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Therapeutic Alliance Among Individuals who Experienced Childhood Interpersonal Trauma: The Role of Cultural Humility, Therapeutic Presence, and Attachment Style

Ramona I. Grad

ACCEPTANCE

This dissertation, THERAPEUTIC ALLIANCE AMONG INDIVIDUALS WHO EXPERIENCED CHILDHOOD INTERPERSONAL TRAUMA: THE ROLE OF CULTURAL HUMILITY, THERAPEUTIC PRESENCE AND ATTACHMENT STYLE, by RAMONA I. GRAD, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education and Human Development, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

_____
Melissa Zeligman, Ph.D.
Committee Chair

_____
Catherine Y. Chang, Ph.D.
Committee Member

_____
Franco Dispenza, Ph.D.
Committee Member

_____
Jonathan J. Orr, Ph.D.
Committee Member

_____
Date

_____
Brian Dew, Ph.D.
Chairperson, Department of Counseling and Psychological Services

_____
Paul A. Alberto, Ph.D.
Dean
College of Education and Human Development

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Ramona Ioana Grad
Counseling and Psychological Services Department
College of Education and Human Development
Georgia State University

The director of this dissertation is:

Melissa Zeligman, Ph.D.
Department of Counseling and Psychological Services
College of Education and Human Development
Georgia State University
Atlanta, GA 30303

CURRICULUM VITAE

Ramona Ioana Grad

ADDRESS: 1100 Lake Station Court
Suwanee, GA, 30024

EDUCATION:

Ph.D.	2019	Georgia State University Counseling and Psychological Services
Masters Degree	2015	Georgia State University Counseling and Psychological Services
Bachelors Degree	2005	Babes-Bolyai University Psychology

PROFESSIONAL EXPERIENCE:

2015-2019	Graduate Research/Teaching Assistant Department of Counseling and Psychological Services Georgia State University, Atlanta, GA
2017-2018	Doctoral Intern Mercer University Counseling Center, Atlanta, GA
2016-2017	Doctoral Intern Ridgeview Institute, Women Center for Trauma, Smyrna, GA
2014-2015	Master Level Intern Mercer University Counseling Center, Atlanta, GA
2004-2013	Psychologist, Psychotherapist Private Practice, Satu Mare, Romania
2003-2004	Bachelor Level Intern Oncology Institute "Ion Chiricuta", Cluj Napoca, Romania

PRESENTATIONS AND PUBLICATIONS:

Grad, R. I. & Breedlove Mize, M. (2018). WEB – A Group Program for Professional Counselors. In Jansel, E.A., & Szilagyi, A. (Eds.) *Counselors' Role in the Local and Global Community*. Bucharest, Romania: Editura Universitara

Zeligman, M.; Varney, M.; **Grad, R. I.** & Huffstead, M. (2018). Posttraumatic Growth in Individuals with Chronic Illness: The Role of Social Support and Meaning Making. *Journal of Counseling and Development 96*(1), 53-63

Grad, R. I. & Zeligman, M. (2017). Predictors of Posttraumatic Growth: The Role of Social Interest and Meaning in Life. *The Journal of Individual Psychology 73*(3), 190-207

Tolleson, A., **Grad, R. I.** , Zaybek, F. & Zeligman, M. (2017). Teaching helping skills courses: Creative activities to reduce anxiety. *Journal of Creativity in Mental Health 12*(4), 428-439. doi: 10.1080/15401383.2017.1281186

Grad, R. I. (2016). The Relationship between Perfectionism and Academic Performance: A Review. *Romanian Journal of Counseling, 2*(2), 140-159.

Grad, R. I. & Mize, M. (2018, February). *Wellness in the Counseling Profession: A Group Program.* NBCC Romania International Conference, Bucharest, RO

Suttles, M., Tolleson, A., Placeres, V., & **Grad, R. I**. (2018, October). *Creative Teaching Strategies and Clinical Techniques to Enhance Career Counseling.* SACES Conference, Myrtle Beach, SC

Mason, E., Merlin-Knoblich, C., Harris, P. Finan, R., **Grad, R. I.**, Huguelet, A., & Placeres, V. (October, 2018). *Current Research on Flipped Learning in Counselor Education: Findings from Three Recent Studies*. SACES Conference, Myrtle Beach, SC

Elston, N., Rumsey, A., **Grad, R. I.**, & Mize M. (2018, September). *Evaluating Self-Reported Counseling Skills Used During the First Fieldwork Experience*. AARC Conference, Richmond, VA

Castleberry, J. & **Grad, R. I.** (2018, September). *Problems in Short Form Development: A Critical Evaluation of the Experiences in Close Relationships Scale Short Form.* AARC Conference, Richmond, VA

Grad, R. I. & Zeligman, M. (2018, April). *Predictors of Posttraumatic Growth: The Role of Social Interest and Meaning in Life*. ACA Conference & Expo, Atlanta, GA.

Mize, M., **Grad, R. I.**, Phofl, W., Brooks, N., Johnson, T., Jones, J. L., Yun, L. H., Boyce Rosen, N., Whisenhunt, J. L., & Shannonhouse, L. (2018, April). *CSI Chapter Collaboration through Counselor Community Engagement: University of Botswana Book Drive*. ACA Conference & Expo, Atlanta, GA

Grad, R. I. & Elston, N. (2018, February). *Self-Care in the Counseling Profession: The Benefit of Connecting with Others*. ASGW Conference, Savannah, GA.

Mize, M.C., **Grad, R. I.**, & Orr, J. (2018, February). *Effective Practices for Group Work in Hospital Crisis Stabilization Units*. ASGW Conference, Savannah, GA.

Grad, R. I. & Elston, N. (2017, October). *Using Image to Discuss White Privilege in Supervisory Relationship*. ACES Conference, Chicago, IL.

Zeligman, M., Gutierrez, D., & **Grad, R. I.** (2017, October). *The Use of Mindfulness in Skill Development and Anxiety Reduction for Counselor-in-Training*. ACES Conference, Chicago, IL.

Grad, R. I. & Elston, N. *The Benefits of Self-Care: Connecting with Others and Becoming an Effective Adlerian Professional Counselor*. (2016, May). NASAP Conference, Twin Cities

Orr, J. & **Grad, R. I.** (2016, February). *A Simple Step Towards Better Group Leadership: How to Utilize a Process Observer.* ASGW Conference. Washington, DC.

PROFESSIONAL SOCIETIES AND ORGANIZATIONS

2018 – Present	AARC (Association for Assessment and Research in Counseling)
2017 – Present	ACROM (Romanian Association for Counseling)
2015 – Present	ACES (Association for Counselor Education and Supervision)
2013 – Present	CSI International (Chi Sigma Iota)
2013 – Present	ACA (American Counseling Association)
2013 – Present	ASGW (Association for Specialists in Group Work)
2012 – Present	NASAP (North American Society of Adlerian Psychology)

THERAPEUTIC ALLIANCE AMONG INDIVIDUALS WHO EXPERIENCED CHILDHOOD INTERPERSONAL TRAUMA: THE ROLE OF CULTURAL HUMILITY, THERAPEUTIC PRESENCE AND ATTACHMENT STYLE

by

RAMONA IOANA GRAD

Under the Direction of Dr. Melissa Zeligman

ABSTRACT

Despite decades of prevention campaigns and research, childhood interpersonal trauma remains a critical mental health problem in the United States with longstanding and harmful negative effects on adult psycho-relational functioning (Dugal, Bigras, Godbout, & Belanger, 2016). In the United States, 678,810 children were found to be victims of childhood abuse in one year (U.S. Department of Health & Human Services, 2013). Estimated prevalence rates of childhood trauma in American adults older than 55 years were 13.5% for verbal abuse, 9.6% for physical abuse and 9.3% for sexual abuse (Bynum et al., 2010). Childhood interpersonal trauma may have a damaging impact on a child's development (Dodge, 2010; Schury & Kolassa, 2012), and in the long run may lead to high rates of suicidality and low levels of social functioning (Stansfeld et al., 2010). Extended interdisciplinary common factor research has identified the

therapeutic alliance as a consistent factor influencing therapeutic outcomes (Flückiger, Del Re, Wampold, Koole & Tschacher, 2016; Symonds & Horvath, 2012). Cultural humility (Hook, Davis, Worthington, & Utsey, 2013; Owen et al., 2014), therapeutic presence (Colosimo & Pos, 2015; Geller & Porges, 2014), and attachment style (Byrd, Patterson, & Turchik, 2010; Marmarosh et al., 2009) have all been found to significantly contribute to the development of the therapeutic alliance. However, these factors have not been investigated together in the context of working with individuals with a history of childhood interpersonal trauma. These variables are of particular importance looking at interpersonal trauma survivors, as healing relationships that provide quietness, safety, presence, protection, and empowerment are integral to their recovery process (Herman, 1992; Levine, 1997). This study investigated the relationships among cultural humility, therapeutic presence, attachment style, and therapeutic alliance when working with childhood interpersonal trauma survivors. Correlation analyses indicated that cultural humility and therapeutic presence were both significantly correlated with therapeutic alliance. Regression analyses revealed that together cultural humility, therapeutic presence and attachment anxiety were the strongest predictors of the therapeutic alliance. Implications and recommendations for professional counselors and counselor educators are provided.

INDEX WORDS: Therapeutic Alliance, Childhood Interpersonal Trauma, Cultural Humility, Therapeutic Presence, Attachment Style

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DEDICATION

To my dad, mom, brother, and Patricia …

For my dad, Johnny. I imagine that you would be so proud of me now. You didn't know what I had in plan for my future however you prepared me to be successful through all the lessons you taught me over the years: always to do my best, to work hard and play hard, to believe that there is a solution to every challenge, and to have a strong desire to grow and be better. Thank you for not leaving me entirely and staying in my heart forever!

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For my brother, Valentin. You always looked out for me and protected me sometimes even more than necessary. It took me some time to realize that this is the way you showed your love for me ... And you have so much love to give. I am happy to have you and thank you for encouraging me to follow my dreams!

For my niece, Patricia. You are the light of my life, my true inspiration!

This dissertation, and all the work I have done and will continue to do for the rest of my life, it is possible because of you all. I am so proud of my family and my Romanian heritage!

DEDICATIE

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1 CHILDHOOD INTERPERSONAL TRAUMA AND THERAPEUTIC ALLIANCE

Trauma

Trauma is a Greek word meaning "wound" (Trauma, 1690s), and it was first regarded as referring to a physical injury. However, trauma is also viewed as a psychological and medical disorder of the mind (Levine, 1997). Freud (1913) talked about trauma "… as a breach in the protective barrier against stimuli leading to feelings of overwhelming helplessness" (p.197). Levine (1997) mentioned the important role played by the body when trying to understand, define, and heal trauma. Van der Kolk (1996) theorized that trauma results from negative life events that overwhelm an individual's coping resources and ability to cope adaptively with the traumatic stressor. The Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-5; American Psychiatric Association, 2013) defines trauma as an:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (a) Directly experiencing the traumatic event(s); (b) witnessing, in person, the event(s) as it occurred to others; (c) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (d) experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (DSM-5, APA, 2013, pp. 271)

General population studies have shown that a large proportion of people in the United States have been exposed to at least one traumatic event (TE) in their lifetime (i.e., 82.7%;

Benjet et al., 2016), and the majority will experience multiple TEs (*M* = 3.30, *SD* = 2.32, Kilpatrick et al., 2013). Some reported TEs include: crime-related encounters, interpersonal violence, accidents, natural disasters and witnessing life-threatening situations (Friedman, 2013). The type of TE is also critical to consider in addition to the total number of TEs. For example, childhood sexual trauma history represents a risk factor for subsequent lifetime TEs, with approximately half of the female victims of childhood sexual abuse later experiencing sexual revictimization in adulthood (Banyard, Williams, & Siegel, 2001). Similarly, witnessing violence between parents in childhood may be associated with an increased likelihood of childhood physical abuse (Finkelhor, Shattuck, Turner, & Hamby, 2014). The increased risk of cumulative TEs may then result in an increased risk of negative psychological and physical health outcomes (Karam et al., 2014). More broadly, the experience of interpersonal trauma may play a unique role in determining risk for further trauma and symptom outcomes. Interpersonal TEs, including assault, physical abuse, and sexual abuse, often lead to increased self-blame and maladaptive cognitions, which then in turn significantly impact daily functioning (Alisic et al., 2014).

Authors classify potentially traumatizing events as *interpersonal* traumas – those events that are inflicted by human perpetrators (e.g., emotional, physical, or sexual abuse) and *impersonal* traumas - those events that are caused by human or natural origins (e.g., accidents or natural disasters) (Allen, 2001). Compared with impersonal traumas, interpersonal traumas are associated with more post-traumatic symptomatology (Bryere, Agee, & Dietrich, 2016). Thus, interpersonal trauma specifically requires further exploration to understand its impact.

Interpersonal Trauma

Interpersonal trauma is defined in the literature as a traumatic event that is completed by another person with the intent to harm or threaten someone (Cloitre et al., 2012; McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000). The World Health Organization (WHO) defines it as "the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p.5). Interpersonal trauma (e.g., intimate partner violence, childhood maltreatment and neglect, emotional, physical and sexual assault by strangers or acquaintances, torture; Berenz et al., 2016; Forbes et al., 2012) is damaging (Lim, Valdez, & Lilly, 2015). Herman (1997) suggests that interpersonal trauma is a specific category of psychological trauma that involves an overwhelming rupture within a significant relationship on which the individual depends for emotional, physical, or spiritual wellbeing. Traumatic events that arise in interpersonal relationships can be particularly detrimental because of the betrayal involved in the violation of basic assumptions underlying interpersonal and social relationships (Frey, 1994, 1996). The experiences of abuse, neglect, or abandonment may represent violations of trust, and thus have important implications for understanding interpersonal trauma and healing processes (Gómez, Lewis, Noll, Smidt, & Birrell, 2016). Psychological interpersonal trauma most often occurs in a dysfunctional and pathological family. This event is interpersonal and is connected with a specific type of bond, mainly a dysfunctional one (e.g., ambivalent, avoidant, disorganized, dissociative; Bowlby, 1975). The most frequent forms of interpersonal trauma are being a victim of emotional, physical, and sexual abuse, and experiencing emotional and physical neglect during childhood; these types of trauma could co-occur and recur over the life

span of an individual (Anda, Butchart, Felitty, & Brown, 2010). Exposure to significant childhood trauma affects a daunting proportion of young people (Anda et al., 2006; Dube et al., 2001) constituting one of the most detrimental impacts on youth development (Kilpatrick, Saunders, & Smith, 2003; Widom, 2000).

