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Therapeutic Alliance, Interpersonal Relations, and Trauma Symptoms: Examining a Mediation Model of Women With Childhood Abuse Histories

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ABSTRACT

The current study explored the dimensions of the early therapeutic alliance (tasks, goals, bonds, and other-therapist [people important to clients who support their involvement in therapy]) as mediators between clients' interpersonal relations problems and outcome measures of trauma symptoms (dissociation and total trauma symptoms). Seventy-six female participants who were receiving treatment for posttraumatic stress due to child abuse (CA), were recruited from a university training clinic. The bond and other subscales mediated the association between interpersonal relations problems and dissociation. The element of client trust associated with the alliance bond, as well as clients' sense that people who are important to them support their involvement in therapy, should be focal in treating CA survivors. Clinical implications revolve around developing, maintaining, and repairing the therapeutic relationship, especially the bond, within the context of dissociation, as well as exploring clients' views of important others and its impact on their therapy.

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The therapeutic alliance is a significant common factor that consistently predicts therapy outcome across studies, populations, and specific treatment orientations (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Martin, Garske, & Davis, 2000). Adults with child abuse (CA) histories often struggle forming a therapeutic alliance due to problems in interpersonal relations resulting from early violations of trust, security, and protection from harm (Courtois & Ford, 2013; Keller, Zoellner, & Feeny, 2010). Nevertheless, studies have noted the important relationship between a strong therapeutic alliance and treatment success with adult survivors of CA (Cloitre, Koenan, Cohen, & Han, 2002; Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004). Conversely, chronic CA and a poor alliance are associated with poor treatment outcome for survivors of childhood abuse (Cloitre, Cohen, & Scarvalone, 2002; Eltz, Shirk, & Sarlin, 1994). While often difficult, research points to adult survivor's ability to form and maintain a strong

therapeutic alliance during the course of treatment, even in cases of multiple and severe types of child abuse (Cronin, Brand, & Mattanah, 2014).

As noted, the alliance has proven to be consistent and durable across studies of general populations (Barber et al., 2009; Martin et al., 2000) and to a lesser degree with trauma populations (Cloitre, Koenan, Cohen, & Han, 2002). Consequently, many trauma scholars have suggested the need to examine more complex associations between the alliance and other variables related to CA (Cloitre et al., 2004; Pearlman & Courtois, 2005). One such variable is clients' intimate relationships with friends, family, and romantic partners. Although relational support is important for recovery from CA (Brewin, Andrews, & Valentine, 2000), survivors' significant interpersonal problems (Zlotnick, Zakriski, Shea, & Costello, 1996) make it difficult for them to form a strong therapeutic relationship (Keller et al., 2010). A better understanding of these relationship processes would allow for a more efficient focus on elements of therapy that are important for change. Kazdin (2008) suggests that an understanding of underlying therapy processes might be "the best long-term investment for improving clinical practice and patient care" (p. 151). As such, the goal of the current study is to explore the dimensions of the early therapeutic alliance (tasks, goals, bonds, and other [people important to clients who support their involvement in therapy]) as mediators between clients' interpersonal relations and outcome measures of dissociation and general trauma symptoms. Though the alliance and interpersonal relations are related to CA symptoms, their simultaneous inclusion in predicting CA symptoms has not been examined. A better understanding of the relationship between these variables is critical to understanding the impact of client histories and change process with CA survivors (Cloitre et al., 2004; Keller et al., 2010).

Interpersonal relationships and the therapeutic alliance

Survivors of CA often experience multiple types of abuse. The National Survey of Children's Exposure to Violence found that 66% had experienced multiple types of abuse, 30% experienced five or more types, and 10% experienced 11 or more types across their lifetimes (Turner, Finkelhor, & Ormrod, 2010). In the majority of these cases, the abuse was interpersonal with caregivers being the primary perpetrators. A history of chronic and multiple types of abuse is associated with interpersonal difficulties largely based on pervasive mistrust of people (Cloitre et al., 2009; Duckworth & Follette, 2012). Thus, it is of little surprise that in a survey of CA survivors Cloitre, Miranda, Stovall-McClough, and Han (2005) found that the most common reason for seeking therapy was interpersonal problems (67%) followed by posttraumatic stress disorder (PTSD) symptoms (59%) and emotional regulation problems (37%). Further, women who had experienced CA reported viewing people as hostile and controlling, and subsequently

