



Research article

Therapeutic alliance over the course of child trauma therapy from three different perspectives



Karina P.M. Zorzella, Sara Lynn Rependa, Robert T. Muller*

Department of Psychology, York University, Toronto, Ontario, Canada

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ABSTRACT

In a multi-site, controlled study with follow up, we looked at the therapeutic alliance in child trauma therapy. Parent, child, and therapist ratings were used to examine how therapeutic alliance changes over the course of Trauma Focused Cognitive Behavior Therapy (TF-CBT), an intervention that uses an exposure based method called a trauma narrative. Participants were 65 children and their caregivers in a community based trauma therapy program in Canada. Children in treatment underwent TF-CBT, including the trauma narrative asking them to write out and process their trauma story in detail. Results indicated that despite how hard it was for children to participate in this intensive treatment method, children, therapists and parents reported positive ratings of the therapeutic alliance throughout treatment. Furthermore, child and therapist's ratings of alliance became significantly more positive from therapy start to finish.

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Research on therapeutic alliance in adults demonstrates that a strong and healthy alliance is essential in maintaining compliance with therapy tasks, in maintaining session attendance, and for overall successful therapeutic outcome (Hawley & Weisz, 2005; Shirk & Karver, 2003; Shirk, Karver, & Brown, 2011). However, despite extensive work done with adults, relatively few studies have examined therapeutic alliance in child trauma therapy. Also, no previous work has examined how that relationship changes over time. Finally, relatively little research has taken a multi-rater perspective when considering therapeutic alliance with this population. Considering these gaps, the current study examined therapeutic alliance over the course of a child trauma therapy, using a multi-rater perspective.

1. Therapeutic alliance: history and importance

Therapeutic alliance has been defined as agreement on therapy goals and tasks, and the emotional bond between client and therapist (Bordin, 1979; Horvath & Luborsky, 1993; Martin, Garske, & Davis, 2000). The concept of therapeutic alliance has influenced psychotherapy for nearly a century. Freud (1912) discussed the importance of transference within the psychoanalytic framework, and Carl Rogers (1957) considered the therapist–client relationship necessary and central to change. Greenson's (1967) model of therapeutic alliance divided the relationship into three components: transference, the working alliance, and the real relationship. Bordin (1979) was considered one of the first to consider contributions from both the therapist and the client in his conceptualization of working alliance.

It is now widely held that therapeutic alliance is a crucial element in most treatment modalities, and thought to be necessary for the effective implementation of most therapeutic tasks and techniques (Hawley & Weisz, 2005; Horvath &

* Corresponding author at: York University, Behavioral Sciences Building, 4700 Keele Street, Toronto, Ontario M3J 1P3, Canada.
E-mail address: rmuller@yorku.ca (R.T. Muller).

Luborsky 1993). Numerous studies hold that this relationship is, in fact, one of the best predictors of positive treatment outcome (Orlinsky, Grawe, & Parks, 1994; Orlinsky, Ronnestad, & Willutzki, 2003; Wampold, 2001). In fact, it has been suggested by various studies that a strong therapeutic alliance is potentially, on its own, curative. (DiGiuseppe, Linscott, & Jilton, 1996; Garcia & Weisz, 2002).

2. Therapeutic alliance and traumatized children

The therapeutic relationship has been shown to be integral in maintaining motivation and adherence to therapeutic process and is therefore important to examine more deeply. This is especially true if there are concerns that a trauma narrative (TN) may challenge the therapeutic alliance (Chiu, McLeod, Har, & Wood, 2009; Kazdin & Durbin, 2012; Lawson, 2009). Considering the robust evidence that the therapeutic relationship is central to trauma therapy outcome in adult populations (e.g., Kazdin & Durbin), it is important to extend this line of research to work involving traumatized children. The few studies that have been done with youth have focused on non-maltreated children and have found that therapeutic alliance affects areas such as motivation during treatment, engagement in the tasks assigned during therapy, and participant retention (Chiu et al., 2009; Kazdin & Durbin, 2012; Kazdin, Marciano, & Whitley, 2005; Pereira, Lock, & Oggins, 2006). In the little research conducted with youth who have not experienced trauma, it was suggested that positive early alliance as well as positive change in alliance over the course of treatment were associated with a higher rate of improvement in symptomatology (Bickman et al., 2012; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Wei-Chin, 2000; Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006). A study conducted with maltreated adolescents demonstrated that those who showed more positive change in therapeutic alliance also displayed more positive treatment outcomes (Eltz & Shirk, 1995).