Childhood Interpersonal Trauma

Exposure to childhood maltreatment, or early interpersonal trauma, is considered an endemic health issue with tragic personal, social and economic repercussions (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Kaffman, 2009). Childhood interpersonal trauma (CIT) is defined as a traumatic event that is completed by another person with the intent to harm or threaten someone (e.g., sexual, physical, and emotional abuse, neglect, domestic violence), and that occurred before the age of 18 (Cloitre, Cohen, & Scarvalone, 2002). Children are exposed to trauma at alarmingly high rates. The National Survey of Children's Exposure to Violence contains data from a large sample of youth (n=4503, age one month to 17 years old) regarding trauma exposure rates for children (Finkelhor, Turner, Shattuck, & Hamby, 2015). According to this study, lifetime rates of different types of abuse are as follows: physical assault: 54.5%, sexual victimization: 9.5%, maltreatment by a caregiver: 25.6%, property victimization including robbery: 40.2%, indirect victimization: 39.2%, and indirect exposure to violence: 10.1%. Additionally, exposure to one trauma increases the likelihood of exposure to other types of trauma. Recent international and US national studies show CIT's alarming prevalence (Finkelhor et al., 2009; WHO, 2015) with 61% of children with a history of at least one type of interpersonal trauma and more than one-third who report two or more additional types of interpersonal violence. Countless studies have shown that exposure to interpersonal trauma during childhood can chronically and pervasively alter social, psychological, and cognitive

development (Cook et al., 2005; Godbout, Lussier, & Sabourin, 2014). Indeed, CIT is associated with an overabundance of serious short-term consequences (Danielson, Ruggiero, Daughters, & Lejuez, 2010; Hodges et al., 2013) and life-long consequences (Irish, Kobayashi, & Delahanty, 2010), such as compromised mental and physical health, increased incidents of affect dysregulation, changes in attention and consciousness, identity impairments, and interpersonal difficulties (Briere, Hodges, & Godbout, 2010; D'Andrea et al., 2012; WHO, 2015).

Researchers have shown that forms of maltreatment rarely occur in isolation and childhood cumulative trauma - the accumulation of different forms of interpersonal traumas experienced before the age of 18 - is associated with a more grave and complex symptomatology such as exacerbated psychological, sexual, and relational distress compared to a single traumatic experience (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014; Berthelot, Hébert, et al., 2014; Bigras, Daspe, Godbout, Briere, & Sabourin, 2017; Hodges et al., 2013). Early interpersonal trauma was associated with the formation of mental representations of self and others (e.g., Fergusson, McLeod, & Horwood, 2013; Turner, Finkelhor, & Ormrod, 2010). These mental representations or schemas significantly influence how a person perceives and relates to the external world (Collins, 1996; Dozier, Stovall, & Albus, 1999). They reflect whether people anticipate that others will be responsive or unresponsive to their attachment needs (Bartholomew, 1990; Solomon & George, 1999). Researchers have established a robust relationship between CIT and attachment disruptions (Ogle, Rubin & Siegler, 2014; Muller, Sicoli, & Lemieux, 2000; Roche, Runtz, & Hunter, 1999; Van Assche, Van de Ven, Vandenbulcke & Luyten, 2019); therefore, there are reasons to believe that attachment plays a critical role in the context of CIT.

Childhood Interpersonal Trauma and Attachment

In the context of trauma, attachment has received increased attention in the literature as childhood abuse is thought to disturb attachment (Muller & Rosenkranz, 2009). According to attachment theory, interactions with significant others in childhood serve as the basis for representations of self and others, which may affect experiences in close relationships over the life span (Bowlby, 1969, 1973) and they guide how individuals manage their relationships and how they interpret their social world (Collins & Read, 1994; Shaver, Collins, & Clark, 1996). Three distinct behavioral styles of infant attachment have been identified: (a) secure, (b) avoidant, and (c) anxious-ambivalent (Ainsworth, Blehar, Waters, & Wall, 1978). Collins (1996) suggested that styles of attachment observed in children appear useful for describing individual differences in adult styles of relating. Secure adults describe themselves as comfortable with closeness and intimacy, willing to rely on others when needed, and confident that they are loved and appreciated. In contrast, adults with avoidant attachment report feeling very uncomfortable getting close to and depending on others, and tend not to be concerned about whether others will accept or reject them. Finally, anxious adults have a strong desire for close relationships, although they are unsure about whether they can depend on others and tend to worry a great deal about being rejected and abandoned. Positive experiences with attachment figures characterized by sensitivity, availability, and responsiveness of the caretaker have been found to encourage the development of positive internal working models regarding the self and others, while negative experiences tend to evoke attachment insecurities (Bowlby, 1973; Mikulincer & Shaver, 2016).

Researchers (e.g., Godbout, Dutton, Lussier, & Sabourin, 2009; Hesse & Main, 2006) have cited a high prevalence of insecure attachment in children who have been abused and neglected, and formerly maltreated adults (Muller & Lemieux, 2000). Individuals with a history

of childhood abuse demonstrate interpersonal difficulties that may stem from a disturbed sense of self and other (Muller, Lemieux, & Sicoli, 2001; Roche et al., 1999). Therefore, finding safety in relationships can be a challenge for survivors of childhood trauma (Herman, 1992; Tyson & Goodman, 1996). Re-experiencing dissociated traumatic experiences can suddenly disrupt their awareness and self-regulation, which might further lead to interpersonal difficulties (Hegeman & Wohl, 2000). However, according to Bowlby (1988), although the attachment patterns that individuals form in childhood persist in adulthood, they may change. Sroufe, Egeland, Carlson, and Collins, (2005) supported Bowlby's hypothesis and found that adults with insecure attachment patterns may develop a secure attachment style when they experience supportive adult relationships. Similarly, Welch and Houser (2010) found that relationship satisfaction, hope, and self-disclosure are relevant predictors of attachment in adults; therefore, mental health professionals have an opportunity to facilitate change through establishing safe, stable and supportive relationships (i.e., a strong therapeutic alliance) with clients with CIT history.

Childhood Interpersonal Trauma and Therapeutic Alliance

The issue of trust—loss of safety, violation of trust, and restoration of interpersonal trust—is at the heart of the experience of interpersonal trauma and trauma treatment (Welkin, 2013). Survivors of CIT have been severely traumatized within the context of an intimate relationship with a person they highly trusted and relied upon (Herman, 1997). According to Welkin (2013), at the core of healing for this type of interpersonal trauma is the construction of safe spaces in physical, interpersonal, and psychological dimensions. Trauma treatment connects the physical, interpersonal, and psychological parts of the process in helping survivors to develop a psychological capacity to feel personally in charge of their own safe space. Yet, 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, Chase Stovall-McClough, Miranda, & Chemtob, 2004; Dalenberg, 2014).

Individuals with a history of CIT demonstrate interpersonal difficulties that stem from a disturbed sense of self and other (Muller, et al., 2001), which in turn influence their capacity to form a strong therapeutic alliance with the therapist (Pearlman & Courtois, 2005). Insecure attachment systems may not only disrupt affect and behavior regulation but also impair one's ability to establish trust relationship and secure attachment bond (Huang, Chen, Su, & Kung, 2017). Because the people who create interpersonal traumas are individuals whom survivors usually know or trust, these survivors may then be unable to trust and feel safe with others after traumas. This makes it difficult for survivors to acquire help and support from others in times of need. Finding safety in relationships can be a challenge for these clients, and they often re-enact themes of powerlessness, shame, guilt, distrust, and abusive patterns within the therapeutic relationship (Herman, 1992; Tyson & Goodman, 1996). Re-experiencing dissociated traumatic experiences can suddenly disrupt their awareness and self-regulation, which might also lead to interpersonal difficulties (Hegeman & Wohl, 2000). Considering that CIT occurs within relationships, and healing may be facilitated in the context of trusting relationships, it is important to understand the factors that might influence the quality and development of the therapeutic relationship in when working with individuals with CIT history.

Therapeutic Alliance

When Freud (1912/1958) discussed different types of transference, he also mentioned the concept of the therapeutic alliance. Even though many theorists and researchers took Freud's ideas and used them in different forms (Fenichel, 1941; Gitelson, 1962; Sterba, 1934, 1940;

Stone, 1961; & Zetzel, 1956), the construct of the working alliance was introduced by Greenson in 1967 (Horvath & Symonds, 1991). Greenson (1967), who described working alliance as a "rational relationship between patient and analyst" (p. 46), argued that this positive collaboration between therapist and client is crucial for effective treatment. The therapeutic alliance is now recognized as a central variable to therapeutic success across the different approaches (Frank, &Frank, 1993; Grencavage, & Norcross, 1990; Wampold, & Imel, 2015). It has repeatedly been highlighted as a key component of treatment efficacy (Martin, Garkse, & Davis, 2000). More precisely, a strong alliance established quickly in a therapeutic relationship, is a predictor of favorable therapy outcomes (Horvath, 2001). The terms working alliance and therapeutic alliance are used interchangeably by theorists, and there are multiple different conceptualizations of this construct. Out of them, Bordin's (1979) conceptualization has dominated the literature and involves three major components: (a) therapist and client agreement on goals for therapy, (b) therapist and client agreement on tasks to achieve those goals, and (c) the emotional bond, including the development of respect, trust, confidence and personal attachment within the therapist and client dyad.

Adults with CIT histories often struggle to form a therapeutic alliance due to difficulties in interpersonal relationships resulting from early breaches of trust, security, and protection from harm (Courtois & Ford, 2013; Keller, Zoellner, & Feeny, 2010). Researchers have regarded the important relationship between a strong therapeutic alliance and treatment success among adult survivors of CIT (Cloitre et al., 2004; Lawson, Stulmaker, & Tinsley, 2017). More specifically CIT and a weak alliance are associated with poor treatment outcomes for survivors of CIT (Cloitre, Cohen, & Scarvalone, 2002). As noted previously, the therapeutic alliance has been found to contribute significantly to treatment outcomes across studies on general populations

(Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Martin et al., 2000) and to a much lesser degree among individuals with a trauma history (Cloitre et al., 2002). Many scholars have suggested the need to examine more complex associations between the therapeutic alliance and other variables related to CIT (Cloitre et al., 2004; Pearlman & Courtois, 2005). Such variables may be attachment style, therapeutic presence, and cultural humility.

Therapeutic Alliance and Attachment

Exposure to interpersonal trauma is associated with increased risk for several psychiatric disorders including Post Traumatic Stress Disorder (PTSD), substance use disorder, and depression (Kimerling, Gima, Smith, Street, & Frayne, 2007). One of the critical effects of prolonged exposure to interpersonal trauma is the fragmentation of the attachment system (Silove, 1999). This idea is supported by researchers that suggest that disruptions of attachment are a consequence of traumatic experiences (De Haene, Grietens, & Verschueren, 2010), and that recovery is associated with restored attachments (Ajdukovic et al., 2013). Researchers also suggest that people seek attachment figures during stress (Mikulincer, Gillath, & Shaver, 2002; Mikulincer, Hirschberger, Nachmias, & Gillath, 2001) and that the availability of real or symbolic representations of attachment confers considerable psychological benefit (Mikulincer & Shaver, 2007).

One's attachment system in adulthood is believed to be activated in times of threat or distress, which may be particularly relevant to the times that many people seek therapeutic help (Bucci, Seymour-Hyde, Harris & Berry, 2016; Mikulincer et al., 2001, 2002). This has led researchers to conceptualize the therapeutic relationship in terms of attachment (Marmarosh, 2015; Obegi & Berant, 2009; Slade, 2016). Bowlby (1988) drew parallels between the role of the parent and the role of the therapist. He theorized that as a parent, the therapist might be viewed

as needing to provide a secure base for the client, which would then allow the client time, space, and safety to explore and develop a greater understanding of themselves and the world. In keeping with an attachment view of therapy, Bowlby suggested the idea that therapeutic change occurs as insecure clients, contrary to their previous experience, experience a containing and responsive relationship with their therapist. If this experience deviates significantly from the individuals' early prototype working model, then their core attachment pattern may be modified (Daniel, 2006). Consistent with this idea, authors have reported that decreases in symptom severity throughout psychotherapy are associated with increases in the self-reported secure attachment (Travis, Binder, Bliwise, & Horne-Moyer, 2001).

A specific line of research has developed investigating the role of attachment style in predicting alliance levels and growth in the alliance, yet more research needs to be done investigating these variables in the context of interpersonal trauma as the researchers seem somewhat inconsistent. Smith and colleagues (2010) conducted a review that explores research that has examined the relationship between clients' self-reported attachment patterns and the therapeutic alliance. In this review, it is suggested that the more secure clients are in their attachment relationships, the better the quality of the alliance they form with their therapist (Bruck, Winston, Aderholt, & Muran, 2006; Tasca, Balfour, Ritchie, & Bissada, 2007; Tereno, Soares, Martins, Celani, & Sampaio, 2008). At the same time, empirical evidence indicates that clients' attachment avoidance and anxiety are not significantly related to alliance ratings while also indicates that having an avoidant attachment pattern reduces the strength of the alliance (Smith et al., 2010). Researchers also claim that attachment insecurity is associated with specific patterns in alliance development (Chen & Mallinckrodt, 2002; Kanninen, Salo, & Punamaki, 2000), and serves as predictors of both therapeutic alliance and treatment outcomes (Bachelor,

Meunier, Laverdiére, & Gamache, 2010; Byrd, Patterson, & Turchik, 2010; Eames & Roth, 2000; Marmarosh et al., 2009; Meyer & Pilkonis, 2001). Insecurely attached individuals may avoid forming a connection with the therapist or alternately worry excessively about the therapist and the therapeutic relationship, both of which have been shown to detrimentally impact the quality of the alliance (Smith, Msetfi, & Goldin, 2010). In support of this idea, in the recent meta-analyses they conducted, (Bernecker, Levy, & Ellison, 2014; Diener, Hilsenroth, & Weinberger, 2009; Diener & Monroe, 2011) researchers found that securely attached individuals displayed stronger working alliance compared with the ones insecurely attached.

Diener and colleagues (2009) conducted a meta-analytic review, and they examined the relationship between adult attachment style and the client-reported therapeutic alliance in individual therapy. They found that greater attachment security was associated with a stronger therapeutic alliance and greater attachment insecurity was associated with a weaker therapeutic alliance. Diener and Monroe (2011) also completed a meta-analytic study where they investigated the relation between the security versus insecurity dimensions of attachment and alliance. They concluded that secure attachment is associated with a stronger alliance (Diener & Monroe, 2011).

In the meta-analytic review conducted by Bernecker and colleagues (2014), the researchers quantified the strength of the relations between attachment avoidance and alliance and between attachment anxiety and alliance. Both relations were found significantly negative, with higher avoidance and higher anxiety predicting weaker therapeutic alliance. These results are consistent with Diener and Monroe's (2011) finding that secure attachment relates to a stronger therapeutic alliance. These results provide additional information to support the idea

that the anxiety and avoidance dimensions of attachment significantly relate to the therapeutic alliance.