generalized this view to current relationships, even when other's behavior were expected to be warm and inviting (Cloitre, Cohen, et al., 2002). Additional studies indicate that compared to women who had experienced abuse as adults, CA survivors reported significantly more interpersonal difficulties across social domains (Zlotnick et al., 1996) and when compared to non-abused women, survivors reported more problems being too submissive or too controlling, and have greater difficulty being assertive (Cloitre & Koenen, 2001). Finally, a meta-analysis indicated that lack of supportive relationships is one of the strongest predictors for the development of PTSD (e.g., Brewin et al., 2000). Unfortunately, for many clients with CA backgrounds, to trust often has meant to be abused (Gobin & Freyd, 2009).

Consequently, establishing a therapeutic alliance is often challenging due in part to preexisting histories of significant interpersonal relations problems frequently manifested through client anger, general emotion dysregulation, and mistrust of the therapist (Cloitre et al., 2004; Dalenberg, 2004). Evidence indicates that higher levels of supportive interpersonal relations and less conflicted relationships are related to a strong therapeutic alliance during treatment of substance disorders (Connors et al., 2000) and bipolar disorders (Strauss & Johnson, 2006). However, only one such study has been conducted with CA survivors. Keller et al. (2010) found that less conflicted and more supportive interpersonal relations were associated with a strong early alliance but not history of CA. Further, for women being treated for PTSD due to CA, the strength of the therapeutic alliance early in treatment predicted reduction of PTSD symptoms in the later stage of treatment (Cloitre et al., 2002). Thus, a better understanding of the relationship between clients' interpersonal relations and the therapeutic alliance is critical for continued improvement in the treatment of CA survivors.

Dissociation and the therapeutic alliance

Dissociation denotes "a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, perception, body representation, motor control, and behavior" (APA, 2013, p. 291), with more severe forms strongly associated with CA (Kluft & Loewenstein, 2007). Frequent symptoms associated with dissociative disorders include depression, PTSD, eating disorders, personality disorders, substance abuse, suicidality, and self-destructiveness (Foote, Smolin, Neft, & Lipschitz, 2008; Johnson, Cohen, Kasen, & Brook, 2006). Clients who experience recurring dissociative symptoms present a host of challenges, including: polysymptoms (Bradley, Greene, Russ, Dutra, & Westen, 2005); dysregulated negative emotions (Cloitre et al., 2004); need for long-term treatment (Mansfield et al., 2010); suboptimal responsiveness to exposure therapy (Kleindienst et al., 2011); high rates of mental health service utilization (Mansfield et al., 2010); and high dropout rates (Tamar-Gurol, Sar, Karadag, Evren, & Karagoz, 2008). Further,

symptom severity is related to age onset of trauma exposure and a dose-response association with earlier onset, more types of abuse, and greater frequency associated with more severe impairment throughout life (Anda & Brown, 2010). For example, the combination of early-disorganized attachment due to invalidating responses from caregivers and CA predict dissociative disorders in adulthood (Stroufe, Egeland, Carlson, & Collins, 2005).

Some trauma scholars have noted that dissociation creates challenges for developing a therapeutic alliance (Dalenberg, 2000; Herman, 1992). Paradoxically, attempts by therapists to establish a safe and trusting relationship may trigger client defenses associated with previous relationship abuse experiences, one of which is dissociation (Pearlman & Courtois, 2005). Pearlman and Courtois (2005) hold that dissociation responses are activated by strong negative emotions such as fear, shame, and rejection, associated with early abusive attachment relationships. Abused children often use dissociative coping styles, which often continue into adulthood (Muller, Sicoli, & Lemieux, 2000), to manage the abuse. Dissociative coping styles may then become the default response when threat is perceived (Brand, Warner, & Alexander, 1997). With respect to treatment, Gedo (2014) notes that dissociation disrupts the connection between the client and therapist, as well as disrupts the client's connection with their inner experience. This may be due in part to an orientation toward avoidance rather than remaining interpersonally engaged when distressed (Marshall et al., 2000). Conversely, a higher client rated therapeutic alliance is associated with fewer dissociative symptoms (Cronin et al., 2014).

