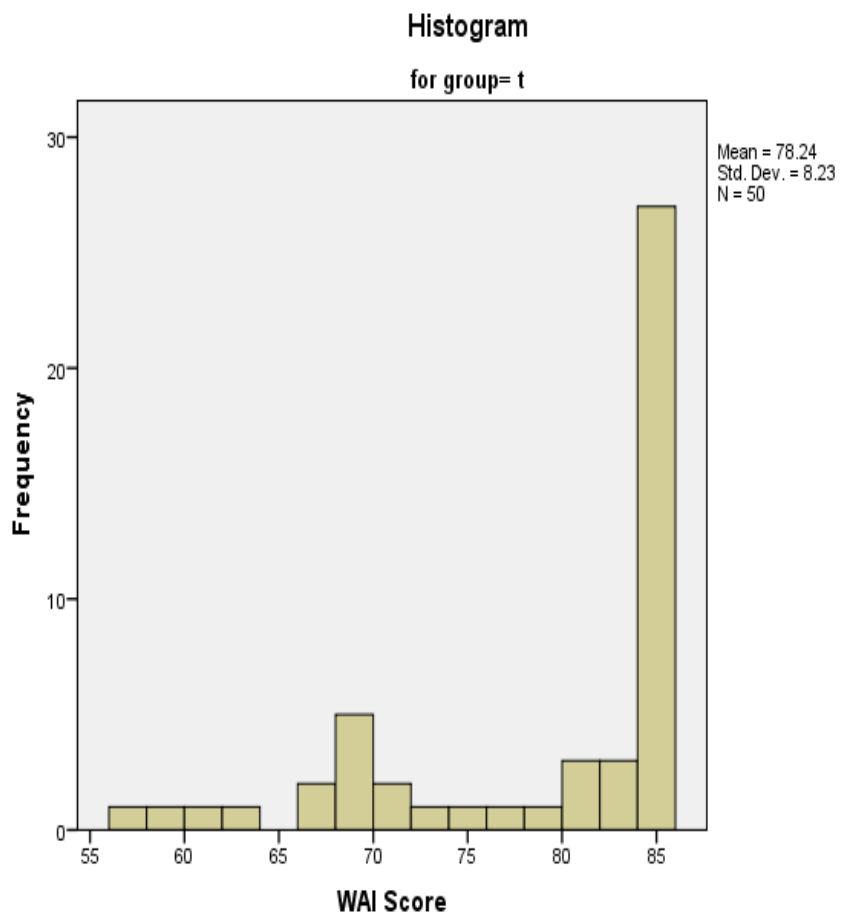
Figure 2. WAI scores, childhood trauma only
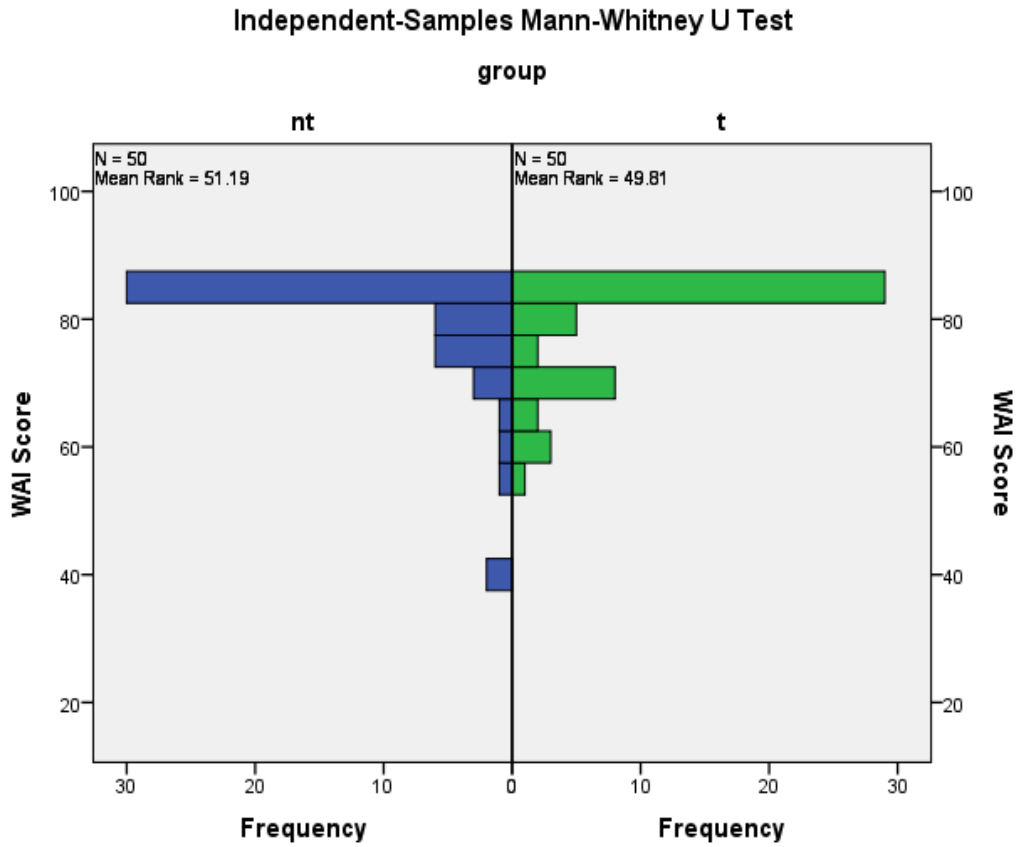
Figure 3. Independent samples Mann-Whitney U test

APPENDIX A

Background Literature and Current Status of Theory and Research

This dissertation intended to further examine how self-reported traumatic experiences may be related to individuals' relationships with their therapists. To provide context for these goals, this background section summarizes the current understanding of trauma definitions and sequelae, as well as the research on social support, the therapeutic relationship, and the working alliance. It is followed by a critique of the current status of the research specifically related to perceived social support, the therapeutic relationship, and the working alliance. This extended review of the literature, revised since the preliminary orals, served as the basis for the final dissertation's brief literature review.

Trauma

The DSM-5 (American Psychiatric Association, 2013) currently defines a traumatic event as one in which "the person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence" (p. 271). Given that people adapt to traumatic events in a variety of ways, the phrase potentially traumatic event or PTE (Bonanno, 2008; Norris, 1992) will be used instead of traumatic event in this dissertation to underscore the fact that most people exposed to PTEs evidence resiliency (Bonanno, 2005; 2008; Bonanno & Mancini, 2008; 2012).

As noted previously, examples of potentially traumatic events that fit the DSM-5 definition include: threatened or actual assault, threatened or actual sexual violence, natural or man-made disasters, and severe motor vehicle accidents (American Psychiatric Association, 2013). Medical incidents that qualify as a traumatic event must be sudden and catastrophic (e.g.,

waking during surgery, anaphylactic shock). The exposure to such an event may not only be directly experienced as happening to oneself, but can also be witnessed happening to another person directly or indirectly. Witnessed events include observing threatened or serious injury, unnatural death, physical or sexual abuse of another, or a medical catastrophe in one's child. Indirect exposure through learning about an event is limited to experiences "affecting close relatives or friends and experiences that are violent or accidental (e.g., death due to natural causes does not qualify)" (American Psychiatric Association, 2013, p. 271). According to Kilpatrick et al. (2013), death of family or close friend due to violence/accident/disaster is one of the most common types of potentially traumatic events (51.8%). Indirect witnessing may also occur for those who are "experiencing repeated or extreme exposure to aversive details of the traumatic event," such as "first responders collecting human remains; police officers repeatedly exposed to details of child abuse" (American Psychiatric Association, 2013, p. 271).

According to Bonanno and Mancini (2012), most people experience at least one and usually several potentially traumatic events during their lives (Breslau, Davis, Peterson, & Schultz, 2000; Copeland, Keeler, Angold, & Costello, 2007; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Norris, 1992). Of the various types of potentially traumatic events (PTEs), this dissertation will focus on sexual, physical and emotional abuse reported by adults that they themselves experienced during childhood or in adulthood. For this reason, this section begins with a description of these types of PTEs and their prevalence rates, followed by a description of their effects.

Sexual assault trauma prevalence and definitions. Random samples of the general population have shown that at least 5% of adults report being sexually assaulted in childhood (Burnam et al., 1988). A more recent study revealed that in the United States, 16% of men and

25% to 27% of women have a history of childhood sexual abuse survival (Pérez-Fuentes et al., 2013). In adult clinical populations, clients who were sexually abused as children are prevalent, representing 25-44% of outpatients and 43-50% of inpatients (Courtois, 1988). Clinician-administered instruments such as the Childhood Maltreatment Interview Schedule (Briere, 1992) and the Sexual Assault and Additional Interpersonal Violence Schedule (Resick & Schnicke, 1992) define childhood sexual abuse as at least one episode of sexual contact (attempted or completed vaginal, oral or anal intercourse, fondling) by a caretaker before the age of 18 (Cloitre et al., 2005).

Recent estimates on the prevalence of adult sexual trauma collected from national data in the United States indicated that 1.7% of adults reported experiencing unwanted sexual activity within the past 12 months (Basile, Chen, Black, & Saltzman, 2007). Researchers exploring adult sexual assault use definitions that reflect different points on a continuum of coercion, ranging from verbal persuasion to violent physical force (Peterson et al., 2011). For example, some researchers define adult sexual assault in a more narrow fashion, including only physical force in their definition of the sexual assault (Cunradi, Ames, & Moore, 2005; Rouse, 1988; Tjaden & Thoennes, 2000). On the other hand, some researchers defined sexual assault more broadly focusing more on sexual acts obtained through force, intoxication, threats, verbal pressure or verbal manipulation (Baynard et al., 2007; Kerbs & Jolly, 2007; Krahé, Scheinberger-Olwig, & Schütze, 2001; Waldner-Haugrud & Gratch, 1997). Following the very broad definition used in the Sexual Experiences Survey ([SES], Koss & Oros, 1982), Fisher (1992) assessed for sexual assault by asking "…did anyone initiate or do anything sexual with you without your wanting to or without your consent" (p.219). Concerning the specific sexual acts that are involved in the definition of an adult sexual assault, research definitions vary widely (Phillips et al., 2011). Some

researchers inquire only about nonconsensual intercourse (Baier et al., 1991; Ratner et al., 2003, Tjaden & Thoennes, 2000); whereas some researches considered sexual assault to include any unwilling sexual contact. These acts range from kissing and petting to intercourse, which would all qualify as sexual assault (Banyard et al., 2007; Conway, Mendelson, Giannopoulos, Csank, & Holm, 2004; Fiebert & Osburn, 2001). It is important to note, however, that some research suggests unwanted sex is not always forced or coerced (Peterson et al., 2011).

There are situations where an individual may consent to engage in sexual behavior that is not entirely wanted (Petterson & Muehlenhard, 2007). Muehlenhard and Cook (1988) found that individuals in their sample had engaged in unwanted sex that did not qualify as coercive (e.g., individuals agreed to engage in unwanted sex because they were sexually attracted to the other person or because of peer pressure). Consequently, these authors believed that not all unwanted sexual interactions should be considered a potentially traumatic event. Therefore, asking the question "did anyone initiate or do anything sexual with you without your wanting to or without your consent" within the definition of adult sexual assault may increase inclusive accuracy (Fisher, 1992, p. 219).

Physical trauma prevalence and definitions. Finkelhor, Turner, Shattuck & Hamby (2013) attempted to provide updated estimates of childhood exposure to a broad range of trauma in a national sample. They found that 54.5% of adults in their sample reported experiencing some form of physical assault in childhood. The World Health Organization (1999) defined childhood physical abuse as: "[T]hat which results in actual or potential physical harm from an interaction or lack of an interaction, which is reasonably within the control of a parent or person of responsibility, power and trust" (p. 15).

Physical abuse can involve hitting, slapping, pushing, kicking, burning, or giving medication inappropriately (Fuentes et al., 2013). Possible signs of physical abuse are fractures, bruising, burns, pain, marks, or signs that the trauma victim prefers not to be touched (Fuentes et al., 2013). Freud defined physical abuse, in general, as an event that "penetrates a kind of mental skin designed to protect a person from excessive external forces" (Brewin, 2003, p. 4). Physical abuse is said to impact the survivor externally, and also leave the physical abuse survivor with the inability to compensate, counterbalance or deflect the injury (Brewin, 2003).