The inconsistency that the author of this current study found in terms of the relationship between attachment style and therapeutic alliance suggests that much of the variance in alliance remains to be accounted for, even after taking into consideration clients' attachment style. In this respect, the findings suggest that an individual's enduring relationship pattern outside of therapy does not automatically map onto the therapeutic relationship (Diener & Monroe, 2011); instead, individuals with more insecure attachment styles can still develop positive working alliances with their therapists (Diener & Monroe, 2011). Given that clients' attachment patterns may change during therapy (Daniel, 2006), the inconsistent results regarding attachment style's impact on therapeutic alliance may suggest that client rated attachment insecurity may be subject to change and thus its impact on the therapeutic alliance may change as the therapy progresses.

Therapeutic Alliance and Therapeutic Presence

The therapeutic relationship has been identified as a consistent factor influencing therapeutic outcomes (Del Re, Flückiger, Horvath, Symonds & Wampold, 2012; Flückiger, Del Re, Wampold, Symonds & Horvath, 2012; Horvath & Symonds, 1991; Koole & Tschacher, 2016; Martin et al., 2000; Wampold, 2000). Over a century ago, Freud (1913) addressed the significance of the relationship between therapist and client. After decades of sound research confirming the critical role of the therapeutic alliance, the mental health field continues to encounter challenges in identifying how to best capitalize on this understanding.

Recent research into the groundwork of the therapeutic relationship has identified the concept of therapeutic presence as being a key factor in developing the feeling of safety in therapy setting (Colosimo & Pos, 2015; Geller & Greenburg, 2012; Geller & Porges, 2014).

There is a general agreement about what defines therapeutic presence (Geller & Greenburg, 2002; Geller, Greenburg & Watson, 2010), and only one objective measure of therapeutic presence exists (Geller, et al., 2010). Therapeutic presence implies at a basic level the therapist's awareness of what is happening within themselves, with the client, and in the therapeutic context in the present moment (Geller & Porges, 2014).

Researchers and theorists hypothesize that a significant way presence may promote a positive therapeutic relationship is by creating a sense of safety for clients (Geller & Greenberg, 2012; Siegel, 2007, 2010). When working with individuals who experience interpersonal trauma, safety has to be established before starting treatment (de Zulueta, 2002). In addition to safety promoting optimal engagement between therapist and client, researchers suggest that a safe therapeutic environment facilitates the development of new neural pathways for the client, which in turn contributes to the repair of attachment injuries and provides the positive social interactions that are essential for health and neural growth for the client (Allison & Rossouw, 2013; Rossouw, 2013). Geller and colleagues (2012) conducted studies that uncover presence as a precondition to a positive therapeutic relationship and alliance. These studies contribute to the validity of the theoretical assumptions that one possibility as to how presence contributes to effective therapy is by promoting a positive therapeutic alliance.

Therapeutic Alliance and Cultural Humility

The integration of cultural factors in the mental health field is gaining more and more interest. Mental health professionals recognize the critical need to match the evolving multicultural world, to acknowledge and integrate into their treatment approaches the injustices that continue to be perpetuated when cultural groups are marginalized and mistreated. Nickerson (2017) identified the need for new approaches for culturally aware and effective intervention to

be developed. Culture shapes the experience of trauma and thus plays a major role in how counselors understand and address trauma (Berger, 2015; Drožđek, 2007). Culture serves as a lens through which people perceive, conceptualize, interpret, make meaning of, and respond to stressful events, as well as seek and use help (Berger, 2015). Each experience of an encounter with a traumatic stressor is unique and is given unique meaning by the life history of the person to whom it occurs (Brown, 2008). Understanding the influence of someone's culture is essential to making an effective therapeutic connection and promote the recovery process (Ardino, 2014).

As the US rapidly becomes a multicultural society and migrations increasingly change the cultural make-up of this country, as well as the rapid changes caused by globalization, a new generation of potential clients are facing complex issues when asking for mental health services (Mattar, 2010). In the field of trauma, there has been a slow yet increased recognition of the need to account for the cultural factors of what is traumatic and what coping mechanisms people use in the face of adversity. A review of the literature on culture and trauma resulted in very few articles and books (e.g., Brown, 2008; Bryant-Davis, 2005; Drožđek, 2007; Kirmayer, Lemelson, & Barad, 2007; Mattar, 2010; Nickerson, 2017) exploring this subject in depth.

The relationship between trauma and cultural background of the individual who experiences a traumatic event is critical because traumatic experiences typically require a response from the culture in terms of healing, treatment, interventions, counseling, and medical care (Chemtob, 1996). A holistic overview of both concepts (i.e., culture, trauma) is needed to gain an understanding of the relationship between these two concepts (Marsella & White, 1989). The researchers discuss the importance of cultural awareness, knowledge, attitudes, and skills. While existing cultural competency training lays essential groundwork for improving the quality of mental health care delivery to the nation's ever-changing population, it is equally important to

revisit what constitutes the construct of culture. Culture shapes lifestyles and beliefs that affect people's response to trauma. Brown (2008) claims that many traumas, particularly interpersonal traumas, are those of enforced intimacy, of shared physical and social realities, and frequently of shared or overlapping cultures and meanings. Trauma is flavored and shaped by those psychosocial, contextual, political, and cultural milieus in which it occurs. Ironically – within a subject matter that is itself a voicing of previously silenced realities – culture, identity, and social context have largely been the invisible components of conceptualizations of working with trauma survivors (Brown, 2008).

In the mental health field, there is a movement towards understanding cultural competency as a process rather than an end product that involves in addition to gaining factual knowledge, the ongoing attitudes toward both clients and clinicians (Hook, Davis, Owen, & DeBlaere, 2017). This process-oriented approach to cultural competency has recently received increased attention in the mental health field. Tervalon & Murray-García (1998) identified the construct of cultural humility as a contrast to cultural competency in health care field with the focus on how to help therapists build skills and competencies in terms of culture and its impact on clients' symptoms and treatment approach. Recent researchers initiated a new way of looking at cultural humility as perceived by the clients. In this regard, cultural humility involves a capacity to remain open to new ways of knowing and to listening to a client with non-judgment, and has been described as a "cultural presence" or "way of being" with a client, that can facilitate trust and self-disclosure (Hook, Davis, Owen, & DeBlaere, 2017).

A growing set of studies have found that engaging clients with cultural humility can be beneficial to the process and outcome of psychotherapy (Davis et al., 2016; Hook et al., 2013; Hook, Farrell, et al., 2016; Owen, Jordan, et al., 2014; Owen, Tao, et al., 2016). In engaging with

clients from different cultural backgrounds, cultural humility has been linked to being able to develop a stronger therapeutic alliance (Davis et al., 2016; Hook et al., 2013), and achieving higher rates of improvement (Hook et al., 2013; Owen, Jordan, et al., 2014). A strong therapeutic alliance is marked by a sense of trust between the therapist and the client, a collaborative and open relationship, and a purposeful joining to meet the needs of the client (Bordin, 1979). Hook and colleagues (2017) suggested that cultural humility can positively affect the three elements of the therapeutic alliance (i.e., bond, goals, and tasks, Bordin, 1979). Close relationships require sacrifice, investment, and support to blossom (Rusbult & Buunk, 1993), and the therapeutic relationship with clients grows and develops similarly. The importance of cultural humility in building, and maintaining a strong emotional bond with clients aligns with theory and research on the benefits of humility for the development, maintenance, and repair of relationships (Davis et al., 2013; Farrell et al., 2015). Clients who view their therapist as culturally humble (i.e., culturally safe, other-oriented, emotionally engaged, and responsive to their needs) are able and willing to deepen the therapeutic bond and therapeutic alliance (Hook et al., 2013). Knowing the research about cultural humility and therapeutic alliance, one might assume that a culturally humble clinician would be necessary for working with individuals who survived CIT trauma, particularly since their level of trust and safety are so affected by the traumatic event.

Implications for Counselors and Counselors Educators

Researchers indicate that trauma is an increasingly common concern among clients asking for mental health services and treatment (Layne et al., 2014). Moreover, interpersonal trauma is more prevalent than impersonal trauma (Berenz et al., 2016; Forbes et al., 2012), and also is more emotionally damaging (Lim, Valdez, & Lilly, 2015). With more clients reporting instances of traumatic experiences, counselors and counselor educators are responsible for

thinking about how to address the overwhelming need for trauma-informed care. Illuminating the role of client's attachment style in the building of the therapeutic alliance has potential clinical utility (Bernecke et al., 2014). Castonguay and colleagues (2006) proposed focusing on attachment style of the client and how it impacts the therapeutic alliance as being one of many efficient directions to include among therapists' techniques for developing and maintaining the alliance. If attachment style affects the therapeutic alliance, targeting attachment during therapy may be a strategy for improving the therapeutic alliance. Knowing more on the potential impact that therapeutic presence might have on the therapeutic alliance may also have implications for how counselor educators and supervisors train and supervise current and future professional counselors. Geller and Greenberg (2012) suggest that counselors' training needs to include relational practices (e.g., relational mindfulness) to help them remove the barriers to meeting another individual with presence as well as to deepen the ability to be fully open with another person while in contact with their own experience. Researchers strongly suggest that the cultivation of therapeutic presence of a person and their personal growth should be a priority in counseling training and can enhance the efficacy of therapeutic technique (Geller & Greenberg, 2012). Teyber (1997) states that the therapeutic relationship is most successful when clients believe their counselor to be someone who:

> … sees their predicament and recognizes their distress, feels with them and is moved or touched by their pain, is on their side and has their best interests at heart, and has an abiding commitment to help through their predicament (p.34).

In this light, a successful therapeutic alliance is one where the client is feeling understood by the therapist. To best understand a client's trauma, it is critical that the clinician takes into account the client's cultural background (Bemack & Chi-Ying Chung, 2017; Ciaccia & John, 2016). This background can inform the client's reaction to the trauma and can dictate how the client processes the aftermath of the trauma (Blackmon, Coyle, Davenport, Owens, Sparrow, 2016). It would seem obvious then, that for a successful alliance with clients who experienced interpersonal trauma, the counselor needs to learn more about the culture of their clients to gain better insight on how to connect with the client, and understand the role their cultural background plays in how they experience, process and cope with the traumatic event. Those who experience a traumatic event experience the distress of the trauma, and attempts to cope with that distress, in the psychosocial realities of a particular time, place, and location in the social and political world (Brown, 2008). Responding effectively to these realities in clinical work requires the development of cultural competence by all trauma-aware counselors. This goal has often seemed daunting largely because of how cultural competence has most commonly been defined. Perceived multicultural competence of therapists was found to positively relate to treatment satisfaction and therapeutic alliance strength (Anderson, Bautista, & Hope, 2019; Constantine, 2002; Fuertes et al., 2006). At the same time, one of the major criticisms of cultural competence frameworks is that has an "emphasis on attempting to know and become competent in understanding another's culture or cultures" (Fisher-Bone, Cain, & Martin, 2015, p.169). When working with trauma, this becomes particularly sensitive since the core experiences of psychological trauma are disempowerment and disconnections from others (Herman, 1992).

Counselor educators serve an essential role in advocating for the profession and promoting best practices for counselors. Understanding the factors that contribute to the

development of the therapeutic relationship in the context of CIT may help counselor educators develop an appropriate curriculum for training and increase awareness of supervision needs while in training. For this reason, future research needs to investigate the experiences of individuals with a history of CIT in counseling. It is also critical to know more about the factors that might potentially contribute to the development of the therapeutic alliance. Though current literature consistently indicates that therapeutic alliance is the strongest predictor of therapeutic outcomes, there is no clear understanding of what counselor and/or client characteristics impact the development of the therapeutic alliance when working with individuals with CIT. Attachment style, cultural humility, and therapeutic presence should be explored together as they were found to be related to the therapeutic alliance when working with general populations.

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2 THERAPEUTIC ALLIANCE AMONG INDIVIDUALS WHO EXPERIENCED CHILDHOOD INTERPERSONAL TRAUMA: THE ROLE OF CULTURAL HUMILITY, THERAPEUTIC PRESENCE AND ATTACHMENT STYLE

Childhood Interpersonal Trauma

Childhood interpersonal trauma (e.g., sexual, physical, and emotional abuse, neglect, domestic violence occurred before the age of 18, Cloitre, Koenen, Cohen, & Han, 2002) is a serious public mental health problem in the US, with recent research indicating that 678,810 children in the United States were victims of childhood abuse in one year (U.S. Department of Health & Human Services, 2013). Approximately 25% of women and 16% of men report a history of sexual abuse prior to the onset of puberty (Badour, Resnick, & Kilpatrick, 2017; Berenz et al., 2016), and one in five women and one in 71 men will be sexually assaulted during their lifetime (Black et al., 2011). Worldwide, approximately one in four children are physically or sexually abused, and one in three women experiences physical or sexual violence (World Health Organization, 2016). The estimated prevalence of childhood trauma in American adults older than 55 years were 13.5% for verbal abuse, 9.6% for physical abuse and 9.3% for sexual abuse (Bynum et al., 2010). Childhood interpersonal trauma (CIT) is experienced in several ways. In a recent study conducted by Berenz et al. (2016), participants in the sample (N = 295) reported experiencing different types of CIT: physical abuse growing up (19.9%); witnessed family violence growing up (38.7%); childhood sexual assault before the age of 13 (25.2%); and childhood sexual assault ages 13-17 (21.5%).

Much has been written about the effects of trauma, especially about fear, anxiety, and terror induced by overwhelming events. Over the past three decades, the centrality of interpersonal features related to childhood trauma has been well established, both in terms of

etiology, consequences, and treatment (Van Nieuwenhove & Meganck, 2017). On the level of etiology, research has shown that (prolonged) interpersonal trauma, such as childhood physical, sexual, and/or psychological abuse, have more detrimental psychological effects than non-interpersonal trauma, such as a natural disaster or a car accident (Ehring & Quack, 2010). Less has been written about the effects of the violation of human bonds and the effects of loss of important human connections. All types of violence, abuse, and oppression can have traumatic effects; however, traumas that occur in childhood and the context of interpersonal relationships can be particularly damaging because of the betrayal involved in the breach of basic assumptions of interpersonal and social relationships (Freyd, 1994, 1996). In support of this viewpoint, Freyd, DePrince, and Zurbriggen (2001) found that physical and emotional abuse completed by a caregiver was related to higher levels of self-reported memory impairment for the events compared with non-caregiver abuse.

Individuals with a history of CIT demonstrate interpersonal difficulties that stem from a disturbed sense of self and other (Muller, Lemieux, & Sicoli, 2001), which in turn influence their capacity to form a strong alliance with therapists (Pearlman & Courtois, 2005). Finding safety in relationships can be a challenge for clients who have experienced CIT, and they often re-enact themes of powerlessness, shame, guilt, distrust, and abusive patterns within the therapeutic relationship (Herman, 1992; Tyson & Goodman, 1996).