Rationale for present study

To date, only one study has examined the relation between the therapeutic alliance and dissociation and other posttraumatic symptoms with dissociative disorder clients. In a longitudinal, naturalistic study of dissociative disordered clients with child abuse histories ($n = 132$), Cronin et al. (2014) examined if the therapeutic alliance predicted various treatment outcomes, including dissociation. Clients were assessed four times (Time 1 through Time 4), but only Times 3 (18 months) and 4 (30-month follow-up) were used because the alliance measure was not employed until the last two measurement times. Clients with higher self-rated alliances reported fewer dissociation symptoms, PTSD symptoms, and general distress symptoms.

The Cronin et al. study was an important one, as it initiated a new line of research concerning the alliance and serious trauma symptoms, especially dissociation. However, several weaknesses were noted. The authors suggested that future research should investigate the relationship of the alliance with outcome measures from the beginning of treatment, as well as examine additional variables related to outcomes with complex trauma clients.

In an effort to extend the Cronin study, the current study collected alliance data from the third or fourth session (Martin et al., 2000). Further, as suggested by Keller et al., the current study employed a measure of interpersonal relations problems due to its relationship to the early alliance. This additional variable will expand understanding of clients' relationship context and its influence on outcome trauma symptoms of adults with CA histories, and thus increase relevant treatment targets.

Further, to our knowledge, no study has examined the therapeutic alliance as a mediator between clients' interpersonal relations and outcome trauma symptoms (dissociation and total trauma symptoms) with a CA sample. Mediation models permit the assessment of whether a third intervening variable accounts for the relationship between an independent and dependent variable (Hayes, 2013). Such an analysis provides a more fine-grain understanding of the relationship between a set of variables that more closely approximate real life situations (Hayes, 2013). Further, multiple mediation models extend the simple mediation models and concurrently assess whether or not multiple intervening variables could account for a relationship between an independent and dependent variable, and which of the mediators exerts the most influence (Hayes, 2013).

Finally, previous studies have employed only the total score for the therapeutic alliance (combination of goals, tasks, and bond scores; e.g., Cloitre et al., 2004; Cronin et al., 2014; Keller et al., 2010), and thus, these studies have not focused on the alliance dimension most relevant to trust for the therapist, the alliance bond. The bond has particular relevance to CA survivors, as it assesses the quality of the client-therapist relationship, including the client's feeling that they are cared for and accepted by the therapist, and the degree to which the client cares about and trusts the therapist (Bordin, 1979). A violation of trust often is a primary theme with clients who experienced CA (Courtois & Ford, 2013; Gobin & Freyd, 2009). It is particularly problematic if client mistrust and perceived threat are triggered by therapeutic material and/or interaction with the therapist, which in turn activates some degree of client dissociation (Briere & Jordan, 2009). Further, the study included an alliance subscale, *other-therapist*, that explores how the client perceives the alliance between his or her "relevant other(s)" and the therapist (e.g., "the people who are important to me would feel accepted by the therapist"; Pinsof, Zinbarg, & Knobloch-Fedders, 2008).

The other-therapist dimension addresses the client system that includes the influence of important people in the client's life, whether or not these people are directly involved in the therapy. Further, it assumes that people in the client's life influence the therapy change process. Thus, the other-therapist scale places individual therapy in a systemic context and, therefore, considers the therapist-client relationship as a part of the client's important larger relational system (Pinsoff et al., 2008). Research suggests that

improvement in individual therapy is associated with clients' belief that significant people in their lives support their involvement in therapy. The other-therapist dimension is associated with client improvement in individual therapy (Pinsof et al., 2008). To date, the other-therapist variable has not been examined with CA clients.

The primary goal of the current study was to test a mediation model in which the dimensions of the therapeutic alliance (tasks, goals, bonds, other) are mediators between clients' interpersonal relations problems and outcome measures of dissociation and total trauma symptoms. The importance of the alliance is consistent with earlier research linking the alliance with dissociation and other trauma symptom outcome measures (Cronin et al., 2014) and the positive association between interpersonal relations and the early alliance (Keller et al., 2010). Therefore, this study examined several relationships between the variables. As a preliminary analysis, we examined the relationships between all the variables using bivariate correlations to determine if mediation was warranted. Further, to establish a context for interpreting the mediation results, the study examined the degree of clients' reported change in dissociation and total trauma symptoms from pretreatment to post-treatment. The primary analyses conducted two mediation analyses employing the same predictor variable—interpersonal relations problems—and the same mediators (tasks, goals, bonds, others) for both analyses. For one analysis, the criterion variable was dissociation symptoms and for the other, total trauma symptoms (i.e., the total score). Finally, to control for baseline measures of dissociation and total trauma symptoms, a pretreatment measure of each variable was included as a covariate in their respective regression analyses.