Domestic violence and elder abuse are types of adult physical abuse. Domestic violence has been defined as escalating, repetitive, violent acts towards an intimate partner, used as a way to attain dominance and/or power. (Cherlin, Hurt, Burton, & Purvin, 2004). It is estimated that 25-50% of women experience physical abuse by their husbands (Straus & Gelles, 1990; Stark & Flitcraft, 1998), and thousands of studies report that women are the preponderant target of violence by men (Kimmell, 2002). In contrast, Kimmell (2002) describes how gender symmetry research in the US also indicates that in heterosexual partnerships women partners can be the perpetrators of physical abuse, and engage in physical aggression at roughly similar rates as men. For example, via a meta-analytic review, Archer (2000) found that men were somewhat more likely (d= -0.05) to be victimized by their female partners by means of physical aggression, and women acted with physical aggression more frequently than their male partners [as measured by the physical aggression scale of the Conflict Tactics Scales (Straus, 1979)]. Yet, Johnson (2006) argues that the contribution (violence, control, or both) of each male and female partner to the relationship is only one factor to consider among others that are salient to understanding violence in heterosexual relationships (e.g., reporting source, level of violence, control dimension, defensive action), and therefore, created a set of categories (i.e., intimate terrorism, violent

resistance, situational couple violence) to acknowledge the full range and impact of violence on not only female partners, but male partners as well. In addition, intimate violence exists in same-sex and bisexual couples (Messinger, 2011). For example, Bryant and Demian's (1994) study of 560 gay couples and 706 lesbian couples found that 11% of gay couples and seven percent of lesbian couples reported physical abuse within their relationships. Additionally, in comparison to heterosexual individuals ($M = 0.15$), intimate partner violence victimization (utilizing the National Violence Against Women Survey on 7,257 females and 6,925 males) statistical means were higher among gay, lesbian and bisexual individuals ($M = 0.31$; Messinger, 2011).

The World Health Organization/International Network for the Prevention of Elder Abuse (WHO/INPEA; 2002) considers elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (p. 3). Overall, based on data from Cooper, Selwood and Livingston (2008), 4.3% of the elder population experiences physical abuse annually. Friedman, Resick, Bryant, & Brewin (2011) studied 41 cases of elder abuse (41% Male, 24% Female), and found that 85% of the perpetrators of physical abuse were family members or intimate partners, and the specific types of assault were use of cutting or piercing instruments (24.4%), unarmed brawl (24.4%), pushed or thrown (12.2%), rape (4.9%), hot water (2.4%) or strangulation (2.4%).

Emotional trauma prevalence and definitions. Research is not nearly as comprehensive on emotional childhood trauma as compared to sexual and physical trauma. Stoltenborgh, Bakermans-Kranenburg, Alink, and van Ijzendoorn (2012) conducted a meta-analysis that included the prevalence of psychological abuse reported in 29 studies worldwide (Countries: Africa, Asia, Australia, New Zealand, Europe, North America, South America;

Ethnicity: African American, Asian, Caucasian and Hispanic). They found that 363 out of a sample of 1,000 adult informants using self-report measures indicated that they experienced emotional trauma in childhood. This study utilized the definition created by the World Health Organization ([WHO], 1999), stating emotional abuse is a caregiver's failure to sustain a developmentally suitable, nurturing environment for the child.

In the past, researchers struggled to explicitly define emotional abuse (Shaver, Goodman, Rosenberg, & Orcutt, 1991). However, consistent with the above mentioned WHO definition, childhood emotional trauma is currently defined by a continued repetition of maladaptive interactions between the child and caregiver (Glaser, 2002). Thirty-six to fifty-two percent of reported child maltreatment cases have been identified as emotional abuse and emotional neglect (Chamberland, Fallon, Black, & Trocmé, 2011; Sedlak et al., 2010; Tonmyr, Darca, Crain, & MacMillan, 2011). Different than physical and sexual abuse, emotional abuse describes a relationship versus an event (Glaser & Prior, 1997). The relationships are characterized as harmful or potentially harmful for the child, and include undesirable interactions or forms of psychological ill treatment (Glaser & Prior, 1997). Child psychological maltreatment includes but is not limited to: isolating, denying emotional responsiveness, and medical, mental health and educational neglect (Goldman, Salus, Wolcott, & Kennedy, 2003).

Much different than childhood emotional trauma, a singular definition of adult emotional abuse is difficult to find, perhaps because it is defined differently, depending on its occurrence in different contexts (e.g., intimate relationships, workplace environment). In general, adult psychological trauma can be considered an event that inundates the survivor's capacity to guard his or her psychological well-being and righteousness (Cloitre, Miranda, Stovall-McClough, & Han, 2005). Compared to physical and sexual abuse, some studies with adults denote

psychological pain as having a strong association with emotional trauma (Meerwijk & Weiss, 2011). Psychological pain is defined by a long-standing unpleasant feeling that develops from a negative appraisal (Meerwijk & Weiss, 2011). In domestic abuse, one intimate partner attempts to dominate and have emotional mastery over the other partner (Smith & Segal, 2015). Domestic abuse can include, for example, name-calling, blaming, isolation from friends or family or manipulation (Deaton & Hertica, 2013). Employee emotional abuse is defined by "repetitive, targeted, and destructive" communication by more powerful members toward less powerful members in the workplace (Lutgen-Sandvik, 2003, p. 472). Seemingly 90% of the American adult population experience workplace harassment at any given time during the span of their careers (Hornstein, 1996).

Effects of adult and childhood trauma. Trauma has proven to be a robust area of research among professionals in the field, including charting its effects and trajectories in childhood and in adulthood. When people are confronted with actual or threatened death, serious injury, or a threat to a person's physical integrity, such traumatic exposure can have a wide range of effects.

Traditionally, a diagnostic approach has been used in the child and adult trauma literatures that focusing on negative symptoms, and characterizes PTE effects as either leading to chronic psychopathology (e.g., PTSD) or the absence of psychopathology, which sometimes is referred to as resilience (Bonanno & Diminich, 2013; Bonanno & Mancini, 2012). A common way to classify posttraumatic psychopathology is Posttraumatic Stress Disorder (PTSD). The DSM-5 criteria for PTSD include: "involuntary and distressing memories of the traumatic event(s), marked physiological reactions to internal or external cues that symbolize the event, avoidance of distress memories or external reminders, persistent and exaggerated negative

beliefs about oneself, others or the world, and hypervigilance" (American Psychiatric Association, 2013, p. 271).

However, the DSM-5 symptoms do not encompass other psychiatric disorders and symptoms that may emerge after a traumatic experience. Such negative symptoms include social withdrawal, sleep problems, difficulty with attention and concentration, and guilt, which are relatively generalized across cultures (Antai-Otong, 2002). Other effects on the child's development related to emotional abuse include depressive symptoms (e.g., hopelessness), low self-esteem, insecure attachment, and diminished satisfaction with life and social support (Stoltenborgh et al., 2012). Culture has also been observed to have significant impact on the expressions of such symptoms. For example, a study that sampled Salvadorian refugees and a variety of other Central American groups, found that somatic expressions of trauma-related distress such as stomach pains, headaches and other body discomfort seemed to be much more acceptable to show than verbally expressed emotions of distress (Tummala-Narra, 2007).

Further, studies on the long-term consequences of trauma have also examined the relation of potentially traumatic life events to subsequent patterns of symptom development across the lifespan. For example, childhood sexual trauma has been correlated with 47% of all childhood-onset psychiatric disorders and 26% to 32% of adult-onset disorders (Pérez-Fuentes et al., 2013). Covering a more comprehensive set of PTEs, Carr et al. (2013) conducted a systematic review of studies that investigated early life stressors (e.g., sexual abuse, emotional abuse, neglect) and determined if certain stressors had a higher chance of being correlated with specific psychiatric disorders and mental disease in adulthood. It was found that: a) physical abuse, sexual abuse and unspecified neglect were associated with mood and anxiety disorders, b) emotional abuse was associated with schizophrenia and personality disorders, and c) physical neglect was associated

with personality disorders. Additionally, it was found that trauma survivors experienced heightened levels of panic disorder, specific phobias, anxiety spectrum disorders and major depression up to 8 years post-trauma when compared to a non-traumatized sample. They also found that trauma survivors experienced physical complaints in decreased self-reported physical-health quality of life. Similarly, Alisic et al. (2014) found that symptoms of acute and short-term posttraumatic stress, depression and anxiety in childhood, along with exposure to parental posttraumatic stress to be significant predictors of posttraumatic symptoms later in life.

Additionally, childhood trauma has been related to behavioral and social problems in adulthood (Joseph & Linley, 2008), such as a general increase in psychopathology, decreased self-esteem, increased interpersonal problems, sexual difficulties (Davis, Petretic-Jackson, & Ting, 2001), risky sexual behaviors (i.e., exposure to HIV, prostitution, and early sexual contact (before age 15; Sikes & Hayes, 2010)), and difficulties in emotion regulation (e.g., hostility, anger management, modulation of feeling) and interpersonal skills ([e.g., reactive aggression, bullying, limited social competence]; Cloitre, Miranda, Stovall-McClough, & Han, 2005). Of note, increased rates of substance dependence of approximately 50% have been observed among individuals with PTSD who experienced trauma in childhood or adulthood (Santa Ana et al., 2006).

Although this binary approach has its advantages (e.g., identifying pathological symptoms of PTE, focusing interventions on those most in need), it has substantial disadvantages as well, including the fact that diagnostic entities are mostly conceptual rather than empirical and that the diagnostic approach provides no information on resilience and the distribution of individual differences in reactions to PTE's that may not be entirely pathological or entirely absent of distress (Bonanno & Diminich, 2013). As a result, more recent approaches use

sophisticated methodologies (e.g., latent grown curve analysis) that demonstrate the heterogeneity in individual differences in prospective or longitudinal patterns of adjustment (Bonanno & Diminich, 2013). Bonanno (2008) identified four trajectories: (a) a chronic disruption in functioning, (b) a delayed onset of distress that increases over time, (c) recovery, where there is an initial disturbance in stable functioning that decreases over time and pre-trauma functioning is recommenced, and (d) resilience in individuals who are able to maintain a relatively consistent state of functioning post trauma.

Furthermore, budding literature investigates the potential for important positive changes in personality schema and people's assumptive worlds following a traumatic event (Joseph & Linley, 2008). Posttraumatic growth is the study of psychological well-being, changes in life philosophy, insight into one's own life and changes in relationships with others (Joseph & Linley, 2008).

Reasons for individual differences in post-traumatic trajectories (as well as in the earlier lines of binary research) include characteristics of the PTE, social support resources, ways that people interpret or appraise a stressful event and past encounters with trauma, and current life stress. (Bonanno, 2008; Brewin, Andrews, & Valentine, 2000; Folkman & Lazarus, 1984; Jospeh & Linley, 2008; Kaniasty & Norris, 2008). Additionally, demographic variables, such as having higher education, being male, having higher income, and being a member of a majority ethnic group have been related to more favorable outcomes (Belle, 1990; Bonanno, Galea, Bucciarelli & Vlahov, 2007; Norris et al., 2003). For the purpose of this dissertation, there will be a focus on the characteristics of the PTE, availability of social support and types of coping with the PTE; each is briefly noted next.

First, characteristics about the potentially traumatic event itself can impact individuals'

well-being later in life, including: severity, victim age, use of force and relationship to perpetrator (Joseph & Linley, 2008). Second, situational factors throughout childhood such as social support from the non-offending caretaker and family functioning seem to be important influences in the determination of the impact of child abuse long-term (Joseph & Linley, 2008). Factors such as parental warmth, social support and marital quality emerged as elements included in the impact of child trauma later in life (Joseph & Linley, 2008). Tremblay, Hebert and Piche (1999) found that behavioral difficulties and evaluations of self-worth were more positive when children felt supported by their parents. Furthermore, a lack of social support is accepted as a potential risk factor for vulnerability to traumatic experiences (Bonanno, 2008; Ellis, Nixon & Williamson, 2009). Social support seems to be a significant moderator in that psychological abuse appeared to predict PTSD symptoms in the presence of low social support but not in high levels of reported social support (Babcock, Roseman, Green, & Ross, 2008). Additionally, Asberg and Renk (2013) found that incarcerated women reported significantly less levels of social support throughout their lives post-abuse when compared to non-incarcerated women post-abuse. In sum, it has been found that those who reported a stronger network showed decreased levels of impairment (e.g., PTSD) when compared to those who reported a weaker peer support network (Morley& Korht, 2013).

Third, coping, defined as cognitive and behavioral efforts to manage stressors (Lazarus & Folkman, 1984), is largely considered to be one of the most important resilience variables (Bonanno, 2008). There are several types of coping, which can lead to different outcomes for the individuals incorporating them into their PTE experience, including: problem-focused coping (dealing with sources of stress), emotion-focused coping (handling feelings and thoughts associated with the stressor), avoidant coping (avoiding dealing with the stressor or associated

emotions), and social support seeking ([obtaining advice or expressing emotions], Carver, Scheier, & Weintraub, 1989; Endler & Parker, 1990; Litman, 2006). Considering that avoidant coping and social support coping are types of coping seen in populations that experienced trauma, they are discussed next.