Therapeutic Alliance

Even though the therapeutic alliance is one of the most frequently studied topics within contemporary clinical psychology (Elvins & Green, 2008; Horvath, Del Re, Flückiger, & Symonds, 2011; Wampold & Imel, 2015), this construct has not received the well-deserved attention in the field of professional counseling. The therapeutic alliance in individual therapy

has been studied for over 45 years now across many different theoretical orientations and treatment approaches and has been consistently identified as a significant predictor of treatment outcomes (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Norcross, 2002, Wampold, 2001). Moreover, the therapeutic alliance has not received nearly sufficient attention in the context of working with individuals who experienced CIT, despite the increasing prevalence of those events in the general population. A search of the literature for the past 20 years produced only three studies examining therapeutic alliance among individuals with a history of CIT (i.e., Lafrenaye-Dugas, Godbout, & Hebert, 2018; Paivio, Hall, Holowaty, Jellis, & Tran, 2001; Zorzella, Muller, & Classen 2014).

Therapeutic Alliance and Childhood Interpersonal Trauma

A therapeutic relationship with mutual trust and efficacy is a necessary foundation for the therapeutic process (Bordin, 1979), because it can create healing power (Yalom, 1980), contribute to treatment engagement (Horvath & Luborsky, 1993), and facilitate therapeutic success across multiple theoretical and treatment interventions (Bordin, 1979; Horwitz, 1974; Horvath & Symonds, 1991; Orlinsky, Ronnestad, & Willutzki, 2004). As Bordin (1979) suggested, some level of trust is important in most therapeutic relationships and especially when working with clients who have experienced chronic levels of betrayal trauma in their interpersonal relations with caregivers (Gobin & Freyd, 2009), and subsequent interpersonal problems in adulthood (Cloiter, Miranda, Stovall-McClough, & Han, 2005). Researchers have acknowledged that the effects of CIT are unique from that of other types of trauma and can manifest in complex ways (Allard, Nunnink, Gregory, Klest & Platt, 2011; Cloitre et al., 2009). Briere (2002) supports the idea that the clients' most frequent presenting problems are not the

many symptoms of Post Traumatic Stress Disorders (PTSD), but rather their failed or failing relationships.

When the client has been humiliated, hurt, and betrayed, as it happens with individuals who have experienced CIT, the process of entering and maintaining a therapeutic relationship becomes very complex, and it is difficult for the therapist to provide safety and protection to their clients (Turner, McFarlane, & Van der Kolk, 1996). Despite these noted connections between trauma and the therapeutic alliance, very few studies have examined variables that contribute to the therapeutic alliance when working with individuals who have experienced CIT.

For a field that is fundamentally relational, relatively little research has been devoted in the field of professional counseling to predictors of the therapeutic alliance. Among the factors that have been found to contribute to the development of therapeutic alliance, there are few that received special attention (e.g., attachment style, cultural humility, therapeutic presence). This study will add to the current literature by looking at these factors (i.e., attachment style, cultural humility, therapeutic presence) that have been studied in the context of the therapeutic alliance, and yet have not been explored when looking at individuals who have a history of CIT.

The role of attachment, therapeutic presence and cultural humility in the development of the therapeutic alliance

Therapeutic Alliance and Attachment

Bowlby (1969/1982) describes attachment as a strong emotional bond between infants and their primary caregiver that facilitates security in the infant. Having a secure attachment figure promotes a sense of security and fosters a positive view about oneself as being good, and an attachment figure as being available. Positive interactions with reliable and consistent caregivers will lead to a secure behavioral pattern (e.g., seeking proximity with a caregiver) to

cope with stressful events (Ainsworth, Blehar, Waters, & Wall, 1978). The interactions with available attachment figures in times of need may then act as resilience resources, which may enhance the inner sense of security or external support sources to overcome traumatic, stressful events in later life (Mikulincer, Shaver, & Horesh, 2006; Mikulincer, Shaver, & Solomon, 2015). In contrast, attachment insecurity is characterized as negative cognitions regarding self as incompetent, others as unsupportive, and the world as unsafe (Bowlby, 1982). Negative expectations for unreliable and inconsistent attachment figures will lead to anxious or avoidant behavioral patterns (e.g., crying for or resistance to caregiving) to adverse events (Ainsworth et al., 1978). Researchers have proposed that the activation of an insecure attachment system may cause a failure of affect and behavior regulation in confronting traumatic life events and prevent insecure individuals from effectively coping with traumas, which may in turn contribute to more PTSD symptoms (Markowitz, Milrod, Bleiberg, & Marshall, 2009; Mikulincer et al., 2006; Mikulincer et al., 2015; Sharp, Fonagy, & Allen, 2012; Woodhouse, Ayers, & Field, 2015). Within the context of interpersonal traumas, the activation of an insecure attachment system may not only disrupt affect and behavior regulation but also impair one's ability to establish trust relationship and secure attachment bond.

Researchers that have investigated attachment have focused primarily on research with White, North American and European populations (Metzger, Erdman, & Ng, 2010). Nonetheless, evidence supports the hypothesis that basic concepts of attachment are universal, although culture plays an essential role on how individuals develop and express attachment (Metzger et al., 2010; Wang & Mallinckrodt, 2006).

Adult self-reported attachment is best assessed by two continuous dimensions – avoidance and anxiety (Brennan, Clark, & Shaver, 1998; Fraley & Waller, 1998). Both avoidance and anxiety dimensions are concerned with how individuals behave in relationships, and a score on those two dimensions indicates individuals' level of security in attachment. Attachment avoidance concerns the degree to which individuals experience discomfort with being close to and depending upon others. Attachment anxiety relates to the extent to which individuals fear others will reject and abandon them in times of need. Individuals who are securely attached will score low on both of these dimensions.

Numerous researchers have investigated and hypothesized possible ways attachment dimensions and therapeutic alliance may interact with each other. Some theorists, particularly those that are part of the analytic school of thought, have suggested that attachment style transfers in the context of the therapeutic alliance (Safran & Muran, 2006), while other theorists (e.g., Holmes, 2001) claim that therapeutic alliance is nothing more than the bond that builds between the client and the therapist. Researchers have hypothesized that attachment style serves as a predictor of the therapeutic alliance (Eagle & Wolitzky, 2009; Mikulincer, Shaver, Cassidy, & Berant, 2009), with the insecure attachment style negatively impacting therapeutic alliance.

Zorzella, Muller, and Classen (2015) conducted a study that investigated the client's perception of their alliance with the therapist in relationship with attachment dimensions. The researchers found that clients' experience of therapeutic relationships varies as a function of their attachment dimensions. These results are consistent with findings in the literature regarding the impact of client attachment classification on the perception of the therapeutic relationship (Daniel, 2006; Kanninen, Salo, & Punamaki, 2000; Muller, 2009, 2010; Muller & Rosenkranz, 2009).

Several empirical studies have shown that attachment style appears to influence perceptions of the therapeutic relationship (Marmarosh et al., 2014). Results from the meta-analysis of 17 studies that explored relationships between attachment style and therapeutic alliance ratings, Diener and Monroe (2011) concluded that secure client attachment style was associated with higher therapeutic alliance ratings than an anxious or avoidant attachment. Consistent with these results, Bernecker, Levy, and Ellison (2014) found that higher attachment avoidance and higher attachment anxiety predicted lower therapeutic alliance. Another review conducted by Mallinckrodt and Jeong (2015) found similar results. These authors reviewed 14 published studies that looked at attachment style and therapeutic relationship in help-seeking clients. Mallinckrodt and Jeong (2015) concluded that secure attachment was strongly positively correlated with the therapeutic alliance, avoidant attachment was negatively correlated with the therapeutic alliance, and anxious attachment was not found significantly correlated with therapeutic alliance.

The systematic review conducted by Smith, Msetfi, & Golding, (2010) where the researchers reviewed research findings by attachment dimension (i.e., anxiety and avoidance), they identified greater inconsistencies in the literature and concluded that there is not sufficient evidence to support a significant relationship between specific attachment dimensions and therapeutic alliance. These results are consistent with results from more recent studies that did not find significant relationships between adult insecure attachment dimensions and therapeutic alliance (Taylor, Rietzschel, Danquah, & Berry, 2015). Levy, Kivity, Johnson, and Gooch (1996) conducted a meta-analysis of 36 studies (which included 3,158 patients), and they found that attachment security served as a moderator for the treatment outcome in the type of therapy approach that focuses on interpersonal interactions and close relationships. There are no studies

that have explored attachment style as a moderator for the therapeutic alliance.

While the current researcher found a theoretical consensus in terms of attachment's role in the development of the therapeutic alliance, the empirically based inconsistency found between attachment dimensions and therapeutic alliance suggests that there is a need for more research to understand the relationship between attachment style and therapeutic alliance.

Therapeutic Alliance and Cultural Humility

Cultural context shapes human behavior (Allwood & Berry, 2006; Wang & Song, 2010), so an inclusive clinical approach for treating individuals who survived interpersonal trauma should recognize the importance of culture. The relationship between trauma and culture is a critical one because traumatic experiences are so prevalent, universal in how they manifest and occur, and typically demand a response from the culture in terms of healing, treatment, interventions, counseling, and medical care (Chemtob, 1996). Marsella and White (1989) theorize that both trauma and culture need to be holistically overviewed to gain a good understanding of the relationship between them. Brown (2008) asserts that a culturally competent trauma therapist is aware of the various components of the client's multiple cultural identities, aware of how those different components of the cultural identity impact the experience, and responds to trauma and integrate them all in the healing process.

In terms of integrating cultural aspects in the therapy process, in recent years there is an increased interest in the mental health field in moving towards a humility approach rather than a competency approach. Hook, Davis, Owen, Worthington, and Utsey (2013) define cultural humility as the ability to display and other-oriented attitude in regards to diverse cultural identities that are most salient to the client. Integral to cultural humility is how attuned a therapist is to recognizing power dynamics (Hook, et al., 2013). Goodrich (1991) draws attention to the

difference between how a "power over" versus a "power to" (empowerment) stance can have effects on the relational context.

The relationship between cultural humility and therapeutic alliance has been investigated and researchers have consistently found that engaging clients with cultural humility can be beneficial to the process and outcome of psychotherapy (Davis et al., 2016; Hook, Farrell, et al., 2016; Owen, Jordan, et al., 2014; Owen, Tao, et al., 2016). Specifically, in engaging with clients from different cultural backgrounds, cultural humility has been linked to developing a stronger working alliance (Davis et al., 2016; Hook et al., 2013), and achieving higher rates of improvement (Hook et al., 2013; Owen, Jordan, et al., 2014). Relationships between cultural humility and alliance have only been conducted in the general population, and there is no study to date that investigates this relationship among individuals who have experienced CIT. Using a culturally humble approach might be critical when working with this specific population because survivors of CIT experience a deep lack of trust, safety, and power in their close relationships due to the profound feeling of betrayal.

Therapeutic Alliance and Therapeutic Presence

Presence is a powerful yet highly delicate form of communication that has been central to existential-humanistic approaches to therapy (Elkins, 2007). Presence is a complex mix of appreciative openness, concerted engagement, support, and expressiveness (Bugental, 1987), and it has also been promoted by many of the most masterful therapists – regardless of orientation (Geller & Greenberg, 2012; Wampold, 2006). In this light, Schneider (2015) theorizes that presence is at the core of the factors research (Wampold, 2006). Geller and Greenberg (2012) further made a strong case for presence as a core dimension of practice. Drawing from a qualitative study they did in 2002 on therapeutic presence, they elaborate four dimensions that

are key to therapeutic presence – the sense of "being grounded, which includes feeling centered"; the sense of being immersed "in the moment with the client"; "the sense of spaciousness or an expansion of awareness" and the sense of "intention for presence to be with and for the client's healing process" (p. 109).

Attachment literature documents that CIT and early lack of attunement (i.e., a caregiver not attuned to the needs of the child) result in emotional dysregulation (Schore, 1994, 2003; van der Kolk, 1994, 2011). When clients experience lack of attachment to their primary caregivers, they can perceive themselves to be chronically in danger; thus, activating a sense of safety through being present with and for clients can down-regulate their defenses and promote growth and change. In addition to promoting optimal engagement between therapist and client, research suggests that a safe therapeutic environment contributes to the repair of attachment injuries and provides the positive social interactions that are essential for health and growth for the client (Allison & Rossouw, 2013; Rossouw, 2013). Researchers (Geller & Greenberg, 2012; Geller, Greenberg, & Watson, 2010) suggest that presence is a precondition to a positive therapeutic relationship and alliance. These studies contribute to the validity of the theoretical assumptions that one possibility as to how presence contributes to effective therapy is by promoting a positive therapeutic alliance.

Each of these factors described above has been found to impact the therapeutic alliance significantly. At the same time, this type of research has yet to be expanded in the context of working with individuals who have experienced CIT. After completing an extensive overview of the literature on interpersonal trauma, Van Nieuwenhove & Meganck (2017) suggest the importance of interpersonal difficulties in the treatment of interpersonal trauma, especially in the formation of the therapeutic alliance. The authors claim that further research should aim at a

deeper understanding of the nature of interpersonal trauma, the ways therapeutic alliances develop, and the processes through which therapeutic alliances can change. This study includes variables related to the experiences of CIT survivors (e.g., attachment, relationship factors such as a therapeutic presence and therapeutic alliance), while including cultural considerations through the inclusion of cultural humility. This important distinction will allow results to inform ways in which mental health professionals might help individuals who experienced CIT. Further, the results from this study may provide empirical evidence for including specific training approaches when working with this specific population in existing CACREP counseling curriculum.

Rationale and Present Study

Individuals with a history of childhood abuse demonstrate interpersonal difficulties that stem from a disturbed sense of self and other (Muller, Lemieux, & Sicoli, 2001), which in turn may diminish their capacity to establish strong therapeutic alliances with the therapist (Paivio & Cramer, 2004; Pearlman & Courtois, 2005). Despite this, key variables might influence the development of the therapeutic alliance when working with individuals with CIT history. The current study examines the potential role of cultural humility, therapeutic presence, and attachment style on the development of the therapeutic alliance. Empirical data documented that greater exposure to CIT is related to more insecure attachment (Godbout et al., 2017). Additionally, negative relationships exist between insecure attachment and therapeutic alliance (Diener & Monroe, 2011), and between trauma and therapeutic alliance (Paivio & Cramer, 2004). Researchers suggest clients' reports of their therapists' therapeutic presence is predictive of the therapeutic relationship (Geller et al., 2010) and the therapeutic alliance (Pos, Geller, & Oghene, 2011). Researchers found that clients who perceived their therapists to be higher in

cultural humility also reported stronger working alliances with their therapists (Hook et al., 2013). Although those relationships exist, the interrelations among them have not been explored together in a sample of individuals with CIT history. The purpose of this study is to explore the relationships among cultural humility, therapeutic presence, attachment style, and therapeutic alliance in the context of working with individuals who experienced CIT. The following research questions and hypotheses guided the study:

Research Question 1: What are the relationships among cultural humility, attachment style, therapeutic presence, attachment style, and therapeutic alliance when working with individuals who experienced CIT?