For the primary analyses, it was hypothesized that the four dimensions of the alliance would mediate the relationship between early interpersonal relations problems and both outcomes, dissociation and total trauma symptoms, and that the bond would be the strongest mediator of the four alliance dimensions.

Methods

Participants

Data for this study were collected over a 3½-year period in a university training clinic. Only women were included in the study, as women comprised approximately 94% of the clients seeking services in the clinic and 98.5% of clients presenting with CA. All women presenting for treatment ($n = 243$) were invited to participate in a larger study that examined relationship factors and treatment. Of these women seeking treatment, 119 reported interpersonal abuse histories and resulting trauma-related symptoms (e.g., PTSD, dissociation, anxiety, and depression). Of these, 94 reported trauma symptoms because of child abuse, with 80 completing treatment and the study inventories.

Because four of the counselors saw two of the participating clients, we randomly dropped one client for each of the four counselors to remove any threat of non-independence, resulting in 76 counselor–client dyads. Participant ranged in age from 18 to 60 ($m = 30.37$). There were 11 African American, 47 Caucasian, eight Hispanic, two Native American, and two were other. Years of education ranged from 8 to 18 ($m = 13.5$). There were 62 currently in a relationship, while 65 had one or more children. Participants were included in the study if they (a) had a history of childhood sexual and/or physical abuse by a parent and/or caregiver; (b) had no current diagnosis or history of organic mental disorder, schizophrenia, or paranoid disorder; (c) were literate in English; and (d) were between the ages of 18 and 70 years. All participants completed a consent form approved by the university Institutional Review Board.

Of the 76 therapists, six were male (8.6%). Ages ranged from 24 to 39 ($M = 27.5$). Sixty were Caucasian, eight were African American, and eight were Hispanic. Eight were doctoral students in school psychology and 68 were master's students in a community-counseling program. All were in their second or third practicum.

Instruments

The 16-item *Individual Therapy Alliance: Revised/Shortened* (ITA-RS; Pinsof et al., 2008) assessed the goals, tasks, bonds, and other of the therapeutic alliance. Each item is rated on a 7-point Likert scale, ranging from 1 (*completely agree*) to 7 (*completely disagree*). Scores are the average of all items for each subscale, with higher scores indicating greater agreement on goals and tasks, a stronger relational bond, and the client's perception that people important to the client are positively disposed toward and in agreement with the therapist (other) about the tasks and goals of therapy (Pinsof et al., 2008). The alpha coefficients for the four dimensions ranged from .67 to .76 for the current sample. Confirmatory factor analysis supported the existence of tasks, goals, bonds, and other factors (Pinsof et al., 2008). The ITA-RS indicated good construct validity for the bonds scale as it was associated with improved well-being and decreased symptoms.

The 104-item *Detailed Assessment of Posttraumatic Stress* (DAPS; Briere, 2001) assesses for a probable diagnosis of PTSD based on the criterion symptoms of reexperiencing, avoidance, and hyperarousal (DSM-IV-TR criteria 309.81) and related symptoms. Raw scores for all DAPS scales are converted to T-scores. A T-score above 65 is considered clinically significant. The DAPS provides information on clients' history of exposure to 13 types of traumatic experiences (e.g., sexual and physical abuse) and 12 scales related to trauma. Alpha coefficients for the 12 scales ranged from .69 to .93 for the current sample. Convergent validity indicated significant correlations with measures of similar constructs, such as the

Trauma Symptom Inventory, the Personality Assessment Inventory, and the Clinician Administered PTSD Scale (Briere, 2001).