Advances in the understanding of therapeutic alliance have remained largely focused on treatment with adults and relatively little is known about the importance of the treatment relationship with children (Kazdin & Durbin, 2012; Schwartz, 1998). However, it has been argued that children in therapy face unique obstacles when engaging in these therapeutic relationships (DiGiuseppe et al., 1996; Green, 2006). Developmental factors may interfere with the child's ability to connect with the therapist. For example, child clients rarely seek help on their own and are not typically responsible for initiation of their own treatment and these factors might compromise engagement in the therapeutic relationship (DiGiuseppe et al., 1996). Older youth may be unsure of what to expect in therapy and can be resistant to complying with the treatment (Kingerly et al., 2006). Younger children may simply not understand what therapy is or why they need it (Green, 2006). Friedberg and McClure (2003) indicate that engaging the child or adolescent client is uniquely challenging, and that it is particularly difficult to find developmentally sensitive and appropriate ways to foster their investment and trust in the relationship.

In addition to the obstacles that children in treatment face in general, maltreated children may face even greater obstacles in forming positive therapeutic alliances (Eltz, Shirk, & Sarlin, 1995). In comparison to non-maltreated children, children with histories of abuse show greater mistrust of others, as well as a greater unwillingness to take part in the therapeutic relationship during therapy (Eltz et al., 1995). If the trauma occurred within the context of a caregiving relationship, these children and adolescents may find it extremely difficult to establish feelings of safety or trust with any adult, including therapists (Eltz et al., 1995; Cloitre, Cohen, & Scarvalone, 2002).

Relatively little research has been conducted on the therapeutic alliance with maltreated children in trauma-focused therapy. It is crucial that we extend our knowledge about alliance over the course of trauma treatment to inform best treatment practices and outcomes in child trauma therapy.

3. TF-CBT and the trauma narrative

Trauma Focused Cognitive Behavior Therapy (TF-CBT) has been shown to be an effective, empirically supported child trauma treatment that is component based and that incorporates an exposure based technique called The Trauma Narrative (Cohen, Deblinger, Mannarino, & Steer, 2004; Konanur, Muller, Cinamon, Thornback, & Zorzella, 2015; Lawson, 2009). TF-CBT was developed based upon a number of randomized controlled trials (Cohen et al., 2004; King et al., 2000). Evidence demonstrates the robustness of TF-CBT in decreasing symptoms when compared to other treatment approaches including non-directive supportive therapy (Cohen & Mannarino, 1996); supportive group therapy (Deblinger, Stauffer, & Steer, 2001); and child-centered therapy (Cohen et al., 2004; Cohen & Mannarino, 1997). Six month and one year follow-up studies found that post-therapy PTSD symptom reductions were maintained (Deblinger, Mannarino, Cohen, & Steer, 2006; Konanur et al., 2015). Clinical and school therapists have successfully implemented the model with children ranging from preschool-age to adolescence (Cohen & Mannarino, 1997; Cohen, Mannarino, & Deblinger, 2006; Feather & Ronan, 2009; Little, Akin-Little, & Gutierrez, 2009).

A central tool used in the TF-CBT model is a method called the Trauma Narrative (TN). This technique helps children meaningfully organize and integrate their thoughts and emotions surrounding the trauma into autobiographic memory (Lawson, 2009). Usually taking the form of a story, picture album, or poem, the narrative involves the child remembering and recording a traumatic event over several therapy sessions. This technique uses gradual exposure to imagined stimuli related to the trauma, invoking conditioning mechanisms such as habituation and reciprocal inhibition to desensitize the child to memories about the traumatic event (Cohen, Mannarino, Berliner, & Deblinger, 2000; Lawson 2009). It also allows the therapist to identify any problematic beliefs or attributions surrounding the traumatic event (Cohen et al., 2006).

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