Hypothesis 1a: A significant relationship will be found between cultural humility and therapeutic alliance.

Hypothesis 1b: A significant relationship will be found between therapeutic presence and therapeutic alliance.

Hypothesis 1c: A significant relationship will be found between attachment style and therapeutic alliance.

Research Question 2: Do cultural humility, therapeutic presence, and attachment style serve as predictors of therapeutic alliance when working with individuals who experienced CIT?

Hypothesis 2a: Cultural humility will predict the therapeutic alliance

Hypothesis 2b: Therapeutic presence will predict therapeutic alliance.

Hypothesis 2c: Attachment style will predict the therapeutic alliance.

Research Question 3: Does attachment style moderate the relationship between therapeutic presence and the therapeutic alliance when working with individuals who experienced CIT?

Hypothesis 3a: Attachment style will moderate the relationship between therapeutic presence and therapeutic alliance

Research Question 4: Does attachment style moderate the relationship between cultural humility and the therapeutic alliance when working with individuals who experienced CIT?

Hypothesis 4a: Attachment style will moderate the relationship between cultural humility and therapeutic alliance

Methodology

Participants and Procedure

Data collection took place following approval from a University Institutional Review Board. Data was collected via Amazon's Mechanical Turk website (MTurk; www.mturk.com/mturk/welcome). MTurk is an online web service that connects researchers to individuals willing to complete tasks for a wage. Participants who qualified for this study were paid $0.50 for completing the 15 minutes study. Participants who did not meet the inclusion criteria received $0.01. An MTurk survey pay rate of 50 cents has been shown to promote increased participation, compared to lower pay rates of two and ten cents, for a thirty-minute long survey (Buhrmester, Kwang, & Gosling, 2011). This suggests that 50 cents per quarter of an hour compensation rate were appropriate for the present study.

Participation was restricted to users who had an account from the United States. Potential participants first read an informed consent document, which described the study and their rights

as participants, and those who indicated consent were directed to the qualification questions. Participants must have reported (a) being 18 years of age or older; (b) experiencing at least one interpersonal traumatic event; (c) currently seeing a mental health professional to address their trauma, and (d) seeing this professional for at least four individual sessions. Participant names were not collected during the research and identifying information (i.e., demographic information) was kept secure throughout the research process.

One of the inclusion criteria was a self-reported experience of childhood interpersonal trauma (e.g., sexual assault, physical assault, emotional abuse, neglect, domestic violence before the age of 18); thus, subjects may have been at risk of being triggered by participation. Smyth's (1996) meta-analysis on written-disclosure studies indicates that writing about emotional topics is associated with significant reductions in distress, and produces long-term improvements in mood and indicators of wellbeing. Participants' potential emotional discomfort was nonetheless taken into consideration when collecting data, and three prompts were inserted within the questionnaire that offers participants the phone number of crisis lines in case they were triggered while completing the study (e.g., "Should you experience any distress triggered from the questions asked in this study, you have the option to discontinue your participation in this study at any time. If you experience any emotional discomfort, please contact the 24- Hour Crisis Line at 1-800-273-8255. This line is free and private.")

Careless and insufficient-effort responding was assessed by the use of four attention checks (i.e., direct instructed items, DeSimone, Harms, & DeSimone, 2015) placed throughout the survey. For example, participants were given information on the 24-hour crisis line, including information stating this line was free of charge and then asked to select if the crisis line had a cost or was free. Other attention checks simply asked participants to select a certain score as their

answer (e.g., "Please select 3 as your answer"). One attention check was inserted in the trauma screening measure, one was inserted in the attachment measure, and the last two inserted in the therapeutic alliance measure. Literature seems to be inconsistent in suggesting the cut-off scores for attention checks. Keith, Tay, and Harms (2017) completed a review of 138 articles utilizing 250 MTurk samples. They claim that on average, attention checks resulted in 43 workers (SD = 70) being excluded, which equates to roughly 13% of samples, on average; however, the common tactic of simply dropping respondents who fail the attention checks is viewed as problematic because the resultant skewed sample can produce severely biased estimates (Berinsky, Margolis, & Sances, 2014). The researcher decided to include in the final sample all participants who successfully responded to at least three out of the four attention checks. Additional precautious were used to ensure data quality. The researcher included completion time as a variable in determining the final sample. In determining the completion cut off score, the researcher calculated the average completion time for the participants who answered at least three attention checks correctly (M = 17.35, SD = 7.57), and this value was used as a cutoff for completion time. Before calculating the average completion time for these participants, one outlier was excluded. After taking all these precaution measures, 27 participants were removed from the sample.

An A Priori power analysis (Cohen, 1988) using G*Power Version 3.1. (Faul, Erdfelder, Lang, & Buchner, 2007) indicated that a minimum sample size of 77 participants would be needed for detecting a medium effect size (.15) with three tested predictors. This assumed the model be tested at $\alpha = .05$ and $1-\beta = .80$ (Cohen, 1988). The statistical procedures used to analyze the data included regression and moderation analyses. Because statistical significance is dependent on multiple factors, it is difficult to anticipate how many participants are needed to

reach statistical significance (Kline, 2005). General guidelines suggest that at least 200 participants are needed for both analyses (Hayes, 2013). The final sample consisted of 251 participants, suggesting adequate power was present.

After removing all participants due to either not meeting the inclusion criteria (57.12%, *n* = 397), missing data (2.87%, *n* = 20), and for not meeting the completion time cut off score (.14%, *n* = 1) and attention checks cut off score (3.74%, *n* = 26), 251 (36.11%) participants remained in the final sample of the study. Participant ages ranged from 18 to 62 (*M* = 33.06, *SD* = 9.78), with 77.3% identifying as female (*n* = 194), 19% (*n* = 50) as male, and 2.8% (*n* = 7) as transgender. The sample was racially diverse with 70.1% identifying as White (*n* = 176), 8.4% (*n* = 21) identifying as Hispanic/Latino, 8% (*n* = 20) identifying as Black/African American, 7.6% identifying as Multiracial (*n* = 19), 4% of the sample identifying as Asian/Pacific Islander (*n* = 10), .8% (*n* = 2) identifying as Native American, one participant (.4%) self-identified as Middle Eastern, one participants identified as South Asian (.4%) and one participant (.4%) of the participants selected that they identified as Asian/Indian. In terms of religion/spirituality, the sample displayed diversity with 18.3% identifying as Agnostic, 15.5% Christian Catholic (*n* = 39), 14.7% identifying as spiritual but not religious (*n* = 37), 12.7% Hindu (*n* = 32), 12.4% Atheist (*n* = 31), 11.6% Christian Protestant, (*n* = 29). In terms of education level, the largest represented group was individuals who have some college years without having a degree (32.3%, *n* = 81) followed by individuals who have bachelor degree (22.7%, *n* = 57), and by those with an associate degree (16.3%, *n* = 41) and in term of employment status, the largest group was the one represented by individuals employed for wages (48.6%, *n* = 122), followed by those who are self-employed (15.5%, *n* = 39), and by students (10.4%, *n* = 26). Participants primarily identified as heterosexual (66.5%, *n* = 167), married/partnered (35.9%, *n* = 90), able bodied

(75.7%, *n* = 190), and with a personal income of less than $14,999 (27.1%, *n* = 68). In this sample, 13.14%, (*n* = 33) participants reported that gender is the most salient aspect of their identity, 12.74% (*n* = 32) reported religion being the first most critical identity, and 11.95%, (*n* = 30) reported that race is the first most important part of their cultural identity. 48.6% (*n* = 122) of the participants reported that they are seeing a psychologist, 37.5% a licensed professional counselor (*n* = 94), and 6.7% a social worker (*n* = 17). In terms of setting, 57.4% reported going to a private practice (*n* = 144), 17.5% outpatient care (*n* = 44), 12.4% a community agency (*n* = 31), and 9.6% a day clinic (*n* = 24). In terms of history of mental health treatment, 31.5% (*n* = 79) of participants reported that this is the first time they are seeing a mental health professional for their trauma. The demographic information for all the participants in the sample is included in Table 1.

Table 1

Participant Demographics (N = 251)

	N	*Range*	*M*	*SD*
Age	251	18 – 62	33.06	9.78
				N (%)
Gender				
Female				194 (77.3)
Male				50 (19.9)
Transgender				7 (2.8)
Race/Ethnicity				
Asian/Pacific Islander				10 (4.0)

Black/African American	20 (8.0)
Caucasian/White	176 (70.1)
South Asian	1 (.4)
Hispanic/Latino	21 (8.4)
Middle Eastern	1 (.4)
Native American/American Indian	2 (.8)
Multiracial/Ethnic	19 (7.6)
Identity not listed	1 (.4)
Religion/Spirituality	
Agnostic	1 (.4)
Atheist	46 (18.3)
Buddhist/Taoist	31 (12.4)
Christian/Catholic	7 (2.8)
Christian/Protestant	39 (15.5)
Christian/Other	29 (11.6)
Hindu	32 (12.7)
Jewish	4 (1.6)
Muslim/Islam	7 (2.8)
Spiritual not religious	37 (14.7)
Wiccan/Pagan/Neo Pagan	12 (4.8)
Identity not listed	6 (2.4)
Sexual Orientation	
Lesbian/Gay	14 (5.6)

Straight/Heterosexual	167 (66.5)
Bisexual	49 (19.5)
Pansexual/Omnisexual	12 (4.8)
Identity not listed	9 (3.6)
Education	
Some high school, no diploma	4 (1.6)
High school/GED	18 (17.2)
Some college, no degree	8 (32.3)
Vocational training	16 (6.4)
Associate degree	41 (16.3)
Bachelor degree	57 (22.7)
Master degree	26 (10.4)
Professional degree	4 (1.6)
Doctoral degree	4 (1.6)
Employment status	
Employed for wages	122 (48.6)
Self-employed	39 (15.5)
Out of work, looking for work	17 (6.8)
Out of work, currently not looking for work	4 (1.6)
Homemaker	22 (8.8)
Student	26 (10.4)
Military	2 (.8)
Retired	3 (1.2)

Unable to work	16 (6.4)
Relationship Status	
Single	72 (28.7)
Dating, monogamous relationship	62 (24.7)
Dating, non-monogamous relationship	7 (2.8)
Married/Partnered	90 (35.9)
Married and separated	4 (1.6)
Divorced	12 (4.8)
Widowed	1 (.4)
Identity not listed	3 (1.2)
Ability Status	
Identified with a disability	61 (24.3)
Not identified with a disability	190 (75.7)
Personal Income	
Less than $14,999	68 (27.1)
$15,000 - $29,999	59 (23.5)
$30,000 - $44,999	53 (21.1)
$45,000 - $59,999	41 (16.3)
More than $60,000	30 (12.0)
History of Mental Health Services	
First time seeing a MHP	79 (31.5)
Seen a MHP before	172 (68.5)
Type of Mental Health Services Provider	

Social Worker	17 (6.8)
LPC	94 (37.5)
Psychologist	122 (48.6)
Other	13 (5.2)
Not aware of their qualification	5 (2.0)
Type of treatment setting	
Day clinic	24 (9.6)
Outpatient care	44 (17.5)
Community agency	31 (12.4)
Private practice	144 (51.4)
Other	8 (3.2)

Measures

Overall Lifetime Trauma Experience. Participants' exposure to trauma was assessed using a modified version of The Early Trauma Inventory Self Report-Short Form (ETISR-SF; Bremner, Vermetten, & Mazure, 2000). The ETISR-SF is a 27-item inventory designed to assess physical, emotional, and sexual abuse, as well as general (non-interpersonal) traumatic experiences that may have occurred before the age of 18. Each of the items is answered "yes" or "*no*". The ETISR-SF has good validity (based on the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995, r = .73-.47) and internal consistency indicated by a Cronbach's alpha range from .70 to .87 (Bremner, Bolus, & Mayer, 2011). Cronbach's alpha for the present study was .82. Frequency of childhood and adulthood experiences of interpersonal trauma was calculated based upon the item that asks participants "How many times did you experience this event as a child and/or as an adult?" Because the author was hoping to gather more detailed

information about the participants' exposure to trauma, modifications were made to the original scale. Interpersonally traumatic events used in the *Trauma History Screen* (THS, Carlson, et al., 2011) were added to make the measure more comprehensive. Also, the instrument was altered so that responses referred to non-interpersonal and interpersonal events that were experienced in childhood and/or adulthood. The new scale (see Appendix A) included 31 items and participants responded "*yes as a child*", "*yes as an adult*", or "*no*" to each event, and also responded to how frequently they had experienced each of the events listed. In this study, the modified version of ETISR-SF was used as a screening tool and to operationalize childhood and adulthood interpersonal and non-interpersonal trauma experience. Only participants who identified as experiencing at least one childhood interpersonal traumatic event were included in the final sample.

Trauma Symptoms. The PTSD Checklist for DSM–5 (PCL-5; Weathers et al., 2013) is a 20-item self-report measure used to assess posttraumatic stress disorder (PTSD) symptoms for individuals' "most traumatic" potentially traumatic events. Each item corresponds to the symptom criteria for PTSD in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM–5; American Psychiatric Association, 2013). Participants indicated the degree to which they have been bothered by a specific problem (e.g., "repeated, disturbing dreams of a stressful experience from the past") in the past 30 days on a scale ranging from 0 (*not at all*) to 4 (*extremely*). The PCL-5 test scores demonstrated good internal consistency ($\alpha = .96$), test-retest reliability ($r = .84$), and convergent and discriminant validity (Bovin et al., 2016). PCL-5 scores demonstrated excellent convergent validity with the posttraumatic stress disorder (PTSD) Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993, $r = .87$) scores as well as with scores on the Patient Health Questionnaire (PHQ; Spitzer,

Kroenke, & Williams, 1999, *r* = .67) depression and generalized anxiety disorder scales. Also, PCL-5 scores demonstrated robust positive correlations with scores on measures of panic, somatization, disability, and functional impairment. PCL-5 scores demonstrated weaker correlations with scores on measures of alcohol abuse and psychopathy. PCL-5 scores and PCL-C scores displayed almost identical correlations with scores on the measures included. The total score of the PCL-5 was used as a measure of PTSD symptoms (α = .95), and a cut-off score of 33 was used to indicate a positive PTSD screen (Weathers et al., 2013) in this study.