The 40-item *Trauma Symptom Checklist-40* (TSC-40; Briere, 1996) assessed how often respondents experienced dissociation symptoms and total trauma symptoms (i.e., total score) prior to the first session and in one of the final three sessions. Items were rated on a 4-point Likert scale ranging from 0 (*never*) to 3 (*almost always*). Subscale scores are the average of all items for each subscale or for the combined subscales for a total score (i.e., total trauma symptoms). Higher scores indicate higher frequency of dissociation symptoms and total trauma symptoms. The total trauma symptoms score (current sample $\alpha = .93$) results from combining six subscales: dissociation (current sample $\alpha = .82$), anxiety, depression, sexual abuse trauma index (i.e., symptoms associated with sexual abuse), sleep disturbance, and sexual problems. The 7-item dissociation scale includes questions related to memory, altered consciousness, derealization, depersonalization, and flashbacks. The TSC-40 discriminates between women who have or have not been abused as children (Elliott & Briere, 1992).

The 11-item Interpersonal Relations subscale (IR) from the *Outcome Questionnaire-45* (OQ-45; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1996) was used to assess satisfaction with, and problems in, interpersonal relations. Each item is rated on a 5-point Likert scale ranging from 0 (*never*) to 4 (*almost always*). The IR score is calculated by summing respondents' ratings on the 11 items. Higher scores correspond to greater levels of distress and impairment in interpersonal functioning. Items address friendships, family, family life and marriage/romantic relationships in order to measure conflict, isolation, and withdrawal in interpersonal relationships (current sample $\alpha = .81$). Other subscales include Symptom Distress and Social Role, and a total score. To establish concurrent validity, the IR subscale was found to be significantly correlated with the Symptom Checklist-90 and the Inventory of Interpersonal Problems (Lambert et al., 1996).

Procedures

All data for this study, except the alliance, were collected prior to the first session (interpersonal relations, relative trauma exposure, dissociation, and general trauma symptoms) and in one of the final three sessions (dissociation and general trauma symptoms). The alliance data were collected during either the third or fourth sessions, the approximate time at which the literature indicates that the alliance becomes more stable (Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin et al., 2000).

The women received integrated relationship and trauma-based Cognitive Behavioral Therapy (CBT) (Courtois & Ford, 2013). Therapists received individual and/or group supervision from the first author. Supervision included attention to trauma-informed cultural competence (Brown, 2008).

The treatment model largely followed a three-phase treatment model: early phase focused on stabilization, safety, and coping skill development for self-regulation; middle phase focused on memory and emotional processing; and the later phase emphasized integration and generalization of skills and new learning (Ford & Cloitre, 2009). Although treatment emphasized skill building (e.g., grounding, mindfulness breathing) and trauma processing (e.g., life narratives, development and rereading of a trauma narrative), attention to and processing of the ongoing client–therapist relationship was central. Number of sessions ranged from 16 to 28, with a mean of 21 sessions.

Results

Of the 76 participants, four experienced one type of abuse, 12 experienced two types, 12 experienced three types, while 48 experienced four or more types. All women reported ongoing abuse lasting months to years. The majority met criteria for probable PTSD ($n = 56$) or subclinical ($n = 20$; met criteria for two of three symptoms of DSM-IV) levels of PTSD based on the DAPS.

Reported types of interpersonal abuse

- Childhood Sexual Abuse (75.0%)
- Childhood Physical Abuse (71.0%)
- Childhood Emotional/Psychological Abuse (92.1%)
- Witnessed Interparental Violence (71.0%)
- Sexual Abuse Beyond Age 17 (68.4%)
- Experienced Intimate Partner Violence (69.7%)
- Experienced Multiple Types of Abuse (94.7%)
- Exposure to Complex Trauma Stressors (77.6%)

Preliminary analyses

Employing independent samples t -tests, completers were compared to non-completers ($n = 14$) on all the variables, including education, gender, and age. Non-completers were significantly younger ($m = 23.22$ years, $sd = 22.22$ vs. $m = 33.30$, $sd = 11.92$ years; $t = 2.18$, $df = 75$, $p = .05$) and reported lower scores on interpersonal relations ($m = 3.95$, $sd = 1.31$ vs. $m = 5.01$, $sd = 1.07$; $t = 2.85$, $df = 75$, $p = .01$), agreement on tasks ($m = 5.18$, $sd = 1.45$ vs. $m = 5.93$, $sd = 1.05$; $t = 2.33$, $df = 75$, $p = .02$), and bond scores ($m = 4.60$, $sd = 1.09$ vs. $m = 5.84$, $sd = 1.04$; $t = 2.38$, $df = 75$, $p = .03$) than completers. No significant differences were found between male and female therapists on any client measures, experience, or race.