Avoidant methods of coping have frequently been shown to relate to increased levels of psychological distress and trauma symptoms (Brand & Alexander, 2003; Johnson, Sheahan, & Chard, 2003). A cross-sectional study using a geographically diverse sample of 99 female undergraduate women (average age, 21; 64% European American, 13% Hispanic/Latina, 7% African American, 4% Asian American) who indicated they had experienced childhood sexual trauma examined avoidant coping strategies in adulthood (Fortier et al., 2009). Fortier et al. (2009) stated that avoidant, maladaptive coping mechanisms such as physical and emotional detachment and withdrawal, as well as substance use and other self-harm behaviors are used to avoid threatening situations. For example, the trauma survivor may not want to discuss the event, or have a conversation that may remind him or her of that significant event. Nevertheless this avoidance that once served as a stress-reducer initially will become problematic and often heightens one's experience of fear (Fortier et al., 2009). This study came to the conclusion that the more severe the childhood sexual abuse, the more the participant engaged in avoidant coping (Fortier et al., 2009). These participants were also at an increased risk for sexual revictimization in adulthood (Fortier et al., 2009).

Social support coping refers to the process of seeking social support as a coping strategy following traumatic experiences (Prati & Pietrantoni, 2009). It has been observed that seeking social support in the coping process contributes to the quality and quantity of available supports (Prati & Pietrantoni, 2009). Furthermore, seeking social support has been shown to enhance

positive appraisals of traumatic events and to stimulate positive health outcome following traumatic experiences (Swikert & Hittner, 2009). Additionally, the use of social support in coping during times of stress provides individuals with opportunities for active problem solving and processing of traumatic experiences (Prati & Pietrantoni, 2009).

Social Support with Trauma Survivors and in the Psychotherapy Context

Of particular interest to this dissertation, social support research has focused on understanding the role and effects of social support among vulnerable populations such as survivors of childhood abuse, adult traumas, and other significant life stressors [e.g., incarceration; homelessness] (Savage & Russell, 2005). Throughout history, it has been observed that outpourings of help have rallied to assist those impacted by traumatic, disastrous events (Kaniasty, 2012). Survivors of these events typically seek each other out with a need to talk and process about what they have experienced (Joseph et al., 1997; Lepore, Ragan, & Jones, 2000). For the purpose of this dissertation, this type of human interaction will be referred to as social support (Cohen et al., 2000). Research conducted over the past 30 years has shown that individuals who have networks of people (e.g., spouses, family, friends) that provide support, either psychological, material or both, typically tend to have better health and well-being than individuals who report smaller or less helpful networks (Barker & Pistrang, 2002; Cohen & Wills, 1985). After describing social support from general networks of people, this subsection discusses social support with trauma survivors, and in the context of the psychotherapy relationship.

Within the general networks of social support, there are two structures: formal social support and informal social support. Formal support can be defined as support provided for an

individual through paid services, such as psychotherapy and other forms of supportive care (Gauler& Kane, 2001; Barker & Pistrang, 2002). For the purpose of this study, informal social support will refer to unpaid help given by family (including spouse, siblings and relatives), friends, neighbors and co-workers (Wei-Qing et al., 2009). The help provided by formal and informal supports can involve various functions, including support (an action that aims to help or assist an individual cope with stressors), advice (communication aimed at providing instruction towards goal achievement), and feedback ([process of evaluation that aims to notify the individual of his or her progress], Tolsdorf, 1976).

The construct of social support is multifaceted and consists of various models [e.g., unidimensional relationship model, main effect model, multidimensional model] (Cohen, Gotlieb & Underwood, 2000) and components (e.g., received, perceived, extended, seeking support coping). Whereas received social support refers to the actual support that a person obtains from another, perceived social support refers to the belief or expectation that support will be available during times of need, which stems from lived experiences with received social support (Joseph et al., 1997; Norris et al., 2007). For example, an individual who was not supported by his or her family during a crisis in the past will have low expectations to receive any support in the present. Experiences with positive and helpful support lead to beliefs that future support will be available, and just as importantly, helpful (Clapp & Beck, 2009; Norris & Kaniasty, 1996). Studies have observed that survivors of trauma who received increased levels of social support (sources of support not specified) immediately post-trauma showed increased levels of perceived support in the future (Kanaisty, 2011; Norris & Kaniasty, 1996). For the purpose of this study, an emphasis and focus will be placed on the investigation of perceived social support.

Perceived social support has been studied extensively and has been found to provide

many benefits to survivors of traumatic events (Norris et al., 2003). When faced with stressful life events, people's ratings of high levels of perceived social support from a friend, spouse or relative was associated with a significant reduction in the presence of psychological distress (Maulik, Eatonn, & Bradshaw, 2010). Perceived support from informal supports have been found to be of great importance in coping with traumatic events, including in minority communities. A qualitative study of support resources among African-Americans who experienced traumatic grief due to the homicides of family members observed that individuals were more likely to turn to informal support relationships in coping with grief (Sharpe, 2008). Specifically, the main supports that were desired for coping were primary and secondary kin, close friends and other, more distal friends (Sharpe, 2008). In general, the literature shows that support from family and friends has a positive influence on the ability to cope with trauma (Brewin, Andrews & Valentine, 2000) and is commonly accepted as a protective factor by aiding in effective coping following exposure to traumatic events (Lyons, 1991). For those who experienced early traumas of war, family support, community support, and peer support were important themes for psychosocial well-being (Morley & Korht, 2013).

Trauma survivors who believe that social support is available and that others are immediately willing to help experience less symptoms of post-traumatic stress than survivors who feel isolated and neglected (Norris et al., 2007). Perceived social support has also been found to be correlated with decreased PTSD symptoms in different trauma populations including burn victims and veterans (Widows, Jacobsen, & Fields, 2000).

As indicated in the above findings, perceived social support has been assessed through qualitative methods (e.g., Morley & Korht, 2013; Sharpe, 2008). Sharpe (2008) measured social support through a 22-question interview process based on the Ways of Coping Questionnaire

(Folkman & Lazarus, 1988) that focused on each participant's approach to seeking social support to cope with the homicide of a family member. Morley and Korht (2013) used inductive thematic analysis of transcribed face-to-face or over the phone interviews to identify and cluster similar themes of perceived social support and the effectiveness of perceived social support amongst their participants. Neither of these studies specifically measured social support within a psychotherapeutic context.

In psychotherapy, self-report measures like the Perceived Social Support Index (PSS; Procidano & Heller, 1983) and The Medical Outcomes Social Support Survey-Abbreviated (MOS; Gjesfield, Greeno, & Kim, 2008) are used for this purpose. Another common self-report measures of perceived social support used in psychotherapy is the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS has been used to measure perceived social support in various different trauma populations including college students (Haden, Scarpa, Jones, & Ollendick, 2006), male war veterans (Dordevic et al., 2011) cocaine-using mothers (Minnes, Singer, Humphrey-Wall, & Satayathum, 2008), injured athletes (Lu & Hsu, 2013), and, similar to this dissertation's population, outpatients attending a research and training clinic (Cecil, Stanley, Carrion, & Swann, 1995 [described below]).

Perceived support has been thought to be more effective and more powerful than received social support because the thought that support is available is, in itself, supportive (Norris & Kaniasty, 1996). In actuality, some received social support may be interpreted as unhelpful, unwanted or critical and thus would in reality be unsupportive (Norris & Kaniasty, 1996). As noted above, formal social support can be provided in the context of psychotherapy. In other words, clients can engage in social support coping by seeking out psychotherapy services. Once in therapy, it can be a place in which to experience received emotional support. Researchers posit

that received social support, when suitable to the client's needs, serves as a protective factor against distress after a traumatic experience (Cohen & Wills, 1985; Lyons, 1991). In fact, Gabert-Quillen and colleagues (2012) stated that emotional support following a traumatic event was deemed more beneficial than other forms of support. Therapy can play an important role in trauma recovery in that it provides a collective process in which the story of the traumatic experience and deep pain is heard, witnessed and shared (Karpelowsky & Edwards, 2005).

However, literature describes the struggle many clinicians experience with forming a therapeutic relationship with adult abuse survivors due to the client's emotional lability, relational instability and mistrust (Schwartz, 2000). Yet once a therapeutic relationship is carefully established, it can serve as a mediating factor in the client's resilience following a traumatic event (Kohlenberg & Tsai, 1991). For this reason, the development of a therapeutic relationship early on in the course of the treatment of trauma survivors is imperative. The therapeutic relationship has been defined as the "feelings and attitudes the participants hold toward one another, and the psychological connection between the therapist and patient, based on these feelings and attitudes" (Gelso & Hayes, 1998, p. 17).

Accordingly, the therapeutic relationship and its related concepts, such as the working alliance, may be helpful to measure and explore, specifically for individuals that have survived PTEs. The next section serves to aid in the understanding of the working alliance that develops between the client and therapist, and describes a way that it is measured and used with general psychotherapy clients as well as those who have experienced PTEs.

Working Alliance

A working alliance is said to develop from a therapeutic relationship, such that it grows from an agreement between client and therapist on therapy goals and tasks (Busseri & Tyler, 2003). It also highlights the progression of a resilient relational bond between the client and therapist (Busseri & Tyler, 2003). Kivlighan (2007) stated the working alliance helps the client and therapist to work together, form a partnership and collaborate in a dyadic environment. Accordingly, research has found that it is related to positive outcomes. For example, Horvath (2001) noted that the best predictor of positive therapeutic outcome is defined by the client's report of a strong early therapeutic rapport, and that the degree of the relationship between alliance and therapy outcome was unrelated to the therapeutic technique practiced. Further, meta-analytic studies found that a strong therapeutic relationship is correlated with better psychotherapy treatment results (e.g., Martin, Garske, & Davis, 2000). Additional discussion of outcome research on the working alliance is found below.

Research indicates that the therapeutic relationship involving clients that have a past history of trauma is likely more complex than for clients who do not have a prior history of trauma (Middle & Kennerley, 2001; Safran, Crocker, McMain, & Murray, 1990). One reason is that someone in a position of authority has betrayed the client's trust (Hill & Alexander, 1993; Middle & Kennerley, 2001). Childhood sexual abuse has also been associated with emotional and interpersonal difficulties in childhood and adulthood (Briere, 1996; Faust, Runyon & Kenny, 1995; Kimerling & Calhoun, 1994). Given this information, researchers have hypothesized that clients who have experienced childhood sexual abuse may likely have more difficulty developing a therapeutic or working alliance than other clients (Keller, Zoellner, & Feeny, 2010; Middle & Kennerley, 2001); specific findings to that end are discussed further below.

Given the possible challenges establishing a therapeutic relationship with many trauma survivors, counselors have been encouraged to approach treatment with this population using a patient, flexible, and nonjudgmental approach (Sikes & Hayes, 2010). Such an approach includes validation of the traumatic experience(s) in order to help the client manage and improve physical, social and mental health functioning and decrease developmental difficulties resultant of the traumatic event(s), according to Linehan (2014), and Sikes and Hayes (2010).

To assist them in their work, therapists can use ongoing assessments of the therapeutic relationship and the therapeutic or working alliance. Researchers use various ways to assess the therapeutic alliance between the client and therapist, including self-report measures like the Helping Alliance Questionnaire and the California Psychotherapy Alliance Scales (Bachelor, 2013). One of the most well regarded and frequently used self-report measures is the Working Alliance Inventory (WAI; Gullo, Lo, & Gelso, 2012). Given that the WAI is to be used in the this dissertation, the subsequent discussion describes this particular measure in more detail as well as an inclusion of the characteristics of the measure, how the measure is generally used, the WAI's connection to the study of the therapeutic alliance, and the WAI's use specifically with regard to the childhood abuse survivor population.

The WAI, developed by Horvath and Greenberg (1986, 1989), was inspired by Bordin (1979) and his theory of the client-therapist agreement of therapy goals and tasks, and the development of a strong relational bond between them (Busseri & Tyler, 2003). The alliance measured using the WAI is defined as the partnership between the client and the therapist, grounded in their agreement on the goals and tasks of therapy and on the development of an attachment bond; hence, both therapist and client are directed to complete the self-report form (Kivlighan, 2007). Parallel therapist, client and observer versions are used to compare various

perspectives of the relationship (Bachelor & Salame, 2000; Ross, Polaschek, & Wilson, 2011).