Attachment. The Revised Adult Attachment Scale (RAAS; Collins, 1996) is an 18-item self-report measure, which assesses adult attachment tendencies on a five-point scale (1 = *not at all characteristic of me*, 5 = *very characteristic of me*). The RAAS measures three subscales: (a) close, (b) depend, and (c) anxiety. The Close dimension refers to the extent to which an individual is comfortable with closeness and intimacy (e.g., "I find it relatively easy to get close to people"). The Depend dimension refers to the extent to which an individual feels he or she can trust and depend on others (e.g., "I know that people will be there when I need them"). The Anxiety dimension refers to the extent to which an individual is fearful about being abandoned or unloved in relationships (e.g., "I often worry that romantic partners don't really love me"). The items on scales have been shown to have strong internal consistency (α = .80, α = .78, and α = .85, for close, depend, and anxiety scales, respectively) (Collins, 2008). For this study, the close and depend dimensions were combined to form an overall index of attachment avoidance, and the anxiety dimension was used as an index of attachment anxiety. This is as an alternative scoring procedure suggested by the author of the scale (Collins, 1996), and that has been used in previous studies (e.g., Huang et al., 2017). In the current sample, the internal consistency for the two subscales (i.e., attachment avoidance and attachment anxiety) was .84 and .88 respectively.

Perceived Therapeutic Presence. Two versions of the Therapeutic Presence Inventory were created and studied: one from the therapist's perspective (TPI-T), and the second from the clients' perspective exploring the client's perceptions of their therapists' presence (TPI-C). TPI-C was developed from the TPI-T scale and it contains three items: "My therapist's responses were really in tune with what I was experiencing in the moment" (to reflect the process of therapeutic presence), "My therapist was fully there in the moment with me" (to reflect the experience of therapeutic presence), and "My therapist seemed distracted" (to reflect client's perception of the therapist not being present and to serve as a check for acquiescent responding) (Geller et al., 2010). Each item is presented on a 7-point Likert scale ranging from *completely* to *not at all*. The TPI-C has demonstrated good face validity and reliability ($\alpha = .85$) (Geller et al., 2010). Within the present sample, scale items had a Cronbach's alpha of .82, suggesting the sample had high internal consistency.

Perceived cultural humility. Perceived cultural humility was assessed using the 12-item Cultural Humility Scale (CHS; Hook et al., 2013) that measures client perceptions of the cultural humility of their counselor. The CHS consists of two subscales: positive (e.g., "My counselor is open to seeing things from my perspective") and negative (e.g., "My counselor makes assumptions about me"), and participants rate each item on a five-point Likert-type scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*. Items on the scale have demonstrated evidence of internal consistency, with Cronbach's alpha coefficients ranging from .86 to .93 (Hook et al., 2013). Further, the CHS shows relationships with the therapeutic working alliance and perceived multicultural competence, demonstrating evidence of construct validity (Hook et al., 2013). For the present sample, Cronbach's alpha coefficients ranged from .87 to .89 for the negative and positive subscales and was .88 for the full scale.

Therapeutic alliance. The Working Alliance Inventory (Horvath & Greenberg, 1986; WAI) is a 36-item questionnaire that can be administered to both clients and therapists. Three versions of the WAI are available: a client version, a therapist version, and an observer version. The client version of the scale was used in this study as earlier studies have shown that the client's appraisal of the alliance has the strongest association with the outcome (Horvath & Symonds, 1991). WAI has three subscales: Goals, Tasks, and Bond, each of which is based on Bordin's (1979) multidimensional theoretical conceptualization of the working alliance (WA). The Goals subscale measures the extent to which a client and therapist agree on the "goals (outcomes) that are the target of the intervention" (Horvath & Greenberg, 1989, p. 224). The Tasks subscale measures the extent to which a client and therapist agree on the "in- counseling behaviors and cognitions that form the substance of the counseling process" (p. 224). The Bond subscale measures the extent to which a client and therapist possess "mutual trust, acceptance, and confidence" (p. 224). Each WAI subscale is scored on a 7-point Likert-type scale ranging from 1 (*never*) to 7 (*always*) and has 12 non-overlapping items. Subscale scores can range from 12 to 84 and can, if desired, be summed to obtain a total score. Thus, total scores can range from 36 to 252. Higher scores reflect more positive ratings of working alliance. Internal consistency estimates of the total scores were .93 (client version; Horvath & Greenberg, 1986, 1989). Within the current sample, internal consistency was .96 for the full scale, suggesting the items had high internal consistency within the current sample.

Demographic Information. The demographic questionnaire (see Appendix B) included questions on age, gender, race/ethnicity, religion/spirituality, sexual orientation, college student generation status, religion, sexual orientation, ability status, education level, income level, employment status, and relationship status. Additionally, the survey included questions that

addressed history of mental health treatment, qualifications of the mental health provider seen by the participants (i.e., professional counselor, social worker, psychologist), and the treatment setting where they meet (i.e., day clinic, outpatient care, community agency, private practice).

Results

Preliminary Analysis

Following data collection process, data were transferred from the Qualtrics survey platform and analyzed using SPSS, version 25. Out of 695 participants who started the survey, 397 were eliminated due to not meeting the four inclusion criteria mentioned above (i.e., 28 reported being younger than 18; 87 did not identify as childhood interpersonal trauma survivors; 183 were not currently seeing a mental health practitioner; 58 reported not seeing a mental health practitioner in an individual setting; and 41 reported seeing a mental health practitioner for less than four sessions). Missing data were evaluated and 20 cases were eliminated for not completing a majority of the items. These participants answered yes to the informed consent, they answered all the demographic questions, but they did not proceed with the questionnaire. In addition, a missing values analysis was conducted in order to see patterns of missing data and determine whether it was reasonable to consider data missing at random. The results of Little's MCAR test demonstrated a nonsignificant result, ($\chi 2 = 18.108$, DF = 10, Sig. = 0.53) indicating that the data were missing completely at random. Due to this being a large sample, power not being an issue, and the assumption of MCAR satisfied, listwise deletion was determined as a reasonable strategy for remaining missing data (Kang, 2013). After removing the 20 cases, missing data were evaluated again, and there was less than 1% missing data for only two of the variables (i.e., cultural humility and therapeutic alliance). Due to the low percentage of missing data, missing values were replaced with the series mean (Tabachnick & Fidell, 2007).

Univariate values were explored to assess the data for normality. Skewness index values ranged from -.866 to -.150 and did not exceed the recommended absolute value of 2 (George & Mallery, 2010) and kurtosis index values did not exceed 7.0 (Curran, West, & Finch, 1996); therefore, the assumption of normality was met. Multicollinearity was checked by exploring tolerance and the Variation Inflation Factor (VIF) as well as the correlation matrix. The preliminary analysis of hierarchical linear regression yielded tolerance ranging from 0.470 – 1.000, and VIF ranging from 1.000-2.128, indicating that collinearity was not a problem for the models (Field, 2013). Additionally, linearity was tested using scatterplots, and even though there were no indications of curvilinear relationships, the author checked correlation coefficients and no predictors were highly correlated ($r > .85$), so it was confirmed that collinearity was not an issue. Research hypotheses 3a, and 4a (i.e., moderation effects) were tested using Hayes's (2013) PROCESS macro in SPSS 25.0. Tabachnick & Fidell, 2013 suggested steps to use before testing a moderation effect using the PROCESS macro (Hayes, 2013) with model 1. The predictor variables were mean centered to minimize concerns for multicollinearity. An interaction effect between therapeutic presence and attachment style and cultural humility and attachment style tested the moderating effect of attachment style between therapeutic presence and therapeutic alliance and cultural humility and therapeutic alliance respectively (Baron & Kenny, 1986).

Descriptive Characteristics

As indicated in Table 2, participants reported three types of interpersonal trauma. 88.8% reported that they had experienced only emotional trauma as a child ($n = 223$), 78.5% reported that they had experienced only childhood physical trauma ($n = 197$), and 60.2% reported that they have solely experienced childhood sexual trauma ($n = 151$), and 84.1% reported that they had experienced a combination of emotional, physical, and sexual childhood trauma ($n = 211$).

Table 2

Exposure to Interpersonal Trauma (N = 251)

	N (%)
Physical Abuse	197 (78.5)
Emotional Abuse/Neglect	223 (88.8)
Sexual Abuse	151 (60.2)
Cumulative Abuse	211 (84.1)

In further exploring the data, multiple separate one-way analyses of variance (ANOVA's) were run to see if there were any mean differences in therapeutic alliance based on demographic characteristics (i.e., gender, race, religion, income and education level, and relationship status). Significant mean differences were found in terms of therapeutic alliance levels, between the participants who identified as female (M = 197.15, SD = 38.62), and male (M = 173.58, SD = 33.16), and in terms of attachment avoidance levels between participants who identified as transgender (M = 48.00, SD = 7.83), females (M = 43.00, SD = 9.36), and males (M = 38.22, SD = 9.81).

The means and standard deviations were calculated for each of the instruments. The results of these calculations, as well as correlations between the variables, are presented in Table 3. In general, individuals showed levels of therapeutic alliance (M = 192.40, SD = 38.54) that are lower than other studies exploring therapeutic alliance in samples of individuals who experienced trauma (M = 208.74, SD = 29.35, Taylor, Rietzschel, Darquah, & Berry, 2015). In terms of attachment, individuals from the sample showed levels of attachment anxiety (M = 3.47, SD = 1.12), and attachment avoidance (M = 3.51, SD = .90) consistent with previous research

(attachment anxiety, *M* = 3.14, *SD* = 0.96; attachment avoidance *M* = 2.90, *SD* = 0.88, Huang et al., 2017). Perceived cultural humility levels (*M* = 4.08, *SD* = .72) were also consistent with previous studies (*M* = 4.02, *SD* = .86; Davis et al., 2016). The mean PCL-5 score (Weathers et al., 2013) for the overall sample (*M* = 43.04, *SD* = 20.69) was above the cut-off score of 33 for PTSD symptoms, with 68.1% of the sample screening positive for PTSD. These results are consistent with results from similar studies looking at interpersonal trauma survivors (51% of the sample demonstrated clinically significant PTSD symptoms, Gobin & Allard, 2016).

Table 3

Correlations, Means, Standard Deviations among Variables (*N* = 251)

Variable	**1**	**2**	**3**	**4**	**5**	**6**
1. PCL5	-					
2. Attachment Anxiety	.555**	-				
3. Attachment Avoidance	.484**	.527**	-			
4. Therapeutic Presence	.000	-.023	-.040	-		
5. Cultural Humility	-.064	-.054	-.007	.725**	-	
6. Therapeutic Alliance	-.121	-.117	-.041	.714**	.785**	-
M	43.04	20.88	42.19	16.89	49.02	192.40
SD	20.69	6.72	9.62	4.00	8.69	38.54
α	.95	.88	.84	.82	.88	.96

Note. **p<.01

The researcher ran correlation analyses to address the first question, *what are the relationships between cultural humility, therapeutic presence, attachment style, and therapeutic*

alliance? Most of the measures were found to significantly correlate with each other. Therapeutic presence and cultural humility were found to significantly correlate with therapeutic alliance ($r = .714$, $p < .01$, and $r = .785$, $p < .01$). Additionally, therapeutic presence was found to significantly correlate with cultural humility ($r = .725$, $p < .01$), and attachment anxiety with attachment avoidance ($r = .527$, $p < .01$). PTSD symptoms were also found to significantly correlate with both dimensions of attachment (attachment anxiety, $r = .555$, $p < .01$, and attachment avoidance, $r = .484$, $p < .01$). None of the two subscales of attachment were found to significantly correlate with therapeutic alliance ($p > .05$).

Predictors of Therapeutic Alliance

To answer the second research question: *Do cultural humility, therapeutic presence, and attachment style serve as predictors for therapeutic alliance in those with CIT*, a multiple regression analysis was performed. Tests for multicollinearity indicated a very low level of multicollinearity (*VIF* = 1.395 for attachment anxiety, *VIF* = 1.393 for attachment avoidance, *VIF* = 2.128 for cultural humility, and *VIF* = 2.124 for therapeutic presence). Results of the regression analysis provided partial confirmation for the research hypothesis. Beta coefficients for the four predictors are: attachment anxiety, $\beta = -.092$, $t = -2.114$, $p = .035$; attachment avoidance, $\beta = .023$, $t = .537$, $p = .592$; therapeutic presence, $\beta = .311$, $t = 5.806$, $p < .001$, and cultural humility, $\beta = .554$, $t = 10.311$, $p < .001$. To further understand the contribution of each of the predictor variables for the outcome variable (i.e., therapeutic alliance), and due to attachment avoidance not making a significant contribution to the regression model, a separate stepwise multiple regression analysis was conducted. Cultural humility was found to be a significant predictor of therapeutic alliance ($R^2 = .615$, $p < .001$), and the addition of therapeutic presence and attachment anxiety made the model even stronger. Together cultural humility, therapeutic

presence and attachment anxiety were the greatest predictors of therapeutic alliance contributing to a significant regression equation F (3, 247) = 164.389, $p < .01$, with an $R^2 = .666$ (Table 4). The author chose this model for its high effect size, explaining 66.6% of the variance in therapeutic alliance scores, while still capturing significant unique predictors of therapeutic alliance (Cohen, 1988).

Table 4

Summary of Stepwise Regression Analysis for Variables Predicting Therapeutic Alliance

Variable	***β***	***t***	***R²***	***F***
Cultural Humility	.562	10.447**	.615	398.511
Cultural Humility + Therapeutic Presence	.307	5.699**	.660	240.691
Cultural Humility + Therapeutic Presence + Attachment Anxiety	-.080	-2.160*	.666	164.389

Note. **p<.0, *p<.05

Attachment style as Moderator

The author explored the third research questions, *does attachment style moderate the relationship between cultural humility and therapeutic alliance and between therapeutic presence and therapeutic alliance* respectively by using a moderated regression analysis. Four separate moderation analyses using the PROCESS macro (Hayes, 2013) with model 1 ran to test the moderation effect, for each combination of the two moderators (attachment anxiety and attachment avoidance) and the two predictor variables (therapeutic presence and cultural humility). The variables were mean centered to minimize concerns of multicollinearity (Tabachnick & Fidell, 2013). Within the analysis, a significant interaction effect would indicate that attachment style (avoidance and anxiety) moderates the relationship between cultural

humility and therapeutic alliance, and therapeutic presence and therapeutic alliance respectively. Following the results of the last research question, the researcher expected that attachment would not moderate the relationships since this construct did not correlate significantly with the studied variables. None of the two dimensions of insecure attachment style moderated the relationship between therapeutic presence and therapeutic alliance, and cultural humility and therapeutic alliance, as evidenced by the non-significant interaction effect ($p > .05$). Table 5 provides a summary of the conditional effects of these moderation analyses.