Bivariate correlations (see Table 1) assessed relationships between (a) interpersonal relations, (b) the four dimensions of the alliance, and (c) dissociation and total trauma symptoms. Significant correlations indicate that lower levels of interpersonal relations problems were associated with higher levels of tasks, goals, bonds, and others, while higher levels of interpersonal problems were associated with higher levels of dissociation and total trauma symptoms. Finally, higher levels of the four alliance measures were associated with lower levels of dissociation and total trauma symptoms.

Paired *t*-tests indicated significant reductions in dissociation and total trauma symptoms from the first session to the final sessions, $t = 3.77$, $df = 75$, $p = .000$, $d = .63$ and $t = 4.45$, $df = 75$, $p = .000$, $d = .74$, respectively (see Table 2 for Means and Standard Deviations).

Primary analyses

The primary analyses addressed the major aim of the study—do the dimensions of the therapeutic alliance (tasks, goals, bonds, and other) mediate the

Table 1. Bivariate Correlations for All Measures.

	1	2	3	4	5	6	7	8
Tasks (1)	—							
Goals (2)	.82**							
Bonds (3)	.78**	.70**						
Other (4)	.83**	.90**	.78**					
Dissoc-FS (5)	-.22*	-.25*	-.27**	-.18				
Dissoc-FinS (6)	-.25*	-.25*	-.32**	-.19*	.79**			
Trauma-FS (7)	-.31**	-.26*	-.40**	-.26*	.79**	.70**		
Trauma-FinS (8)	-.36**	-.26*	-.36**	-.25*	.66**	.83**	.75**	
IR	-.34**	-.19*	-.32**	-.23*	.45**	.41**	.68**	.63**

Note. RTE = Relative Trauma Exposure (Detailed Assessment of Post-traumatic Stress); Dissoc-FS = Dissociation Symptoms-First Session (Trauma Symptom Checklist); Dissoc-FinS = Dissociation Symptoms-Final Sessions (Trauma Symptom Checklist); Trauma-FS = Total Trauma Symptoms-First Sessions (Trauma Symptom Checklist); Trauma-FinS = Total Trauma Symptoms-Final Sessions (Trauma Symptom Checklist); IR = Interpersonal Relations (Outcome Questionnaire-45).

* $p < .05$. ** $p < .01$.

Table 2. Means (Standard Deviations) for All Treatment Measures ($n = 76$).

Means (SD)		
ITA-RS		
Tasks	6.05 (1.00)	
Goals	5.90 (1.62)	
Bond	5.90 (1.22)	
TSC-40		
	First Session	Final Sessions
Dissociation	1.60 (.66)	1.30 (.76)*
Total Trauma	1.40 (.48)	1.18 (.51)*
IR (OQ-45)	20.00 (12.52)	

Note. ITA-RS = Individual Therapy Alliance: Revised/Shortened; TSC-40 = Trauma Symptom Checklist-40; IR = Interpersonal Relations (Outcome Questionnaire-45).

* $p < .001$. Participants' Final Sessions scores were significantly lower than the First Session Scores.

relationship between clients' interpersonal relations problems and outcome measures of dissociation and total trauma symptoms—using a bootstrapping multiple mediation method (Hayes, 2013). This approach to mediation was preferred over Sobel's (1982) method of estimated standard error and Baron and Kenny (1986) causal steps method because Hayes' method employs bias-corrected and accelerated (BCa) confidence intervals (CI). This method possesses greater power to detect a mediated effect. Further, Hayes' method does not require large samples or the assumption of normality of the sampling distribution. This method provides acceptable control over type I error (MacKinnon, Lockwood, & Williams, 2004). Finally, baseline dissociation and total trauma symptoms were entered as covariates in their respective analyses.