The short form inventory (WAI-S) is composed of 12 items that are rated on a seven-point Likert measure, which originated from the 36-item version that included three 12-item scales; higher scores indicate a stronger working alliance (Gullo, Lo & Gelso, 2012; Horvath & Greenberg, 1989; Kivlinghan, 2007). The 36-item WAI has proven to be successfully interchangeable with the WAI-S scales (Busseri & Tyler, 2003). The three dimensions included in the WAI include agreement on therapeutic tasks (TASK), development of affective bonds (BOND), and agreement on goals (GOAL; Bachelor, 2013). Busseri and Tyler (2003) indicated that internal consistency evaluations for client and therapist WAI-S subscales and total scores were high and ranged from .83 to .98. Also, validity has been demonstrated through the study of noteworthy correlations between WAI ratings and counseling outcomes (Horvath, 2001). According to A.O. Horvath (personal communication, March 7, 2017), the WAI is considered to be ipsative, meaning the measure was "not standardized on a homogeneous population." Therefore, researchers are encouraged to utilize group means of their study samples in order to categorize results as "high" or "low" (A.O. Horvath, personal communication, March 7, 2017).

With regard to general populations of psychotherapy clients, research using the WAI has been used to study the impact of the therapeutic alliance on the client and therapist relationship over time. One study used a replication sample from an earlier study of 38 adults (12 men, 26 women, 33 Caucasian, 2 Asian American, 3 African American; age range 19-25) who attended 4 sessions of therapy with counselor trainees in a community clinic and endorsed a moderate level of interpersonal distress using the Inventory of Interpersonal Problems (Kivlighan & Shaughnessy, 2000). Tracking the WAI of the participants each of the four sessions, the researchers found that the outcome of a strong therapeutic alliance could develop from different

patterns of change throughout the therapeutic process (Kivlighan & Shaughnessy, 2000). Specifically, some results showed linear, stable, and quadratic growth of the WAI across 4 sessions of psychotherapy. Twelve showed linear growth, which suggests a positive, gradually increasing WAI strength over time. Sixteen demonstrated stable growth, which is defined as a moderate WAI strength throughout the course of treatment and a non-distinctive pattern of growth over time (Kivlighan & Shaughnessy, 2000). Finally, ten evidenced quadratic growth, which is defined by the high-low-high scenario, in which the working alliance begins strong, successively regresses, and then successfully strengthens to initial high levels (Kivlighan & Shaughnessy, 2000). Of note, the study did not mention the WAI version utilized, and how scoring was accomplished. Given the ipsative nature of the WAI measure, one can assume that this study utilized the means of the test results in order to categorize scores as "high", "moderate" or "low." However, this information on interpretation of scores was not clearly defined in the article. Efforts were made to contact the authors to clarify scoring procedures on March 21, 2016, and sequentially throughout the last year. However, the contact information provided was no longer in service. Throughout the completion of this study, ongoing efforts were made to obtain more current contact information. This information would have been utilized in order to communicate with the identified authors to obtain a more clear explanation of scoring procedures.

Similar to studies that investigated the use of the working alliance on the general population, researchers have also shown curiosity for studying the working alliance in international samples of people with symptoms of posttraumatic stress disorder (PTSD). Four studies are briefly presented here; the first is the only one of the four finding that those with reported PTSD symptoms rated their alliance with their therapists as high and that the WAI

improved over the course of treatment (linear growth). Subsequently, three studies that

investigate the WAI among adults that endorsed a history of childhood trauma will be discussed.

Knaevelsrud and Maercker (2007) examined the working alliance ratings by a German

sample with PTSD ($N = 49$; ages 18-68; 90% female; 44% had a university degree) during

Internet therapy. The researchers found that the working alliance was high at session four

(overall mean of 5.6 on Likert scale of 1-7) and reported that it had significantly increased at the

tenth session of treatment ([$M = 5.8$; F 1,40] $= 25.45$, P<. 001). WAI subscale scores showed an

increase too: agreement on therapeutic goals went from a mean of 5.8 to 6.3, agreement on

therapeutic tasks went from a mean of 5.7 to 6.2, and therapeutic bond went from a mean of 6.2

to 6.4 on the tenth session. Results also indicated that stronger WAI scores after ten sessions

conducted over five weeks were correlated with a lesser report of psychological symptoms than

reported before treatment (Knaevelsrud & Maercker, 2007). Lastly, the authors of this study did

not mention the WAI version utilized, and how scoring was accomplished. As with the

aforementioned study, given the ipsative nature of the WAI measure, one can assume that this

study utilized the means of the test results in order to categorize scores as "high"." However, this

information on interpretation of scores was not clearly defined in the article. Efforts were first

made to contact the authors to clarify scoring procedures on March 21, 2016; however the

contact information provided was no longer in service. Similar to what was noted above,

attempts were also made to contact the authors by other means; however, efforts were

unsuccessful.

The following three studies did not find that those with PTSD symptoms rated their

therapeutic relationship as high with a linear progression. The first study, by Wagner, Brand,

Schulz, and Knaevelsrud (2012), analyzed WAI scores for 47 participants diagnosed with PTSD

undergoing Internet Cognitive Behavioral Therapy. Results suggested that those who experienced symptoms of PTSD in Iraq (mean age = 27.7; 78% female, Arabic-speaking) were able to establish and maintain a positive and stable therapeutic relationship over time (Wagner et al., 2012). The WAI was administered mid-treatment (after session four) and after the final session (session ten). Similar to the previous study, researchers found that a positively rated working alliance early in treatment (session four; $M = 6.04$) predicted more advantageous therapeutic outcomes post-treatment ($\beta = .37$, t = 2.81, P = .007). However, this study found that high WAI ratings at session four remained stable and did not increase significantly from session four to session ten (M = 6.16). Consequently the authors of this study did not mention the WAI version utilized, and how scoring was accomplished. Efforts were made to contact the authors to clarify scoring procedures first on March 21, 2016; however the contact information provided was no longer in service and so efforts were made, although unsuccessful, to contact the authors by alternative means. Similar to the above, one can presume the ipsative nature of the WAI measure was utilized in order to interpret scores; however, the authors did not confirm this within the article.

The second study, by Howgego et al., (2005), researched the impact of PTSD and exposure to traumatic events (33.3% met criteria for PTSD, 74% exposure to multiple traumatic events; 10 females, 10 males) on WAI outcome at the end of therapy (six months) in Australia. Specifically, the WAI was administered at three months, and again at six months. Their study outlined that the WAI was not clearly impacted by PTSD symptomology and exposure (Howgego et al., 2005); however, the authors did not include such data outlining the WAI outcome within the article. Efforts were made first on March 21, 2016 and subsequently thereafter to obtain more information regarding the WAI version utilized as well as WAI scores

and results; however, the authors did not respond to this request. This study attempted to obtain other current contact information (e.g., phone, email); however, they were unfortunately unsuccessful attempts.

Additionally, the final study, by Kanninen, Salo, and Punamaki (2000), examined WAI outcomes among male Palestinian political ex-prisoners that experienced torture and ill treatment (50 clients; mean age=31; 25 individual therapy participants; 25 group therapy participants). PTSD was not an inclusion factor for the study population; however, all participants endorsed some symptoms of PTSD on a dimensional scale using the Harvard Trauma Questionnaire (results not mentioned; Mollica et al., 1992). The authors indicated that the WAI utilized for this study contained 27 items rated on a Likert scale of 1-5 (1 = never, 5= always (Horvath & Greenberg, 1989); however, there appears to be a documentation error because that version of the WAI actually contains 36 items. The participants completed the WAI at the third session, in the middle of treatment (fifth or sixth month) and then following the second to last session of therapy (between the 10th and 12th month). The study found that early working alliance results (after the third session) were similar (M=1.67-1.93; [described as high by the authors, despite such means appearing to represent a low score in other WAI versions]). Again, efforts were made to contact the authors regarding the discrepancy in WAI items and for clarification of scoring. However, the email address provided by the article was no longer in service. Continuing efforts were made in order to obtain more current contact information as a means to clarify scoring procedures utilized in the aforementioned study; however, similar to the above, the efforts were unsuccessful.

Much like studies outlining the working alliance using samples that experienced symptoms of PTSD, the client-therapist relationship is also an integral part of the foundation of psychotherapy with adult survivors of child abuse (Paivio & Patterson, 1999). The nature of this relationship is sometimes described and studied using the WAI, which is a part of research regarding treatment with adult clients who have been exposed to traumatic experiences as children. The three such studies found in the literature are discussed next.

Paivio and Patterson (1999) used the WAI at sessions three, four, ten and termination (average of 20 total sessions; session termination range: 12-27) with a sample of 33 child trauma survivors (26 women and seven men; 91% Caucasian; 76% household income less than $39,000). Nine (27%) met DSM IV criteria for an Axis II diagnosis (Paivio & Patterson, 1999) and 70% endorsed a history of therapy experiences to address anxiety, marital distress, substance dependence or depression. Results showed that the child trauma survivors generally endorsed strong early alliances with their therapists on the WAI at session 3 (M=5.74; SD=0.66), and a steady increase in alliance strength throughout the course of therapy, specifically in the bond dimension (linear pattern). These findings share some similarities with the previously discussed general population study that described and identified a linear growth pattern (gradually increasing WAI strength over time; Kivlighan & Shaughnessy, 2000).

Of note, however, the results varied by abuse severity (Pavio & Patterson, 1999). Specifically, early alliance struggles (lower initial ratings of the WAI, but WAI scores from this subgroup were not reported in the study) were correlated with the exposure of higher numbers of severe traumatic events as a child, such as physical or emotional trauma, or neglect, measured on the Childhood Trauma Questionnaire (CTQ, 1994) and Posttraumatic Stress Disorder Symptom Severity- Interview (PSSI). 68% of participants reported that they experienced multiple

childhood traumatic events (Paivio & Patterson, 1999). Results indicated that subscales of the

CTQ such as emotional/physical abuse (-0.31), emotional neglect (-0.28), and physical neglect (-0.27) were negatively correlated with early alliance scores at the fourth session. Thus, the more

severe abuse that clients experienced as a child, the lower the participants rated their initial

working alliance with their therapist; moreover, they also endorsed suffering from interpersonal

damage as an adult, measured by the Inventory of Interpersonal Problems (IIP), and received a

personality disorder diagnosis on Axis II in the DSM-IV (Pavio & Patterson, 1999).

Paivio and Patterson (1999) subsequently compared their above mentioned study utilizing

a sample of participants who endorsed a history of trauma to WAI results from two general

population samples from different studies. The first comparison study, by Paivio and Bahr

(1998), included 33 participants who reported symptoms of depression, anxiety and moderate

employment and interpersonal functioning problems. The researchers included participants based

on criteria for short-term therapy outlined by Malan (1976); the criteria included motivation for

treatment, capacity to develop a therapeutic relationship, and the ability to target a current

personal issue or problem. The WAI was measured at sessions three and termination (average of

12 sessions of experiential psychotherapy; session termination range: 8-16), and results showed a

positive linear growth pattern, from high to higher scores, from session three ($M = 5.68$, $SD = 0.68$) to the termination session ($M = 6.24$, $SD = 0.46$). Thus, Paivio and Patterson (1999) found

a slightly stronger initial alliance rating in those who experienced childhood trauma ($M = 5.74$;

$SD = 0.66$) compared to Paivio and Bahr's general clinical sample ($M = 5.68$, $SD = 0.68$), and

both studies indicated positive linear growth over time. It should be noted that the authors did not

include the WAI version utilized for the study, nor did they include specifics outlining the

calculation of the mean scores. Further, they did not include the process of interpretation of mean

scores. As stated elsewhere, given the ipsative nature of the WAI measure, one can predict that this study utilized the means of the test results in order to categorize scores as "high." However, this information on interpretation of scores was not clearly defined in the article. Efforts were made to contact the authors to clarify scoring procedures and measures first on March 21, 2016, and subsequently thereafter. However, to date, a response was not received.

The second comparison study referred to by Pavio and Patterson was conducted by Mallinckrodt (1996), which included a sample of 34 participants in the general population who participated in a general nonabuse-focused brief therapy model (mean number of sessions = 14.96; session termination range: 8-20). Participants who had fewer than eight sessions of therapy were excluded from the data analysis. The WAI was administered at session three, and again at the termination of therapy. Overall, Mallinckrodt (1996) study's early alliance ratings ([session 3]; $M = 5.02$; SD = 0.75) were not rated as high as Paivio and Patterson's (1999) results of early alliances (sessions three and four) in those with a history of childhood trauma ($M = 5.74$; SD = 0.66).