Table 5

Conditional Effects of Therapeutic Presence and Cultural Humility on Therapeutic Alliance with Attachment Anxiety and Attachment Avoidance as Moderators

Moderator	Effect	*SE*	*t*	*p*	CI
Therapeutic Presence					
Attachment Anxiety	.0250	.0660	.3783	.7055	[-.1051, .1550]
Attachment Avoidance	-.0320	.0439	-.7305	.4658	[-.1184, .0543]
Cultural Humility					
Attachment Anxiety	-.0075	.0289	-.2579	.7967	[-.0644, .0495]
Attachment Avoidance	-.0019	.0188	-.0996	.9208	[-.0389, .0351]

Discussions

This study contributes to the body of therapeutic alliance research and is the first to investigate cultural humility, therapeutic presence, and attachment style as variables that may impact therapeutic alliance among adults who have a history of CIT. Perceived cultural humility and perceived therapeutic presence were found to be strongly correlated with therapeutic

alliance, above the attachment style, which emerged as a non-significant correlate of the therapeutic alliance. Together, cultural humility, therapeutic presence, and attachment anxiety were found to serve as the strongest predictors of the therapeutic alliance.

In this study attachment avoidance and attachment anxiety were not found to significantly correlate with therapeutic alliance. Moreover, both dimensions of insecure attachment style were not found to serve as moderators between therapeutic presence and therapeutic alliance, or between cultural humility and therapeutic alliance. Nevertheless, attachment anxiety was found to make a significant contribution in the variance of the therapeutic alliance.

The non-significant relationship between insecure attachment and therapeutic alliance is consistent with the findings from a recent study (Bucci, Seymour-Hyde, Harris, & Berry, 2016) where the researchers found similar results. Attachment insecurity not being found to significantly correlate with therapeutic alliance is also consistent with other reviews and studies (Smith et al., 2010; Reynolds et al., 2017) and it is hypothesized that this result may be related to the fact that some anxiety and avoidance is expected, and, at lower levels even beneficial (provides motivation), in the therapeutic relationship (Miller et al., 2015). The results in the current study may be an indication that attachment style is not a significant correlate of the therapeutic alliance; a result that is consistent with previous studies (Reynolds et al., 2017). It appears that although there is compelling evidence for the relationship between attachment security and the alliance, the evidence for a significant relationship between attachment insecurity is mixed (Smith et al., 2010). Bernecker and colleagues (2014) suggest negative correlations between attachment avoidance and therapeutic alliance, and attachment anxiety and therapeutic alliance, similar with claims that other researchers support (Diener et al., 2009; Diener & Monroe, 2011).

Participants in the current sample were all seeing a mental health professional for at least four sessions, which is towards the middle stage in the development of the therapeutic alliance, as the first phase of therapy coincides with the initial development of the alliance and peaks during the third session (Ardito & Rabellino, 2011). This result could suggest that insecure attachment is salient in the initial stages of therapy and maybe not be as relevant to alliance development during the middle to latter stages of therapy (Reynolds et al., 2017). Such interpretations should be made with caution though they are consistent with previous research. Hersoug and colleagues (2009) reported that client interpersonal difficulties indicative of a cold, detached, dismissive attachment style only had a detrimental effect on the early development of the alliance, but that this negative impact substantially reduced over time. Other authors such as Schore (2001) would argue that as therapy progresses it may induce subtle changes in neurobiological mechanisms of affect regulation, which may foster a positive alliance and a more secure form of attachment.

Another possible explanation for why attachment style was not found as a significant correlate for the therapeutic alliance is that data in this study was collected using MTurk, and because many MTurk respondents are quite prolific and participate in many studies (e.g., Chandler, Mueller, & Paolacci, 2014; Chandler, Paolacci, Peer, Mueller, & Ratliff, 2015; Peer, Brandimarte, Samat, & Acquisti, 2017), some of them may not be naive to common research material and procedures. Such prior exposure may have contaminated and skewed the results in this study (e.g., Chandler et al., 2015). Another factor that is worth mentioning is that participants in the current study attended at least four therapy sessions, which means that despite their attachment style, they remained committed to seeing a mental health practitioner. 68.5% of participants in this sample reported that they had been previously in counseling, and roughly

60% of participants in this sample reported being in a committed relationship (i.e., 35.9% reported being married and 24.7% dating one person). Attending therapy and being involved in romantic relationships might have altered the levels of their attachment insecurity. A growing body of research (e.g., Grossmann, Grossmann, & Waters, 2005) examining attachment continuity suggests that patterns of attachment are both relatively stable over long periods of time and subject to change, influenced by a variety of factors including ongoing relationships with family members, new romantic relationships, traumatic life events, and psychotherapy (e.g., Fraley, 2002). These findings are consistent with Bowlby's idea that attachment theory is not limited to infant-parent relationships.

Although attachment anxiety was not found to significantly correlate with therapeutic alliance, it was found to account for 6% of the variance in therapeutic alliance. When added to the regression model together with cultural humility and therapeutic presence, attachment anxiety made a unique and significant contribution to the model. It could be that this construct is so different than the first two variables (i.e., cultural humility and therapeutic presence) that it adds to a significant regression model that helps better predict therapeutic alliance.

Survivors of CIT have been traumatized within the context of an interpersonal violation of trust or rupture of relationship (Herman, 1997). At the core of healing for this type of interpersonal trauma is the construction of safe space in physical, interpersonal, and psychological dimensions (Welkin, 2013). Welkin (2013) suggests that if therapeutic safe space is a protected physical place where people who have been damaged by the misuse of power can feel trust, interpersonal empowerment, and a sense of agency or control, the process of therapy may even reach beyond the personal to create a wider social space of liberation.

The ability of the therapist to provide safety, and maintain a state of focused self- and other-awareness and physiological attunement (i.e., presence) (Colosimo & Pos, 2015; Geller & Porges, 2014; Schneider, 2015) was found in this study to be a significant correlate of the therapeutic alliance, a result that is congruent with other studies (Geller et al., 2010; Pos et al., 2011). Schneider (2015) asserts that presence is at the core of the so-called contextual factors research. Wampold (2006) suggests that contextual factors account for far more of the variance than interventions in the facilitation of effective psychotherapy. This current study adds support for these findings and found that therapeutic presence serves as a predictor for the therapeutic alliance, alone accounting for 46.6% of the variance in the therapeutic alliance. When working with individuals who have a trauma history, beyond identifying trauma and trauma-related symptoms, the initial objective of trauma-informed care is establishing safety. Borrowing from Herman's (1992) conceptualization of trauma recovery, safety is the first goal of treatment (SAMSHA, 2014). Establishing safety is especially crucial at the outset of trauma-informed treatment and often becomes a recurrent need throughout the treatment. According to SAMSHA (2014), in the context of trauma-informed care, safety has a variety of meanings (e.g., safety from trauma symptoms such as nightmares, flashbacks, dissociations; safety from intense feelings such as sadness, anger, shame, feeling overwhelmed, trapped and abandoned, and safety in relationships). An effort in trauma treatment is thus helping the client gain more control over trauma symptoms (and be able to label them as such), helping them re-gain trust and safety in relationships, and stay more grounded in the healing process. Feeling safe is a necessary prerequisite to establishing strong therapeutic relationships, (Geller & Greeberg, 2012), that are potentially helpful or healing for a client. Through a present-centered approach that includes eye contact, softening and warmth in voice, vocal prosody, emotional attunement, and in-the-

moment engagement, the client perceives safety. This experience of safety eventually shuts down the client's defenses, which is healing in and of itself and also helps the therapist and client engage in therapeutic work. The capacity to feel calmer and emotionally healthier is facilitated when a safe therapeutic environment is promoted through the cultivation and expression of therapists' presence (Allison & Rossouw, 2013; Cozolino, 2006; Geller & Greenberg, 2012; Porges, 2011). In other words, therapeutic presence as a critical factor in providing client safety also appears to be instrumental in securing a strong therapeutic alliance.

Another ability of the therapist that has been described as a "cultural presence" or "way of being" with a client termed cultural humility was found to be a strong correlate and predictor of the therapeutic alliance, accounting for 59.4% of the variance in therapeutic alliance when examined alone. This finding is consistent with previous research, as clients who perceived their therapist to be highly culturally humble also reported stronger therapeutic alliances with their therapists and greater improvements in therapy (Hook et al., 2013). Indeed, cultural humility was previously found to predict therapeutic alliance over and beyond the effects of multicultural competence (Mosher et al., 2017). A core tenet of cultural humility theory and research has been that cultural humility can help build stronger therapeutic relationships with culturally diverse clients. This is perhaps the most strongly supported research finding thus far (Hook et al., 2013; Hook et al., 2017; Owen et al., 2014). This reasoning is built on a strong foundation of research that has revealed humility to be important in the development and maintenance of social bonds (Davis et al., 2013; Farrell et al., 2015). For the majority of clients, their cultural background is an important aspect of their identities, as well as not only how they see and move through the world, but also how they experience, interpret and respond to trauma. Communicating to clients, both implicitly and explicitly, that their cultural identities are important and will be respected

within therapy can be a key building block of the therapeutic alliance and set the stage for effective therapeutic work. It is within the therapist' responsibility to understand how a trauma survivors' multiple cultural identities and social contexts lend meaning to the experience of trauma and the process of recovery (Brown, 2008).

The levels of attachment avoidance and attachment anxiety reported by the individuals in the current study are consistent with the levels of insecure attachment found in other studies that investigated individuals with interpersonal trauma history (Lafrenaye-Dugas, Godbout, & Hebert, 2018). It has been suggested that survivors of childhood interpersonal trauma may develop schemas, beliefs, and behaviors that impact the formation and maintenance of interpersonal relationships across the lifespan (Colman & Widom, 2004; Young, Klosko, & Weishaar, 2003). This study supports the idea that the experiences of interpersonal trauma that occur in childhood may contribute to the development of insecure attachment styles.

Regardless of the presence of insecure attachment style and the severity of PTSD symptoms, individuals with CIT reported that the therapist being humble and present is what makes a significant difference in the therapeutic process. The high positive correlations between cultural humility, therapeutic presence, and therapeutic alliance found in this study, contribute to the body of evidence that therapeutic alliance is a function of what transpires in the therapy room. Attachment anxiety was found as a significant predictor for the therapeutic alliance. Despite they insecure attachment style, clients are not predestined to fail to form alliances; it is imperative upon both the therapist and client to account for attachment style and to behave in ways that nurture therapeutic alliance during the therapy process.

Implications for Counselors and Counselor Educators

The finding that cultural humility serves as the most significant predictor of therapeutic alliance encourages clinicians to explore ways to address cultural issues in session in ways that are culturally humble and respect the client's cultural background and experiences. The finding in the current study is consistent with the recent theory on cultural humility that taking advantage of opportunities to explore the cultural background of the client, and identifying ways in which culture impacts their healing in session, is an important aspect of working effectively with culturally diverse clients (Owen et al., 2013). Cultural humility has been described as showing respect for and being considerate of the other (i.e., being genuinely interested in, open to exploring, and wanting to understand the other's perspective), not making foreordained assumptions about the other, not acting superior, and not assuming that much is already known about the others culture (Hook et al., 2013). This becomes even more important when working with individuals with CIT. The fact that culture shapes the experience of trauma, and thus plays a major role in understanding and addressing it, has been extensively documented (Berger, 2015; Drožđek, 2007). Cultural affiliations serve as lenses through which people perceive, conceptualize, interpret, make meaning of, and respond to stressor events as well as seek and use help. Mattar (2010) indicated that while in the field of traumatology there has been a slow but steady acknowledgment of the importance of cultural sensitivity in understanding and addressing trauma, recommendations on how to do this and how to prepare practitioners to adopt a culturally sensitive approach to those who are traumatized are limited. Hook and colleagues (2017) identified specific methods that can be implemented by both clinicians and counselor educators to help in developing a culturally humble attitude. Examples of engaging cultural issues with humility and respect include being curious about cultural issues, asking questions that

indicate a willingness to learn and explore, being nonjudgmental, and communicating openness about different worldviews, rather than viewing one's perspective as best or ideal.

The finding that cultural humility serves as a strong predictor of therapeutic alliance emphasizes the significance of the therapist being open and humble toward the client's cultural background and experiences. Cultural humility can positively impact all three aspects of the therapeutic alliance (i.e., bond, goals, and tasks; Bordin, 1979; Hook et al., 2017). Hook and colleagues (2017) provide a theoretical framework for applying cultural humility in therapy by building therapeutic alliance. For example, they suggest engaging a client with openness, curiosity, and respect, which may lead to positive feelings and closeness between the therapist and the client (i.e., bond). The authors also encourage therapists and client to come together and collaboratively create direction and focus (i.e., goals). Finally, they mention expressing openness and a desire to understand how the client views and interacts with the world, which improves connection and cooperation about what happens in the therapy room (i.e., tasks). In working with individuals who experienced CIT, therapists may display a culturally humble attitude by being alert, searching for ways to connect with and bring culture into the therapy room, linking cultural issues to the experience of trauma, or using the client's culture as a source of support. These approaches promote a holistic understanding of the client, and respect and receive the client as a whole human being.

By embodying cultural humility, the therapist helps the client feel known and accepted as a cultural being, and as the results of this current study suggest, plays a crucial role in supporting therapeutic alliance. It becomes critical for a therapist that works with individuals who experience CIT to display a culturally humble attitude and presence. Hook and colleagues (2017) suggest multiple ways in which a therapist may do this. For example, a therapist might inquire

with an authentic curiosity about a client's cultural background and explore related values, such as the role of family and friends, any religious/spiritual influences, experience of gender and social class, and sexual beliefs and norms, and how multiple dimensions of their culture may be linked to their trauma experience.

Although qualitative research has linked client perceptions of therapist's presence with the strength of the therapeutic alliance (Geller et al., 2010), to the best of the researcher's knowledge, this is the first quantitative study that links perceived therapeutic presence with therapeutic alliance. The finding that therapist's presence, as perceived by the clients who have a history of CIT, strongly predicts therapeutic alliance has multiple implications for counselors' training. According to Geller and colleagues (2010), counselor trainees should develop both a conceptual and practical understanding of therapeutic presence to aid in their effectiveness. Next, it is important for clinicians to be aware of their relationship and alliance with clients in session as this may impact therapeutic outcomes. Validated alliance inventories (e.g., Working Alliance Inventory, WAI, Horvath & Greenberg, 1986, 1989), and therapeutic check-ins may be used by therapists to improve their awareness, and as a consequence improve alliances (Bernards, 2017).