The mediation analyses was conducted using Hayes' (2013) macro for the Statistical Package for the Social Sciences (SPSS). The 95% CI for the estimate of the mediated effect was obtained with 5,000 bootstrap resamples to create BCa CI to estimate the total direct effect (i.e., effect of X on Y) and the specific indirect (i.e., mediation) effect for each individual alliance dimension, while simultaneously controlling for the other alliance dimensions. A mediation effect is determined to be significant at the .05 level if the CI does not include zero.

In the model with dissociation symptoms as the dependent variable, there was a direct effect of interpersonal relations problems on dissociation symptoms, 95% BCa CI (.0124–.0562). Of the four alliance dimensions, the bond and other scales produced a significant indirect effect, 95% BCa (CIs of –.0024 to –.0238 and –.0330 to –.0006, respectively), indicating that these scales significantly mediated the association between interpersonal relations problems and dissociation symptoms. The variable coefficients indicated that more interpersonal relations problems were associated with lower levels of the therapeutic bond and other (i.e., clients' perceiving less agreement of their important relationships with the therapist about tasks and goals), which in turn was associated with higher levels of dissociative symptoms. Finally, examination of pairwise contrasts of indirect effects indicates that the specific indirect effects through bonds (–.0126) was larger than the specific indirect effect through other (–.0120) with a BCa 95% CI of .0076 to .0536. Overall, the full regression model was significant, $F(5, 70) = 5.03$, $p < .0005$, $R^2 = .25$. The covariate, baseline dissociation, was not significant.

In the second model with total trauma symptoms as the dependent variable, there was a significant direct effect of interpersonal relations problems on total trauma symptoms, 95% BCa CI (.0226 to .0492). However, none of the four mediators were significant. Overall, the full regression model was significant, $F(5, 70) = 10.43$, $p < .0000$, $R^2 = .41$. The covariate, baseline total trauma symptoms, was not significant.

Discussion

This is the first demonstration that the bond and other-therapist dimensions of the alliance play a mediating role between client early session interpersonal relations problems and final sessions dissociation. Results extend earlier research that indicated a strong relationship between total scores on therapeutic alliance measures and trauma symptoms (Cloitre et al., 2004), and interpersonal problems and trauma-related symptoms (Cloitre, Cohen, et al., 2002). Further, results expand Cronin et al.'s (2014) study on the importance of the alliance with survivors of CA who have severe trauma symptoms, by examining mediation effects of the dimensions of the early alliance in treatment. Results partially supported our hypotheses that the four alliance dimensions would mediate the relationship between interpersonal relations problems and trauma symptoms.

Of particular importance, the present research shed light on the precise mechanism, the alliance bond and other dimensions, by which clients' interpersonal relations problems are associated with client dissociation. As the bond is most often associated with client-therapist trust and acceptance, greater interpersonal relations problems predicted greater dissociation through clients' perception of lower trust and acceptance of the therapist and clients' negative perception of how important people to them perceive the therapist. These relationships are consistent with what would be expected with a lower bond and other dimensions scores. Some level of trust is important in most therapeutic relationships (Bordin, 1979) and to the degree that "attention is directed toward the more protected recesses of inner experience; deeper bonds of trust and attachment are required and developed" (p. 254). Bordin's statement especially applies to CA clients who have experienced chronic levels of betrayal trauma in their interpersonal relations with caregivers (Gobin & Freyd, 2009) and subsequent interpersonal problems in adulthood (Cloitre et al., 2005). The results highlight the importance of targeting the bond and other dimensions in treating CA survivors who may mistrust the therapist, which is associated with greater dissociation. Given the reduction of dissociation over treatment, an alternative interpretation could be that lower interpersonal relations problems predict lower total trauma symptoms through the relationship with higher bond and other dimensions. Either interpretation does not diminish the importance of the bond and other dimensions as mediators.

The influence of clients sense that the people who are important to them are not positively aligned with the therapist (other-therapist dimension), though not as impactful as the bond, nonetheless, appears to contribute to higher dissociation symptoms. The results indicate that the other dimension is more important with the dissociation model than the total trauma symptoms model. It is possible that dissociation, more than total trauma symptoms, has a stronger association with relationship systems beyond the client and therapist relationship (i.e., other

dimension), particularly if dissociation is a coping mechanism (Muller et al., 2000) associated with abuse by a significant person in a client's life (Brand et al., 1997). With 77.6% ($n = 59$) of our sample exposed to complex traumatic circumstances (i.e., chronic abuse and polyvictimization within the caregiver system), many of these clients may have negative childhood associations with abusers in their caregiver systems that in turn could taint their sense of how important others perceive the therapist.