The second study related to childhood trauma used the WAI to study a group of women aged 18-57 years old (41 Caucasian, 29 African American) who met criteria for a current Major Depressive Episode (MDE) identified by the Structured Clinical Interview for DSM-IV-TR Disorders (SCID), who also experienced sexual abuse as children (Smith et al., 2012). The study hypothesized that this sample would experience difficulty forming and maintaining secure relationships in their lives measured by the Experiences in Close Relationships Scale (ECR) at baseline, which, in turn, would be associated with low subjective working alliance ratings at the third session, and therefore increase treatment resistance (Smith et al., 2012). This study utilized a 12-item WAI and stated the total scaled scores ranged from 12-84. Although the researchers

did not specify whether the results for the ECR (attachment anxiety $M = 4.80$, SD = 1.02; attachment avoidance $M = 4.24$, SD = 1.22) and the WAI ($M = 64.03$) were classified as high or low, they did indicate and verify that there was not a significant relationship between attachment style and working alliance, as they hypothesized (Smith et al., 2012). Moreover, it was hypothesized that a strong therapeutic relationship facilitates acute symptom reduction and a decrease in vulnerability to distress (Smith et al., 2012). When clients in the Smith et al. (2012) study endorsed higher working alliance scores, larger improvements in the alleviation of depressive symptoms were found using the Beck Depression Inventory-2 (BDI; Beck, 1996), which was administered at baseline, and again at the tenth, 24th and 36th week of therapy. Specifically, one standard deviation increase (11.74 points) of the WAI rating correlated with a 4.32-point average decrease in BDI scores over the course of therapy (Smith et al., 2012).

In the third study, those who experienced sexual trauma as a child and indicated strong social support on the Social Reactions Questionnaire (SRQ; Ullman, 2000) administered pretreatment showed that this support assisted them in forming a strong therapeutic bond during the start of treatment as measured by the WAI 12-item short form at the beginning of sessions two and four (Keller et al., 2010). These results are in line with the previous studies, wherein a childhood sexual abuse history did not indicate a poor early alliance, as predicted (Paivio & Patterson, 1999). This study included 188 participants (144 women and 44 men) between the ages of 18 and 65 who were given the primary diagnosis of chronic Post Traumatic Stress Disorder (PTSD) using the PTSD Symptom Scale (PSSI, 1993) and the Structured Clinical Interview for DSM-IV (SCID-IV, 1995). The participants were randomly assigned to a 10-week treatment of either a Psychotherapy or Pharmacotherapy treatment group (Keller et al., 2010). The psychotherapy treatment utilized prolonged exposure (PE; Foa, Hembree, & Dancu, 2002),

and the Pharmacotherapy group, which included sertraline (SER) at a mean dosage at the end of treatment of 135.68 mg/day (SD = 66.80) and weekly visits to the psychiatrist to track side effects and provide support throughout (Keller et al., 2010). The results of sessions two and four indicated a mean average early working alliance of 65.37 and a standard deviation of 12.59. The difference in early therapeutic alliance was significant, as the study participants in the PE group reported a stronger early working alliance (M = 67.37, SD = 11.07) than those in the SER group (M = 62.00, SD = 12.59).

In sum, researchers have utilized the WAI to study not only the therapeutic relationship in the general population, but further, the relationship of PTSD symptomatology and/or childhood traumatic experiences with the working alliance. Overall, the studies mentioned in this section indicated the general population rated their working alliances as high, with some variation in WAI scores for those with PTSD symptomology (some report of high and linear scores, some high and stable). Despite many hypotheses stating that those who reported childhood abuse are unable to form solid therapeutic relationships with their therapists, existing research with participants who reported childhood history of trauma indicates that they are able to form strong working alliances with their therapists. The next section outlines a critique and need for further study for the utilization of this working alliance measure.

Critique and Need for Further Study

Although this literature review revealed a breadth of research on trauma and its relationship to interpersonal dysfunction, less was known in regards to the connection of trauma, with client relationships in regard to professional support. This subsection critiques this smaller literature pertaining to the therapeutic alliance and utilizing the Working Alliance Inventory

(WAI) on a population that has endorsed past experiences of trauma.

The Working Alliance and Childhood Trauma. Many studies have used the Working Alliance Inventory (WAI) to understand clients' impressions about the progress of the therapeutic bond, acceptance of therapeutic tasks, and confidence in the treatment goals (Knaevelsrud & Maercker, 2007). Although an estimated 82% to 94% of clients who pursue therapeutic treatment in a community mental health clinic have survived a traumatic event at certain times in their lives (Williams, Helm, & Clemens, 2012), only six studies have examined the therapeutic alliance using the WAI among this population. Four studies outlined WAI results in samples of adults with PTSD symptoms. Additionally, only two studies sought to specifically study the WAI among adults who experienced childhood trauma and sought therapy in a community clinic. These studies that were described above, are critiqued next.

General limitations regarding the four studies that utilized the WAI with adult samples with PTSD symptoms will be critiqued first. In general, the samples used in these studies may restrict the generalizability of their results. More specifically, Knaevelsrud and Maercker (2007) excluded 253 participants due to exclusion criteria due to dissociation, psychosis, suicidal thoughts, low symptom severity or the inability to provide informed consent.

Other issues regarding sample generalizability include sample size and ethnicity. Knaevelsrud and Maercker's (2007) sample contained a sample of 49 participants. Additionally, information regarding the sample's ethnicity was not provided. Next, two studies included even smaller sample sizes: Howgego et al. (2005) included 20 participants and Kanninen et al. (2000) utilized 36 participants. Thus, small sample sizes increase the difficulty in generalizing the information and results gathered to other populations or groups. Again, ethnicity information

was not included in either of the two aforementioned studies. Overall, the absence of information regarding the ethnicity of the samples studied can likely challenge the reader to question whether the findings can be generalized to a specified ethnic group of interest.

Another limitation concerns the reliance on self-report instruments to measure PTSD symptoms and working alliance. Wagner et al. (2012) utilized a self-report questionnaire (Posttraumatic Diagnostic Scale; Foa, 1995) to assess the PTSD symptoms of the study participants. Given this information, a clinical interview for each participant may have assisted the researchers in a more accurate assessment and clinical diagnosis. The WAI is also reliant upon the self-report of the participant. This is a possible limitation, as study participants may rate their working alliance as stronger or less strong than their actual experiences. Further, the various studies outlined in this document utilized different versions of the WAI and scoring techniques (means, standard deviations, etc.), which made the differentiation between studies more difficult without standard scores for comparison. A written narrative may suggest a more accurate account of the subjective interpretation of the working alliance. In addition, the working alliance can be measured by people other than the client, such as the clinician, and an observer (e.g., researcher, case manager). Yet, this study planned to use the client report as earlier research stated that the client's appraisal of the working alliance is a better indicator of therapeutic outcome compared to the therapist's or observer's rating of the working alliance (Horvath & Symonds, 1991).

Regarding the two studies that are most comparable to this dissertation, each will be discussed separately. As the reader may recall, Keller et al. (2010) examined the therapeutic alliance with the WAI that was rated by adult clients who reported experiencing childhood sexual abuse. Overall, this study found that for both treatment groups, a history of childhood

sexual abuse was not indicative of a lower early working alliance as the researchers first predicted, as a mean score of 62-67 indicated strong working alliance ratings (Keller et al., 2010). However, the researchers went further to then utilize the participants' WAI results to compare the two treatment groups. Participants in the psychotherapy group reported a stronger early working alliance (Mean = 67.37, Standard Deviation = 11.07) than participants in the pharmacotherapy group (Mean = 62.00, Standard Deviation = 12.59; Keller et al., 2010). Since the Pharmacotherapy group participants only visited their psychiatrists to monitor medication for PTSD and did not obtain other therapeutic treatment, this treatment condition could possibly have affected the WAI ratings, which take into account treatment process, goals and bond. It is possible that medication adherence may not require a specific understanding of the treatment process similar to psychotherapy treatment (Keller et al., 2010). Further, the participants' confidence in the reasoning or logic behind the use of medication for treatment of PTSD may not be as necessary (Keller et al., 2010).

Methodological limitations of this study include sample characteristics that may have affected generalizability of results. First, the sample included 76.6% women and 23.4% men (age range of total sample was 18 to 65; average age 37.1 years). The small sample of male participants may suggest difficulty when applying findings to the general male population. Also, of the 188 total participants, 69.1% of the sample indicated they were without a college education. The sample population ethnicity identification included 64.9% Caucasian, 21.5% African American and 13.6% Other. Further, the assigned psychiatrist or client caregiver could have tracked adherence to medication in order to decrease possible error in the data results. Finally, administration of the WAI and a social support measure (Inventory of Socially Supportive Behaviors; Barrera, Sandler, & Ramsey, 1981), both self-report questionnaires, may

have exaggerated the results of the two measures given shared method variance.

Additionally, as mentioned in the literature review, efforts were made to contact the authors of multiple studies (i.e., Howgego et al., 2005; Kanninen, Salo, & Punamaki 2000; Kivlighan & Shaughnessy, 2000; Knaevelsrud & Maercker, 2007; Paivio & Patterson, 1999; Wagner et al., 2012**)** that included use of the WAI, but failed to mention the WAI version (short form versus traditional form) and the method and interpretation of scoring. Due to lack of information regarding scoring and interpretation, as well as WAI utilized, this dissertation was unfortunately unable to compare and contrast the analysis of scores (e.g., mean scores) to the aforementioned past related studies. Again, one should note that this study would not have the ability to compare categorization of scores (what scores qualify as high/low) regardless of if the information was present, based on the ipsative nature of the WAI measure.

There are several aspects of this study that appeared to differ from the proposed dissertation. While Keller et al. (2010) utilized clinicians who obtained a master's-level clinical training degree and above, the researchers did not specifically outline if the therapists were in training. Also, although this study involved a group of adults that experienced childhood sexual trauma, it was not clear that results would be similar to a sample of adults that had experienced physical or emotional abuse or other types of trauma. Furthermore, was is unclear as to whether or not results would be similar to adults that had a history of childhood abuse or other types of potentially traumatic events but were not currently diagnosed with PTSD. Finally, although the aforementioned studies outlined the WAI using a particular empirically supported therapy, this dissertation did not focus on the therapeutic orientation among the therapists-in-training at a community clinic. Researchers did not examine the therapeutic orientation because many therapists-in-training do not likely have a strong understanding of a particular therapeutic model;

thus, it would be difficult to analyze if therapeutic orientation (or fidelity to treatment modality) had an impact on WAI scores.

In contrast to Keller et al.'s study (2010), Pavio and Patterson's (1999) study included and compared 33 clients who reported experiencing trauma in childhood with those who did not report a history of childhood trauma. To their credit, the authors appeared to be very thoughtful about their consistency with utilizing the same therapeutic treatment (EFT-AS) for each participant to increase the reliability of the study results. Similarly, the WAI was measured at four time points; however, if the WAI was administered every session the results would have a more accurate representation of the pattern and progression of the therapeutic alliance ratings over time. Further, this study did not address the therapists' interpretation of the working alliance through the therapist-rated WAI version. This would have been helpful in identifying the relationship between the therapists' rating of the therapeutic relationship and whether or not it is comparable to the client-rated alliance scores.

Although this study did not find a significant difference between the WAI scores in those who reported a childhood trauma history and those who did not, the results should be interpreted with caution due to the small sample size. Also, generalizability may have been affected by the characteristics of the study sample. For example, the majority of the sample included Caucasian participants (91%). This may decrease generalizability to other races or ethnicities. Additionally, other sample characteristics included an age range of 19 to 72 (mean age 39), and a modal education level of high school.

Next, the study results selectively included participants who completed the treatment through termination; consequently, results did not include participants who may have

experienced struggles with therapeutic alliance and terminated (fewer than 12 sessions) therapy prematurely (Paivio & Patterson, 1999). Furthermore, as mentioned, the majority of the study sample endorsed a history of previous therapy experiences (70%). Thus, the previous experiences may have helped the participants to facilitate relationships with their therapists and to be more open and accepting of the therapeutic process than participants without a prior history of therapy.

Other aspects of this study that appeared to differ from this dissertation include the use of separate studies to compare a general population sample to a sample that endorsed a history of childhood trauma. This study included participants using a selected sample of the clinic's research database (those who did not endorse a history of childhood trauma and completed the WAI in adulthood), and compared this sample to a group of participants from the same database (those who endorsed a history of childhood abuse/trauma only). In other words, our method employed data collected in one study, as opposed to three.

Furthermore, Pavio and Patterson utilized the CTQ to identify each participant's reported history of childhood trauma, and reported history of multiple past traumatic experiences via unknown methodology, whereas this dissertation utilized participants' self-reported history of childhood abuse/trauma. There are benefits to exploring whether participants reported multiple experiences of childhood trauma, as this data would have been helpful in ascertaining if there was a significant difference in WAI scores between those who report multiple histories of trauma in childhood versus those who report a single incident in childhood. However, given the state of the literature at this point (e.g., only the aforementioned study researched severity of trauma and the relationship to the WAI), this study did not investigate single versus multiple traumatic events and their relationship to the WAI.