The findings of this study can be used to improve the educational experiences of counseling students, and the services these students provide, and may further be helpful for clinicians by encouraging them to apply the theoretical and empirical material presented in their practices. Counselor educators and supervisors can help students to become more aware of who/how they are as counselors emotionally, psychologically, and spiritually. With practice, through attempting to display the emotional and attitudinal signs of therapeutic presence and cultural humility, students can learn to integrate those facets of themselves into their work with clients. Colosimo and Pos (2015) conducted the most recent research in which they identified

four core models of presence that are associated with concrete behaviors, and that show therapists' expression of being therapeutically present in-session: (a) being-here, (b) being-now, (c) being-open, and (d) being-with. In the modified Delphi study conducted by Austin (2017), the researcher identified 13 physical and emotional recognizable signs expressed by counseling students when they are therapeutically present, specifically in sessions (e.g., the student has the courage to stay with a client's strong emotions, the student feels comfortable during productive silences in session). Counselor educators and counselors can use the suggested ways to develop therapeutic presence to sharpen the counseling skills of their students and supervisees (Austin, 2017). The researcher suggests that counselor educators introduce the suggested methods in practicum courses by focusing on theoretical, and experiential activities to foster therapeutic presence.

Both therapeutic presence and cultural humility were found to serves as strong predictors of the therapeutic alliance, which suggests that an open self- and other-awareness, and being in the present moment, are significant in enhancing therapeutic alliance. Therapist's ability to be present and "tune in" to clients and empathize with their emotional state may also be an important factor in therapeutic outcomes (Koole & Tschacher, 2016). Results in this current study may further imply the importance of immediacy, as a skill to show therapeutic presence, especially if therapists are struggling to know what is going on for a client in the moment. Asking clients about their emotional and physiological experience (a) lets therapists be more aware of client experience; (b) helps clients be more aware of their own experience and thereby potentially increase their presence; and (c) lets the client know the therapist is interested in and aware of their present experience, thus increasing the sense of feeling understood (Siegel, 2011).

In this current study, attachment anxiety was found to make a significant and unique contribution to the variance in the therapeutic alliance. Illuminating the role of the client's attachment in the therapeutic alliance has potential clinical utility. Targeting attachment during therapy may be a strategy for improving the alliance. Addressing the alliance with anxiously attached clients could act to change attachment by ‘‘[paving] the way for corrective relational experiences" (Castonguay, Constantino, & Grosse Holt- forth, 2006, p. 276) which in turn may improve the client's maladaptive interpersonal schemas.

The challenge of treating interpersonal trauma survivors with an anxious attachment style has been scarcely documented in the literature and includes difficulties with interpersonal closeness and need for dependence at times of distress. Clients with anxious attachment style seem to want interpersonal closeness while feeling worried that others will reject them, yet they are willing to use relationships and respond well to empathic connection with the therapist, despite their struggles and fears of being in relationships. Therapist working with these individuals, need to attend to clients' anxious attachment style-related needs and difficulties when developing therapeutic alliance with individuals CIT and respond in ways that are beneficial for these clients. Many individuals with CIT experiences 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).

Knowing that the degree to which clients feel cared for, accepted, and safe in the therapeutic relationship (Bordin, 1979) has a significant influence on clients' willingness to engage in therapy (Lawson, Stulmaker, & Tinsley, 2017), mental health professionals have the responsibility of addressing the fear of rejecting that these individuals experience so with time, they develop the trust and safety that they yearn for. In psychotherapy, therefore, clinicians are

encouraged to pay particular attention to the quality of the therapeutic alliance when working with individuals with a history of anxious attachment. This type of attachment histories could serve as "red flags," allowing the therapist to predict the potential for ruptures in the alliance and intervene proactively to minimize their deleterious effects while also capitalizing on the therapeutic opportunities inherent in working through them. With such clients, therapists would do well to carefully monitor the relationship for signs of discontent. When therapists spot these signs, they can use relationally based interventions to repair the alliance (e.g., Crits-Christoph et al., 2006).

Limitations and Future Research

Although the present study brings important findings for mental health professionals, it is not without limitations. First, this study has the limitation of being cross-sectional, and therefore it is impossible to know if the results accurately represent the causal order of the variables. Another limitation of this study is that it is completely reliant upon self-report measures. One of the overarching issues with self-report measures is that of credibility. Motives of self-preservation and self-enhancement, along with potential issues with self-deception and memory can limit the credibility of a measure that is based on self-report (Robins, Fraley, & Krueger, 2009).

Participants in this study were all treatment-seeking individuals, and thus it is not possible to generalize these findings to the broader community of CIT survivors. Somewhat uniquely, the present study obtained alliance ratings from participants engaged primarily in the middle to end stages of completion and found that perceptions of therapists' cultural humility and therapeutic presence were the most salient correlates of the therapeutic alliance. Such findings tentatively suggest that therapists' factors may be important in affecting the therapeutic alliance

in the middle and later stages of therapy. Also, the results are based on ratings that come from participants that remained committed to the therapeutic process despite their insecure attachment style. This study did not include either the participants who are in the early stages (i.e., less than four sessions in) or those who are not currently in therapy. For future studies, the use of comparison groups is recommended (i.e., participants who are currently in counseling at the beginning stages, middle stages, later stages, and those who are no longer in counseling) in order to have a holistic understanding of the factors that might contribute to the development of the therapeutic relationship.

Both dimensions of attachment were not found to correlate with the therapeutic alliance. These findings are consistent with research on the association between avoidant and anxious attachment and the therapeutic alliance as many of the studies did not differentiate between anxious and avoidant attachment. For example, the meta-analysis that examined attachment and alliance in individual therapy (Deiner & Monroe, 2011) lumped these two types of attachment into the single category: insecure attachment. A replication of the current study is suggested where differentiation between secure and insecure attachment style would be used so that it not only would create the opportunity for a comparison group, but it would also allow for a more comprehensive approach to attachment style with a broader range of dimensions being included.

Data for the therapeutic alliance were also gathered from one point in time; since it is accepted that ratings of alliance change over time, in future studies longitudinal, repeated measures of the alliance should be implemented to increase the validity of findings (Kramer, de Roten, Beretta, Michel, & Despland, 2009).

Last, participants were recruited from MTurk. The most commonly identified advantages of MTurk are efficiency, cost-effectiveness, diversity, and relative anonymity which presumably

encourages respondents to be more candid (Casler, Bickel, & Hackett, 2013; Litman, Robinson, & Abberbock, 2016). In regards to the quality of data, some researchers have reported that MTurk respondents are more attentive to task instructions than face-to-face subjects (e.g., Hauser & Schwarz, 2016; Kees, Berry, Burton, & Sheehan, 2017). At the same time, some disadvantages exist. Most notably, when comparing MTurk samples restricted to the US (as this current sample is) to nationally representative samples (e.g., U.S. Census, Survey USA), MTurk workers have lower income, are more educated, and younger (Keith, Tay, & Harms, 2017), which demonstrates that MTurk samples are not representative of the general US population. Additionally, MTurk workers may seek to please requestors who are paying for their work, and their levels of social desirability are higher than student samples (Behrend, Sharek, Meade, & Wiebe 2011). Past research has also revealed that MTurk workers may be dishonest (Peer, Vosgerau, & Acquisti, 2014). Critical information can be gained from MTurk, and it is an easily obtained, efficient, and the cost-effective method by which to examine the initial hypotheses proposed in this study, but such limitations should be kept in the forefront.

Conclusions

The results of this study have several important clinical implications. Therapists who work with trama may be encouraged by the findings that although clients may present with complex relational needs, they are not insurmountable barriers in therapy, and useful therapeutic alliances can develop over time. This interpretation emphasizes the importance of the client-therapist dynamic in psychotherapy, which is particularly salient considering that the quality of the alliance is also predictive of eventual therapeutic outcomes (Martin et al., 2000). In the present study, therapist's characteristics, as perceived by the client (i.e., cultural humility and therapeutic presence), and anxious attachment style as evaluated by the client were found to

account for 66.6% in therapeutic alliance. This finding was consistent with well-known approaches to therapy, which emphasize the therapeutic relationship as a crucial element; further, the quality of the therapeutic relationship appears to be an avenue for change and serves a meaningful purpose in psychotherapy. Although certainly not the only two components related to outcomes in psychotherapy, therapeutic presence, and cultural humility may establish the foundation from which other positive change and growth may occur, despite the client's attachment style. Encouragingly, traditionally hypothesized barriers to the alliance such as insecure attachment dimensions (e.g., attachment anxiety and attachment avoidance) were not found to be significantly correlated with the therapeutic alliance among individuals who experienced childhood interpersonal trauma. Future studies should aim to expand on the current findings and assess client and therapist factors across stages of therapy to comprehensively map out the varying influences on the alliance across the therapeutic journey.

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APPENDICES

Appendix A

Trauma Screening Instrument

The events below may or may have not happened to you. Check:

"YES as a child" if that thing has happened to you **before the age of 18**
"YES as an adult" if that thing has happened to you **at the age of 18 or after**
"NO" if that kind of thing has not happened to you

If you check "YES as a CHILD" and/or "YES as an ADULT" for any events: **put a number** in the "how many times" column to indicate how many times something like that happened to you. Please check all that apply.

Part 1. Non-interpersonal Trauma

	Check if			If yes, please indicate how many times	
	Yes, as a child	Yes, as an adult	No	As a child	As an adult
Where you ever exposed to a life-threatening natural disaster (i.e. hurricane, flood, earthquake, tornado, fire)?					
Where you involved in a serious accident (i.e. car, boat, train, airplane)?					
Did you ever suffer a serious personal injury or illness?					
During military service, have you ever seen something horrible or were badly scared?					
Did you ever experience the death or serious illness of a parent or a primary caretaker?					
Did you ever experience a sudden move or loss of home and possessions?					
Did you ever experience the divorce or separation of your parents/caretakers?					
Did you ever experience the death or serious injury of a sibling or other close family member?					
Did you ever experience the death or serious injury of a friend?					
Did you ever witness violence towards others, including family members?					
Did anyone in your family ever suffer from mental or psychiatric illness or have a "breakdown"?					

Did your parents or primary caretakers have a problem with alcoholism or drug abuse?					
Did you ever seen someone murdered?					

Part 2. Physical punishment

	Check if			If yes, please indicate how many times	
	Yes, as a child	Yes, as an adult	No	As a child	As an adult
Were you ever slapped in the face with an opened hand/arm?					
Were you ever burned by someone else with hot water, a cigarette, or something else?					
Were you ever punched or kicked?					
Were you ever hit with an object that was thrown at you?					
Were you ever pushed or shoved?					
Were you ever attacked with a gun, knife, or weapon?					

Part 3. Emotional abuse/neglect

	Check if			If yes, please indicate how many times	
	Yes, as a child	Yes, as an adult	No	As a child	As an adult
Were you often put down or ridiculed?					
Were you often ignored or made to feel that you didn't count?					
Were you often told you are not good?					
Most of the time, were you treated in a cold, uncaring way or made to feel like you were not loved?					
Did your parents/caretakers and/or partner often fail to understand you or your needs?					
Did you ever experience sudden abandonment by spouse, partner, parent, or other close family member?					

Part 4. Sexual events

	Check if			If yes, please indicate how many times	
	Yes, as a child	Yes, as an adult	No	As a child	As an adult
Were you ever touched in an intimate or private part of your body (breasts, tights, genitals) in a way that surprised you or made you feel uncomfortable?					
Did you ever experience someone rubbing their genitals against you?					
Were you ever forced or coerced to touch another person in an intimate or private part of their body?					
Did anyone ever have genital sex with you against your will?					
Were you ever forced or coerced to perform oral sex on someone against your will?					
Were you ever forced or coerced to kiss someone in a sexual rather than an affectionate way?					

Appendix B

Demographic Questionnaire

1. Please indicate your age in years:

2. Please indicate your gender:

    a. Male _____

    b. Female _____

    c. Transgender _____

3. Please circle the racial/ethnic group with which you identify:

    a. Asian/Pacific Islander _____

    b. Black/African American _____

    c. Caucasian/White/European American _____

    d. South Asian _____

    e. Hispanic/Latino/Latina _____

    f. Middle Eastern _____

    g. Native American/American Indian _____

    h. Multiracial/ethnic _____

    i. My racial/ethnic group is not listed. Please specify: _____

4. Please indicate your spiritual/religious affiliation (if applicable)

    a. Agnostic

    b. Atheist

    c. Buddhist/Taoist

    d. Christian/Catholic

    e. Christian/Protestant

f. Christian/Other

g. Hindu

h. Jewish

i. Muslim/Islam

j. Spiritual, but not religious

k. Wiccan/Pagan/Neo-Pagan, Please specify_____

l. My spiritual/religious affiliation is not listed. Please specify _____

5. Please indicate your sexual orientation:

a. Lesbian/gay

b. Straight/heterosexual

c. Bisexual

d. Pan-sexual/omni-sexual

e. My sexual orientation is not listed. Please specify _____

6. Please indicate the highest degree or level of school you have completed. If currently enrolled, highest degree received.

a. Some high school, no diploma

b. High school/GED

c. Some college credit, no degree

d. Trade/Technical/Vocational training

e. Associate degree

f. Bachelor degree

g. Master degree

h. Professional degree

h. Doctorate degree

7. Please indicate your employment status:

a. Employed for wages

b. Self-employed

c. Out of work and looking for work

d. Out of work and currently not looking for work

e. Homemaker

f. Student

g. Military

h. Retired

i. Unable to work

8. If you ate in school, please indicate which year are you in:

a. Freshman

b. Sophomore

c. Junior

d. Senior

e. Not in school

9. If you graduated from college, please indicate if you are:

a. 1st generation college student (you are the first person in your immediate family to go to college)

b. 2nd generation college student

c. 3rd generation college student

10. Please indicate your relationship status:

a. Single

b. In a monogamous dating relationship (i.e., dating only one person)

c. In a non-monogamous dating relationship (i.e., dating more than one person)

d. Married/Partnered

e. Married/Partnered, but separated

f. Divorced

g. Widowed

h. My relationship status is not listed. Please specify _____

11. Do you identify as an individual who has a disability (e.g., hearing impairment, physical disability, etc.).

a. Yes.

b. No

12. If you answered yes to the previous questions, do you perceive this disability as a barrier in your academic success and social connection?

a. Yes

b. No

13. Please indicate your personal income:

a. Less than $14,999

b. $15,000-$29,999

c. $30,000-$44,999

d. $45,000-$59,999

d. More than $60,000

For the following questions, please think about your experiences in trauma counseling.

14. What kind of mental health professional are you seeing?

a. Social worker

b. LPC

c. Psychologist

d. Other

e. I am not aware of their qualification

15. Please indicate the type of treatment setting where you are currently receiving mental health services:

a. Day clinic

b. Outpatient care

c. Community agency

d. Private practice

e. Other

18. How many sessions have you seen your counselor?

a. Less than 4 sessions

b. 4 sessions

c. More than 4 sessions

19. Is this the first time you are seeing a mental health professional for your trauma?

a. Yes

b. No