Given the pervasive interpersonal problems for CA survivors (Zlotnick et al., 1996), awareness and attention to the bond and other dimensions of the alliance is important, with a particular focus on the ebb and flow of the alliance, that often occurs without the therapist discerning precipitants for these changes (Chu, 1992). For many CA survivors, trust for the therapist occurs only through a time of relational testing (Kinsler, Courtois, & Frankel, 2009). Many survivors of CA do not possess the necessary foundation to form and maintain a stable interpersonal relationship, and especially with others who are reliable, safe, and trustworthy, including the therapist (Pearlman & Courtois, 2005). Ironically, these aspects may create the opposite effect intended for the client-mistrust, anxiety, and threat, which may be reflected in the current study results. The degree to which clients feel cared for, accepted, and safe in the therapeutic relationship (Bordin, 1979) and perceive important others as viewing the therapist positively (Pinsof et al., 2008) has a significant influence on clients' willingness to engage in therapy and ultimately to reduce dissociation symptoms.

Given the current design, several alternative explanations are worth noting. Other possible variables may have accounted for the results, such as the influence of shame, which attenuates improvement in therapy (Andrews, Brewin, Rose, & Kirk, 2000), particularly as it influences the alliance (Black, Curran, & Dyer, 2013). Shame is a common emotional experience for CA survivors, but such research is lacking with CA samples. Another possible confounding variable is client treatment expectations, which affects client hope and engagement in the treatment process (Constantino, Ametrano, & Greenberg, 2012). Finally, attachment pattern is an important precursor to and influence on the alliance (Diener & Monroe, 2011). Any or all of these variables could have had a confounding influence on the results.

Limitations

Several aspects of the sample and the methodology employed in this study may limit generalizability of the results. All participants were female; therefore, our findings could not be applied to male victims of CA. The formation of the alliance and levels of interpersonal problems may be different for male clients. Additionally, employing novice therapists with CA clients likely produced different results than would be the case with more experienced therapists who had considerably more experience

processing childhood trauma material. Finally, given the complexity of dissociation and general trauma symptoms, other self-report measures of trauma symptoms, such as measures for dissociative identity disorder and complex trauma symptoms, as well as, in-session observational methods might produce different results.

Conclusions

Despite the above limitations, the importance of the bond and other dimensions in mediating the relationship of interpersonal relations problems and dissociation is important. Client trust, associated with the bond and other-therapist dimensions, should be focal in treating CA survivors, particularly treatments such as trauma informed cognitive behavioral approaches, that, while central to treatment regimens for trauma, may lean toward the technical over the relational components of treatment (Courtois & Ford, 2013).

Clinical implications revolve around developing, maintaining, and repairing the therapeutic relationship, especially the bond and other dimensions (Safran, Muran, & Eubanks-Carter, 2011), within the context of dissociative symptoms. As noted earlier, dissociative responses may be triggered by the client–therapist relationship. Thus, it is important for therapists’ to be aware of subtle or obvious shifts in CA clients’ detachment from self and/or their surroundings, particularly when addressing attachment-based abuse relationships, such as caregivers (Pearlman & Courtois, 2005). Further, given survivors’ histories of significant interpersonal problems and long-standing relationship trust violations, it should be anticipated that building, maintaining, and repairing the alliance will be an ongoing process, and yet also an opportunity for reworking clients’ working models of relationships and improving interpersonal skills and management (Briere & Scott, 2015). Such a focus also may improve clients’ interpersonal relations problems, providing a new, more positive emotional experience that may generalize to other relationships (Safran et al., 2011).

On a related issue, as CA clients may evoke strong reactions from therapists, they must be aware of their own countertransference responses to clients’ dissociation processes and interpersonal difficulties in order to identify and understand clients shifting states, as well as to manage their own emotions in reaction to these shifts (Dalenberg, 2000). Finally, our results suggest the importance of considering the relation between interpersonal relations problems, dissociation, and the therapeutic alliance, especially the bond and others dimensions, in modulating treatment intensity, timing of responses, and therapy process interventions.

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