Finally, as mentioned, although the aforementioned studies included the WAI during a particular empirically supported therapy with a sample of therapists with more than one year of experience, this study's database included treatment as usual and did not have the means to identify use of specific empirically supported treatments or the therapeutic orientation of the therapists-in-training at a community clinic.

Considering the emerging research on therapeutic alliance with this dissertation's population of interest, the need remained to further investigate the working alliance among those that report a history of childhood trauma (emotional, physical or sexual abuse) with an adult population that did not report a history of childhood trauma/abuse, regardless of the treatment modality. One way to do this is to use a variety of self-report questionnaires that aim to measure the client's perspective of the therapeutic alliance, such as the Helping Alliance questionnaire developed by Luborsky (1985), as it is highly correlated with the WAI (0.74; Hatcher & Barends, 1996). In addition, to name a few, the California Psychotherapy Alliance Scale (Gaston & Marmar, 1993) depicts the client's assessment of the therapeutic alliance and commitment to the therapeutic process, and the Kim Alliance Scale (Kim et al., 2001) is a 30-item client self-report questionnaire that measures empowerment of the client (responsibility for making life choices), and also includes the same three dimensions as in the WAI (tasks, bond and goals; Bordin, 1979).

Summary. In sum, despite the breadth of information available on the therapeutic alliance, there was a considerable need for additional research on the strength of the therapeutic alliance, rated by the clients utilizing the WAI. This study aimed to shed light on the therapeutic relationship as rated using the WAI by childhood abuse survivors and adult clients who did not report childhood abuse.

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APPENDIX B

IRB Approval Letter

Date: August 23, 2016
Protocol Investigator Name: Nina Polyne
Protocol #: 16-02-197
NOTICE OF APPROVAL FOR HUMAN RESEARCH
Project Title: Exploring the Relationship between Childhood Trauma History and Working Alliance in Psychotherapy
School: Graduate School of Education and Psychology

Dear Nina Polyne:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today August 23, 2016, and expires on August 22, 2017.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond August 22, 2017, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chairperson
cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Regulatory Affairs Specialist

APPENDIX C
Client Consent Form

**Pepperdine University
Counseling and Educational Clinics
Consent for Services**

INITIALS

Welcome to Pepperdine University's Counseling and Educational clinics. Please read this document carefully because it will help you make an informed decision about whether to seek services here. This form explains the kinds of services our clinic provides and the terms and conditions under which services are offered. Because our clinic complies with the Health Insurance Portability and Accountability Act (HIPAA), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

Who We Are: Because the clinic is a teaching facility, graduate students in either the Clinical Psychology Doctorate Program or the Masters in Marriage and Family Therapy Program provide the majority of services. Our graduate student therapists are placed in the clinic for a time-limited training position, which typically lasts 8-12 months. In all cases, all therapists are supervised by a licensed clinical psychologist or a team that includes a licensed mental health professional. The clinic is housed in Pepperdine University and follows the University calendar. As a general rule, the clinic will be closed when the University is not in session. No psychological services will be provided at those times.

- I understand and agree that my services will be provided by an unlicensed graduate student therapist who will be working under the direct supervision of a licensed mental health professional.
- I understand and agree that, as required by law, my therapist may disclose any medical, psychological or personal information concerning me to his/her supervisor(s).
- I confirm that I have been provided with information on how to contact my therapist's supervisor(s) should I wish to discuss any aspects of my treatment.

I understand and agree with the above three statements.

_____

Services: Based on the information you provided in your initial telephone interview, you have been referred to the professional service in our clinic appropriate to your concern. The clinic provides the following professional psychological services:

Psychotherapy: The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be made regarding whether to continue with services at our clinic, or to provide you with a referral to another treatment facility more appropriate to your needs. As part of your services, you will be asked to complete questionnaires during your intake session, at periodic intervals (e.g., every fifth session), and after you have completed treatment. Psychotherapy has both benefits and risks. Risks sometimes include being asked to discuss unpleasant aspects of your life and experiencing uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Sometimes decisions are made in therapy that are positive for one family member and can be viewed negatively by another family member. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. In order for therapy to be effective, a commitment to regular attendance is necessary. Frequent cancellations or missed therapy appointments may result in termination of services or a referral to an alternative treatment setting. Unless otherwise arranged, therapy sessions are scheduled once a week for 50 minutes. Educational Therapy is also offered in some of our clinics. This is an intervention that focuses on learning difficulties

by addressing how circumstances in a person's life contribute to these difficulties. Educational therapy combines tutoring as well as attention to socio-emotional issues that affect learning.

Psychological Assessment: The clinic provides psychological and psycho-educational assessments. These assessments may be initiated by you, your therapist or a third party. Assessment sessions are longer than therapy sessions and can take several hours to complete. The number of sessions required for conducting the assessment will be determined based on the nature and number of tests administered. You have the right to request a copy of your assessment report and test data. You also have the right to receive feedback regarding your assessment results. However, there are some situations in which we may not be able to release test results, including test data, to you: a) When such a disclosure may cause substantial harm or misuse of the test results and test data, and/or b) When you were notified and agreed in advance and in writing that the assessment was ordered and/or paid for by a third party and that we would release your results only to that third party. The benefits of psychological assessment include a clearer understanding of your cognitive and emotional functioning.   Although the risks of participating in a psychological assessment are generally no greater than the risks of counseling, test results may reveal information that may be painful and/or difficult to accept. If that is the case, we recommend that you review with the examiner options for addressing your concerns.

Consent to Video/audio taping and Observations: It is standard procedure at our clinic for sessions to be audio taped and videotaped for training/teaching and/or research purposes. **It should be noted that videotaping for teaching/training purposes is a prerequisite for receiving services at our clinic**. In addition, sessions may be observed by other therapists and/or supervisors at the clinic through the use of a one-way mirror or direct in-session observation.

- For Teaching/Training purposes, check all that apply:
  I understand and agree to   _____

    _____ Video/audio taping
    _____ Direct Observation

Psychological Research: As a university based clinic, we engage in research activities in order to determine the effectiveness of our services, including client satisfaction, as well as to better understand assessment and therapy practices. Participation in research is totally voluntary and means that the forms you complete as a part of your treatment will be placed in a secure research database. Clinic staff will remove any of your identifying information (e.g., name, address, date of birth) from the written materials before they are placed in the database. You may also consent to have your taped sessions included in the research database, and if so these tapes will be used and stored in a confidential manner. Only those professors and graduate students who have received approval from the Clinic Research Committee, and who have signed confidentiality agreements, will be granted access to the database in order to conduct scholarly research. If any information from the database is involved in a published study, results will be discussed in reference to participant groups only, with no personally identifying information released. Your services do not depend on your willingness to have your written and/or taped materials included in our research database. You may also change your mind about participation in the research database at any time. While there is no direct benefit to you to have your materials placed in the database, your participation may provide valuable information to the field of psychology and psychotherapy.

Please choose from the following options (confirm your choice by initialing in the margin).

- I understand and agree that information from my services
  will be included in the Research Database (check all that apply).
    _____ Written Data
    _____ Videotaped Data
    _____ Audiotaped Data

OR

- I <u>do not</u> wish to have my information included in the
  Research Database.   _____

- I understand and agree that I may be contacted in the future
  about the opportunity to participate in other specific research
  programs.   _____

  OR

- I <u>do not</u> wish to be contacted in the future
about the opportunity to participate in other specific research
programs.   _____

Fees: The fee for the initial intake is nonrefundable.
Payment for services is due at the time the services are rendered. You're on
going fee will be based on your income (for minors: the income of your parents) or upon your ability to pay. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24-hour notice of cancellation prior to the appointment time. Please notify us of your cancellation via phone. Please do not use E-mail since we cannot guarantee a secure and confidential correspondence. Failure to pay for services may result in the termination of treatment and/or the use of an outside collection agency to collect fees. In most collection situations, the only information released is your name, the nature of services provided and amount due.
Payment for psychological assessment services: The intake fee is due at the time of the first appointment. Following this appointment, the full cost of the psychological testing will be determined. Payment in full for the psychological testing is required prior to the completion of the testing. Feedback from the testing as well as a test report will be provided after payment has been made in full. Fees for psychological testing cover: initial interview, test administration, scoring and interpretation, oral feedback of test results, and a written test report. Any additional services requested will be billed separately.

After Hours and Emergency Contact: Should you need to reach your therapist during or after business hours you may leave a message on the clinic's voice-mail. The therapist will most likely return your call by the next day. Should you need to contact your therapist for an urgent matter, you may use the clinic's pager number, provided to you, to get in touch with the on-call therapist. Please be aware that the clinic is not equipped to provide emergency psychiatric services. Should you need such services, during and/or after business hours, you will be referred to more comprehensive care centers in the community.

Confidentiality & Records: All communications between you and your therapist are strictly confidential and may not be disclosed to anyone outside the clinic staff without your written authorization. However, there are some situations in which disclosure is permitted or required by law, without your consent or authorization:
- Your therapist may consult with other mental health professionals regarding your case. The consultants are usually affiliated with Pepperdine University. Your therapist may also discuss your case in other teaching activities at Pepperdine, such as class discussions, presentations and exams. Every effort is made to avoid revealing your identity during such teaching activities.
- If the situation involves a serious threat of physical violence against an identifiable victim, your therapist must take protective action, including notifying the potential victim and contacting the police.
- If your therapist suspects the situation presents a substantial risk of physical harm to yourself, others, or property he/she may be obligated to seek hospitalization for you or to contact family members or others who can help.
- If your therapist suspects that a child under the age of 18, an elder, or a dependent adult has been a victim of abuse or neglect, the law requires that he/she file a report with the appropriate protective and/or law enforcement agency.
- If you are involved in a court proceeding and a request is made for information about the services provided to you, the clinic cannot provide any information, including release of your clinical records, without your written authorization, a court order, or a subpoena.
- If you file a complaint or lawsuit against your therapist and/or the clinic, disclosure of relevant information may be necessary as part of a defense strategy.
- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

If such a situation arises, your therapist will make every effort to fully discuss it
with you before taking any action. Disclosure will be limited to what is necessary
for each situation.

Your Records: The clinic keeps your Protected Health Information in your clinical records.   You may examine and/or receive a copy of your records, if you request it in writing, except when: (1) the disclosure would physically or psychologically endanger you and/or others who may or may not be referenced in the records, and/or (2) the disclosure includes confidential information supplied to the clinic by others.

HIPAA provides you with the following rights with regard to your clinical records:

- You can request to amend your records.
- You can request to restrict from your clinical records the information that we can disclose to others.
- You can request an accounting of authorized and unauthorized disclosures we have made of your clinical records.
- You can request that any complaints you make about our policies and procedures be recorded in your records.
- You have the right to a paper copy of this form, the HIPAA notice form, and the clinic's privacy policies and procedures statement.

The clinic staff is happy to discuss your rights with you.

Treatment & Evaluation of Minors:
As an un-emancipated minor (under the age of 18) you can consent to services subject to the involvement of your parents or guardians.

- Over the age of 12, you can consent to services if you are mature enough to participate in services and you present a serious danger to yourself and/or others or you are the alleged victim of child physical and/or sexual abuse. In some circumstances, you may consent to alcohol and drug treatment.
- Your parents or guardians may, by law, have access to your records, unless it is determined by the child's therapist that such access would have a detrimental effect on the therapist's professional relationship with the minor or if it jeopardizes the minor's physical and/or psychological well-being.
- Parents or guardians will be provided with general information about treatment progress (e.g., attendance) and they will be notified if there is any concern that the minor is dangerous to himself and/or others. For minors over the age of 12, other communication will require the minor's authorization.
- All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

My signature or, if applicable, my parent(s) or guardian's signature below certifies that I have read, understood, accepted, and received a copy of this document for my records.   This contract covers the length of time the below named is a client of the clinic.

_____   and/or   _____
Signature of client, 18 or older   Signature of parent or guardian
(Or name of client, if a minor)

                                                                   _____
                                                                   Relationship to client

                                                                   _____
                                                                   Signature of parent or guardian

_____
Relationship to client

_____ please check here if client is a minor. The minor's parent or guardian must sign unless the minor can legally consent on his/her own behalf.

_____   _____
Clinic/Counseling Center   Translator
Representative/Witness

_____
Date of signing

APPENDIX D

Therapist Consent Form

**INFORMED CONSENT FOR THERAPIST PARTICIPATION
IN PEPPERDINE CLINICS RESEARCH DATABASE PROJECT**

1. *I, _____ , agree to participate in the research database
    project being conducted under the direction of Drs. Eldridge, Ellis, and Hall, in collaboration
    with the clinic directors. I understand that while the study will be under the supervision of
    these Pepperdine GSEP faculty members, other personnel who work with them may be
    designated to assist or act in their behalf. I understand that my participation in this research
    database is strictly voluntary.*

2. *One purpose of research at the Pepperdine University GSEP Clinics and Counseling Centers is
    to examine the effectiveness of new clinic policies and procedures that are being
    implemented. This is being done through standard internal clinic practices (headed by the
    clinic directors and the Clinic Advancement and Research Committee) as well as through the
    construction of a separate research database (headed by Drs. Eldridge, Ellis, and Hall).
    Another purpose of this research project is to create a secure database from which to
    conduct research projects by the faculty members and their students on other topics
    relevant to clinical practice.*

3. *I have been asked to participate in the research database project because I am a student
    therapist or intern at a GSEP Clinic or Counseling Center. Because I will be implementing the
    new clinic policies and procedures with my clients, my input (or participation) will provide
    valuable data for the research database.*

My participation in the research database project can involve two different options at this
point. I can choose to participate in any or neither of these options by initialing my consent
below each description of the options.

First, my participation in the research database project will involve being asked, from time to
time, to fill out questionnaires about my knowledge, perceptions and reactions to clinic
trainings, policies and procedures. In addition, my participation involves allowing
questionnaires that I complete about my clients (e.g., treatment alliance) and/or tapes from my
sessions with clients to be placed into the database.

Please choose from the following options by placing your initials on the lines.

- I understand and agree that the following information will be included in
  the Research Database (check all that apply).
  _____ Written questionnaires about my knowledge, perceptions
  and reactions to clinic trainings, policies and procedures

    _____ Written Data about My Clients (e.g., Therapist Working Alliance Form)

    _____ Video Data of sessions with my clients (i.e., DVD of sessions)

    _____ Audio Data of sessions with my clients (i.e., CD or cassette tapes of sessions)

OR

- I <u>do not</u> wish to have <u>any/all</u> of the above information included in the Research Database.

   _____

<u>Please choose from the following options by placing your initials on the lines.</u>

- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

   _____

OR

- I <u>do not</u> wish to be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

   _____

4. *My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.*

5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.

6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.

7. I understand that I may choose not to participate in the research database project.

8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also

understand that there might be times that the investigators may find it necessary to end my study participation (e.g., if my client withdraws consent for participation in the research study).

9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.

10. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that information I have provided regarding provision of clinical services to my clients, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.

11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.

12. I understand I will receive no compensation, financial or otherwise, for participating in study.

13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Mesha Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.

14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.

15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a

copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

_____ _____
Participant's signature   Date

_____
Participant's name (printed)

I have explained and defined in detail the research procedure in which the participant has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

_____ _____
Researcher/Assistant signature   Date

_____
Researcher/Assistant name (printed)

APPENDIX E

Client Information Adult Form

ID # _____

CLIENT INFORMATION **ADULT FORM

THIS FORM IS INTENDED TO SAVE YOU AND YOUR INTAKE INTERVIEWER TIME AND IS IN THE INTEREST OF PROVIDING YOU WITH THE BEST SERVICE POSSIBLE. ALL INFORMATION ON THIS FORM IS CONSIDERED CONFIDENTIAL. IF YOU DO NOT WISH TO ANSWER A QUESTION, PLEASE WRITE "DO NOT CARE TO ANSWER" AFTER THE QUESTION.

TODAY'S DATE_____

FULL NAME_____

HOW WOULD YOU PREFER TO BE ADDRESSED?_____

REFERRED BY:_____

      MAY WE CONTACT THIS REFERRAL SOURCE TO THANK THEM FOR THE REFERRAL? ☐ YES   ☐ NO

      IF YES, PLEASE PROVIDE CONTACT INFORMATION FOR THIS PERSON/AGENCY

_____

_____

Personal Data

ADDRESS:_____

      _____

TELEPHONE	(HOME):	_____	BEST TIME TO CALL:	_____	CAN WE LEAVE A MESSAGE ?	☐ Y ☐ N
	(WORK):	_____	BEST TIME TO CALL:	_____	CAN WE LEAVE A MESSAGE ?	☐ Y ☐ N

AGE: _____   DATE OF BIRTH   ____/___/_____

MARITAL STATUS:

☐ MARRIED   ☐ SINGLE   HOW LONG?   _____

☐ DIVORCED   ☐ COHABITATING   PREVIOUS MARRIAGES?   _____

☐ SEPARATED   ☐ WIDOWED   HOW LONG SINCE DIVORCE?   _____

LIST BELOW THE PEOPLE LIVING WITH YOU:

NAME	RELATIONSHIP	AGE	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE: _____

RELATIONSHIP TO YOU: _____

Medical History

CURRENT PHYSICIAN: _____

ADDRESS: _____

CURRENT MEDICAL PROBLEMS: _____

_____

MEDICATIONS BEING TAKEN: _____

_____

PREVIOUS HOSPITALIZATIONS (MEDICAL OR PSYCHIATRIC)

DATE

_____

_____

_____

OTHER SERIOUS ILLNESSES

DATE

_____

_____

_____

_____

PREVIOUS HISTORY OF MENTAL HEALTH CARE (PSYCHOLOGIST, PSYCHIATRIST, MARRIAGE COUNSELING, GROUP THERAPY, ETC.)

DATE

_____

_____

_____

Educational and Occupational History

HIGHEST LEVEL OF EDUCATION ATTAINED:

☐ ELEMENTARY/MIDDLE SCHOOL: LIST GRADE_____

☐ HIGH SCHOOL: LIST GRADE_____

☐ GED

☐ VOCATIONAL TRAINING: LIST TRADE_____

☐ COLLEGE: LIST YEARS_____

☐ GRADUATE EDUCATION: LIST YEARS OR DEGREE EARNED_____

☐ HS DIPLOMA

☐ CURRENTLY IN SCHOOL? SCHOOL/LOCATION:

_____

CURRENT AND PREVIOUS JOBS:

JOB TITLE	EMPLOYER NAME & CITY	DATES/DURATION

HOUSEHOLD INCOME:

☐ UNDER $10,000

☐ $11,000-30,000   OCCUPATION:_____

☐ $31,000-50,000

☐ $51,000-75,000

☐ OVER $75,000

Family Data

IS FATHER LIVING?

YES ☐   IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____   OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

NO ☐

IF NOT LIVING, HIS AGE AT DEATH: _____   YOUR AGE AT HIS DEATH: _____

CAUSE OF DEATH: _____

IS MOTHER LIVING?

YES ☐   IF YES, CURRENT AGE: _____

RESIDENCE (CITY): _____   OCCUPATION: _____

HOW OFTEN DO YOU HAVE CONTACT? _____

NO ☐

IF NOT LIVING, HER AGE AT DEATH: _____   YOUR AGE AT HER DEATH: _____

CAUSE OF DEATH: _____

BROTHERS AND SISTERS

NAME	AGE	OCCUPATION	RESIDENCE	CONTACT HOW OFTEN?

LIST ANY OTHER PEOPLE YOU LIVED WITH FOR A SIGNIFICANT PERIOD DURING CHILDHOOD.

NAME	RELATIONSHIP TO YOU	STILL IN CONTACT?
_____	_____	_____
_____	_____	_____

THE FOLLOWING SECTION WILL HELP US UNDERSTAND YOUR NEEDS AND FACTORS THAT MAY IMPACT YOUR LIFE OR TREATMENT. BELOW IS A LIST OF EXPERIENCES WHICH MAY OCCUR IN FAMILIES. PLEASE READ EACH EXPERIENCE CAREFULLY. PLEASE INDICATE WHETHER ANY OF THESE EXPERIENCES HAVE HAPPENED TO YOU OR YOUR FAMILY. SOME OF THESE MAY HAVE BEEN TRUE AT ONE POINT FOR YOU OR IN YOUR FAMILY BUT NOT TRUE AT ANOITHER POINT. IF THE EXPERIENCE NEVER HAPPENED TO YOU OR SOMEONE IN YOUR FAMILY, PLEASE CHECK THE "NO" BOX. IF YOU ARE UNSURE WHETHER OR NOT THE EXPERIENCE OCCURRED FOR YOU OR IN YOUR FAMILY AT SOME TIME, PLEASE CHECK THE "UNSURE" BOX. IF THE EXPERIENCE HAPPENED TO YOU OR IN YOUR FAMILY AT ANY POINT, PLEASE CHECK THE "YES" BOX.

	SELF			FAMILY			
WHICH OF THE FOLLOWINIG HAVE FAMILY MEMBERS, *INCLUDING YOURSELF*, STRUGGLED WITH:	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	NO- NEVER HAPPENED	UNSURE	YES- THIS HAPPENED	PLEASE INDICATE WHICH FAMILY MEMBER(S)
SEPARATION/DIVORCE	☐	☐	☐	☐	☐	☐	_____
FREQUENT RE-LOCATION	☐	☐	☐	☐	☐	☐	_____
EXTENDED UNEMPLOYMENT	☐	☐	☐	☐	☐	☐	_____
ADOPTION	☐	☐	☐	☐	☐	☐	_____
FOSTER CARE	☐	☐	☐	☐	☐	☐	_____
MISCARRIAGE OR FERTILITY DIFFICULTIES	☐	☐	☐	☐	☐	☐	_____
FINANCIAL STRAIN OR INSTABILITY	☐	☐	☐	☐	☐	☐	_____
INADEQUATE ACCESS TO HEALTHCARE OR OTHER SERVICES	☐	☐	☐	☐	☐	☐	_____
DISCRIMINATION (INSULTS, HATE CRIMES, ETC.)	☐	☐	☐	☐	☐	☐	_____
DEATH AND LOSS	☐	☐	☐	☐	☐	☐	_____
ALCOHOL USE OR ABUSE	☐	☐	☐	☐	☐	☐	_____
DRUG USE OR ABUSE	☐	☐	☐	☐	☐	☐	_____
ADDICTIONS	☐	☐	☐	☐	☐	☐	_____
SEXUAL ABUSE	☐	☐	☐	☐	☐	☐	_____
PHYSICAL ABUSE	☐	☐	☐	☐	☐	☐	_____
EMOTIONAL ABUSE	☐	☐	☐	☐	☐	☐	_____
RAPE/SEXUAL ASSAULT	☐	☐	☐	☐	☐	☐	_____
HOSPITALIZATION FOR MEDICAL PROBLEMS	☐	☐	☐	☐	☐	☐	_____
HOSPITALIZATION FOR EMOTIONAL/PSYCHIATRIC PROBLEMS	☐	☐	☐	☐	☐	☐	
DIAGNOSED OR SUSPECTED MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	_____

SUICIDAL THOUGHTS OR ATTEMPTS	☐	☐	☐	☐	☐	☐	_____
SELF HARM (CUTTING, BURNING)	☐	☐	☐	☐	☐	☐	_____
DEBILITATING ILLNESS, INJURY, OR DISABILITY	☐	☐	☐	☐	☐	☐	_____
PROBLEMS WITH LEARNING	☐	☐	☐	☐	☐	☐	_____
ACADEMIC PROBLEMS (DROP-OUT, TRUANCY)	☐	☐	☐	☐	☐	☐	_____
FREQUENT FIGHTS AND ARGUMENTS	☐	☐	☐	☐	☐	☐	_____
INVOLVEMENT IN LEGAL SYSTEM	☐	☐	☐	☐	☐	☐	_____
CRIMINAL ACTIVITY	☐	☐	☐	☐	☐	☐	_____
INCARCERATION	☐	☐	☐	☐	☐	☐	_____

Current Difficulties

PLEASE CHECK THE BOXES TO INDICATE WHICH OF THE FOLLOWING AREAS ARE CURRENT PROBLEMS FOR YOU AND REASONS FOR COUNSELING. PLACE <u>TWO</u> CHECK MARKS TO INDICATE THE MOST IMPORTANT REASON(S).

☐	FEELING NERVOUS OR ANXIOUS	☐	DIFFICULTY WITH SCHOOL OR WORK
☐	UNDER PRESSURE & FEELING STRESSED	☐	CONCERNS ABOUT FINANCES
☐	NEEDING TO LEARN TO RELAX	☐	TROUBLE COMMUNICATING SOMETIMES
☐	AFRAID OF BEING ON YOUR OWN	☐	CONCERNS WITH WEIGHT OR BODY IMAGE
☐	FEELING ANGRY MUCH OF THE TIME	☐	FEELING PRESSURED BY OTHERS
☐	DIFFICULTY EXPRESSING EMOTIONS	☐	FEELING CONTROLLED/MANIPULATED
☐	FEELING INFERIOR TO OTHERS	☐	PRE-MARITAL COUNSELING
☐	LACKING SELF CONFIDENCE	☐	MARITAL PROBLEMS
☐	FEELING DOWN OR UNHAPPY	☐	FAMILY DIFFICULTIES
☐	FEELING LONELY	☐	DIFFICULTIES WITH CHILDREN
☐	EXPERIENCING GUILTY FEELINGS	☐	DIFFICULTY MAKING OR KEEPING FRIENDS
☐	FEELING DOWN ON YOURSELF	☐	BREAK-UP OF RELATIONSHIP
☐	THOUGHTS OF TAKING OWN LIFE	☐	DIFFICULTIES IN SEXUAL RELATIONSHIPS
☐	CONCERNS ABOUT EMOTIONAL STABILITY	☐	FEELING GUILTY ABOUT SEXUAL ACTIVITY
☐	FEELING CUT-OFF FROM YOUR EMOTIONS	☐	FEELING CONFLICTED ABOUT ATTRACTION TO MEMBERS OF SAME SEX
☐	WONDERING "WHO AM I?"	☐	FEELINGS RELATED TO HAVING BEEN ABUSED OR ASSAULTED
☐	HAVING DIFFICULTY BEING HONEST/OPEN	☐	CONCERNS ABOUT PHYSICAL HEALTH
☐	DIFFICULTY MAKING DECISIONS	☐	DIFFICULTIES WITH WEIGHT CONTROL
☐	FEELING CONFUSED MUCH OF THE TIME	☐	USE/ABUSE OF ALCOHOL OR DRUGS
☐	DIFFICULTY CONTROLLING YOUR THOUGHTS	☐	PROBLEMS ASSOCIATED WITH SEXUAL ORIENTATION
☐	BEING SUSPICIOUS OF OTHERS	☐	CONCERNS ABOUT HEARING VOICES OR SEEING THINGS
☐	GETTING INTO TROUBLE		

ADDITIONAL CONCERNS (IF NOT COVERED ABOVE):

_____

Social/Cultural (Optional)

1. RELIGION/SPIRITUALITY: _____

2. ETHNICITY OR RACE: _____

3. DISABILITY STATUS? _____

APPENDIX F

Intake Evaluation Summary

Pepperdine Psychological and Educational Clinic

Intake Evaluation Summary

Client: _____ Intake Therapist:_____

Intake Date(s):_____ Date of Report:_____

I   Identifying Information
(Name, age/D.O.B., gender, marital status, # of children, occupation/employment status, education, ethnicity, and current living arrangements)

II   Presenting Problem/Current Condition
(Description of client's current difficulties, and why s/he is seeking help at this time; describe symptoms and impact on current functioning, including onset, frequency and duration)

III   History of the Presenting Problem & History of Other Psychological Issues
(Trace development of present problem, including previous psychological treatment, hospitalizations, medication; discuss other significant psychological difficulties and prior treatment. Address history of substance abuse, suicidal ideation/attempts, & aggressive/violent behavior)

IV   Psychosocial History
      A   Family History
      (Family constellation, family of origin and current family, family dynamics, domestic violence/abuse; Include family psychiatric, medical and substance abuse history)

      B   Developmental History
      (Note progression of development milestones, as well as particular strengths or areas of difficulty)

      C   Educational/Vocational History
      (Highest grade completed, strengths/weaknesses, learning issues/interventions; Work history, including any work related difficulties)

      D   Social Support/Relationships
      (Current social support network; Intimate relationships and their history, especially as related to presenting problem)

E   Medical History
(When was client last seen by a doctor? Describe current/past medical conditions, injuries, medications, procedures/surgeries)

F   Cultural Factors and Role of Religion in the Client's Life
(Cultural group identification/identity, acculturation issues relevant to presenting problems/therapy)
(Religious affiliations, strength of commitment to and/or involvement in religion, view of spirituality and its role in emotional problems/suffering and intervention)

G   Legal History
(Arrests, incarcerations, parole/probation, current lawsuits, child custody. Is the client court ordered into therapy?)

V   Mental Status Evaluation

Hygiene & grooming:

Interpersonal presentation/behavioral observations:

Orientation (person, place, time, situation):

Speech (pitch, pace, tone):

Motor Activity (calm, restless, agitated, retarded):

Mood (euthymic, dysphoric, elevated, irritable, anxious):

Affect (appropriate/inappropriate to mood, labile, expansive, blunted, flat):

Thought Process (associations may be logical, tight & coherent, or loose & tangential):

Thought Content (appropriate; delusions; odd ideations):

Perceptual Disturbances (hallucinations):

Cognitive Functioning (intellectual functioning, fund of knowledge):

Concentration, Attention & Memory:

Judgment & Insight (intact, good, fair or poor/impaired):

VI   Client Strengths
(Intelligence, personality, internal resources, coping skills, support system, talents and abilities, motivation, education/vocational skills, health)

VII   Summary and Conceptualization
(Summarize your understanding of the client's central issues/symptoms, how these developed, and factors that maintain them. Present differential diagnosis, with justification for diagnosis given):

VIII   DSM-IV TR Multiaxial Diagnosis

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Global Assessment of Functioning (GAF) Scale:
         Current GAF:
         Highest GAF during the past year:

IX   Client Goals

X   Treatment Recommendations
Be as specific as possible. Note: suggested therapy modalities and frequency of contact, issues to be addressed, adjunctive services such as psychological testing or medication evaluation. Recommendations should be connected to presenting problem and diagnoses.

_____   _____
Intake Therapist   Supervisor

_____
Date

APPENDIX G

Treatment Summary

TREATMENT SUMMARY

Identifying Information:

_____
_____
_____

Treatment Information (*date of initial evaluation, number of sessions, treatment modality [e.g., individual or conjoint], date of termination*):

_____
_____
_____
_____

Course of Treatment (*conceptualization of client's difficulties, therapy orientation, client's response to treatment, emergency/crisis issues. Be sure to connect this with the client's presenting problem, nature of therapeutic relationship, etc*):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Revised 4-15-2009

Diagnosis at Termination:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____
_____

Disposition (*state whether the case has been transferred or terminated, and give reasons why*):

_____
_____
_____
_____
_____
_____
_____

Recommendations for Follow-Up (*if the case is being transferred, list specific treatment recommendations for the next therapist, including what worked and did not work with the client(s).*):

_____
_____
_____
_____
_____
_____
_____
_____

Student Therapist _____   **Supervisor** _____

Date _____   **Date** _____

Revised 4-15-2009

APPENDIX H

Research Assistant Instructions for Participant Selection Criteria

Measure Identification-Study 1

1. Open hard copy research file and search it for a completed URICA and completed MSPSS at the **point of intake**. A completed assessment requires that there are no blank questions, and that each question has an appropriate answer. For example, sometimes potential participants will circle 2 answers for a question if they are unsure. This makes the measure invalid for the study, and their chart will not be able to be used.

2. Once appropriate assessment measure is identified, score the measure. Scoring procedures are found in the PARC resources binder in the locked research cabinet.

3. Record the Readiness to Change score for the URICA and Total Mean score for the MSPSS in the "PARC Trauma database" excel file for each of these selected research participants.

Measure Identification-Study 2:

1. Open hard copy research file and identify if it contains a WAI client form completed within sessions 3-7. A completed assessment requires that there are no blank questions, and that each question has an appropriate answer (i.e., only one selection circled per question). As mentioned in Study 1, circling more than one response for each question, or if the participant fails to circle a response for an item, the measure becomes invalid for the study, and the particular participant's chart will not utilized for the proposed study.

2. Score the WAI. Scoring procedures are found in the PARC resources binder in the locked research cabinet.

3. Record the WAI score in the "PARC Trauma Database" excel file.

4. Next, record/enter demographic information in the database for each research file:
    a. Under the "Age" column, enter the age of the client at the time of intake.

    b. Under the "Education" column, enter the number of years the client attended a formal education (e.g., a high school diploma would equal 12 years of education).

    c. Under the "Gender" column, enter "1" for Male, "2" for Female, or "3" for Other.

    d. Under the "Ethnicity" column, enter:

        i.   Middle Eastern / Middle Eastern American=1

      ii.   Asian / Asian American=2

      iii.   African American=3

      iv.   Caucasian=4

      v.   Latino/Latina=5

      vi.   Native American=6

      vii.   Other = 7

            i. Note: If coded as "Other", please note/list the specific ethnicity or ethnicities in the "Other Ethnicity Notes" column.

      viii.   Alaskan native=8

      ix.   Pacific Islander=9

<u>Trauma Identification</u>

1. Open "PARC Trauma Database" excel file that contains all of the research file numbers and completed study measure data. Of note, the "PARC Trauma Database" will contain and identify participants that did not report a history of abuse, those that endorsed a history of abuse or assault in adulthood, and also those that endorsed a history of abuse in childhood.
2. For each research file number that you are looking at, locate the hard copy research file. Specifically, please follow the numerical order of the files so that each file is evaluated for its potential study group (trauma vs. non-trauma).
3. In the redacted hard copy research file, locate the Pepperdine clinic intake packet
4. Find the Client Information Adult Form. Flip to page four where clients check off whether they personally experienced any abuse or assault (has columns of check boxes).
5. Check to see if any of the following boxes were marked off: Physical abuse, Emotional Abuse, Verbal Abuse, Rape/Sexual Assault.
6. Note abuse or assault information in the excel document under the "Trauma" column:
   - PA- Physical Abuse
   - EA- Emotional Abuse
   - SA- Sexual Abuse
   - RSA - Rape/Sexual Assault
   - VA- Verbal Abuse
   - V- Victim
   - P- Perpetrator

       o EXAMPLE: Client was the victim of physical &
        emotional abuse ->
         PA, EA, V
     • If no abuse or assault is indicated, simply write "no" in the
      "Trauma" column

7. Locate the Intake Evaluation Report, Telephone Intake Summary and the Treatment Summary Form in the research file.
8. If the client did not report being a survivor/victim or perpetrator of abuse or assault in the demographic form but there is an indication of it in the Intake Evaluation Report and/or the Telephone Intake Summary or the Treatment Summary Form, then include those cases in the "trauma column."

9. **Timing.** For the cases in which there has been an indication of abuse or assault, read through the Intake Evaluation Report, Telephone Intake Summary, or the Treatment Summary Form to see WHEN the abuse / assault was reported to have taken place (childhood, adulthood, etc.).

   Document the timing of abuse / assault using the following 4 categories in the "Trauma Timing" column:
   a. If the client indicated that all abuse or assault occurred during childhood ONLY (defined as occurring up until age 18), write "Child."
   b. If all the abuse / assault occurred at any time outside of childhood (18 and over) write "Adult".
   c. If abuse / assault was reported to have occurred during both childhood and adulthood, then write "Both."
   d. If no specific information is given, write "Unknown."

Thus, for example, if the client experienced emotional abuse in childhood, the "Trauma" column would read "EA, V", and the "Trauma Timing" column would state, "Child." Additionally, if the client experienced physical abuse in adulthood, the "Trauma" column would read "PA, V", and the "Trauma Timing" column would be marked as "Adult."

10. **Frequency**. If the information is available, document the amount of times the abuse/assault was said to have happened using the following categories. Indicate if frequency is unknown or unspecified ("unknown"). Only input 0 if this amount was clearly indicated in the research file.

  a. **Overall total frequency**. Tally the total number of times abuse/assault was said to have happened across the lifetime (combining childhood and adulthood) in the "Total Frequency" category. If unknown, enter "unknown." Note that the total number may underestimate the actual numbers experienced by the client, and may not match the more specific categories below, given variance often found in reports or discussions of abuse and assault.

    b. **Childhood frequency.** If the client endorsed a history of abuse or assault in childhood, count how many times these experiences or incidents happened or were reported, and enter that number (or "unknown") under the columns "Childhood Abuse Total Frequency", and the columns representing the specific abuse/assault types abuse: Childhood Frequency SA, Childhood Frequency RSA, Childhood Frequency PA, Childhood Frequency EA, and Childhood Frequency VA.

    For example, if the client reported experiencing emotional abuse twice in childhood, the RA should mark "2" under "Childhood Frequency EA."

    c. **Adulthood frequency.** Similarly, if the client endorsed a history of abuse or assault in adulthood, count how many times these experiences or incidents happened or were reported, and enter that number (or "unknown") under the columns "Adulthood Abuse Total Frequency", and the columns representing the specific types of abuse/assault abuse: Adulthood Frequency SA, Adulthood Frequency RSA, Adulthood Frequency PA, Adulthood Frequency EA, and Adulthood Frequency VA.

11. Carefully review how you have documented all indications and reports of abuse accurately, and then re-file the research file in numerical order by research code.
12. Repeat for next research file.