The Role of the Therapeutic Alliance in Trauma-Focused Cognitive Behavioral Therapy with Child and Adolescent Survivors of Complex Trauma

by

Michelle Rivkind

Paper submitted in partial fulfillment of the requirements for the degree of

Master of Counselling
in the
Division of Arts and Sciences

City University of Seattle
2022

This paper is accepted as conforming to the required APA standard
September 2022

____

Berhanu Demeke, PhD
Research Supervisor
City University of Seattle

Dedication

To my parents, boyfriend, and best friend

Acknowledgements

To my parents, who gave up their life in Israel so that I could pursue my dreams without first having to risk my life serving in the Israel Defense Forces: Thank you. Thank you for always being my secure base and for encouraging me to express my emotions, stand up for myself and speak my mind, explore my independence, and pursue my passions. There are not enough words to express how grateful I am for the life you have provided for me. To my boyfriend, Craig, who stood by my side and showed me unconditional love and support; always made sure that I was fed, hydrated, and accountable for my self-care: Thank you for being my rock and for mentally and physically supporting me throughout this journey. To my best friend, Ashlie, who was incredibly patient and understanding when I had to prioritize research over spending time together and who listened to me talk about my research for hours on end, helped me to process my thoughts out loud, read and reread all of my drafts: Thank you for playing a key role in keeping me sane throughout this process. To my practicum and now work supervisor, Janine Groeneveld: Thank you for providing me with the incredible opportunity to do such meaningful work and further reinforcing my passion for working with trauma. Your support and guidance are invaluable. Last but not least, to my capstone advisor, Dr. Behanu Demeke: Thank for all of the support, patience, guidance, and encouragement that you have given me through every step of this capstone process.

Abstract

This paper is an analysis of two qualitative, one mixed-methods, and seven quantitative peer-reviewed studies to gain a better understanding of the role of the therapeutic alliance in trauma-focused cognitive behavioral therapy (TF-CBT) with child and adolescent survivors of complex trauma. Complex trauma refers to repetitive harmful experiences that frequently occur in the interpersonal domain, most commonly beginning during childhood and spanning over extended periods of time (Van Nieuwenhove & Meganck, 2017). TF-CBT is an approach that researchers have recommended as first-line treatment with strong empirical support that improves posttraumatic stress disorder (PTSD) in children and adolescents (Cohen & Mannarino, 2015). Although J. A. Cohen et al. (2018) have argued that the therapeutic alliance plays a central role in empowering children, adolescents, and their nonoffending caregivers (caregivers who did not perpetrate the abuse) to heal meaningfully following exposure to trauma, research on the role of the therapeutic alliance in child and adolescent trauma populations remains scarce. The results of this study indicate that the therapeutic alliance facilitates initial therapy engagement, promotes overall therapy participation and that a relationship between the therapeutic alliance and the outcome of treatment exists. These findings offer insights into the role of the three key interrelated constructs that make up the therapeutic alliance (development of an affective bond, agreement on goals, and collaboration on tasks). Therapists can utilize this information to develop therapeutic alliances that promote safety, empowerment, collaboration, and healing.

Keywords: *trauma-focused cognitive behavioral therapy*, *therapeutic alliance*, *trauma, childhood maltreatment, complex trauma*, *posttraumatic stress disorder*

Table of Contents

Introduction ... 8
Statement of the Problem ... 10
Purpose of the Study ... 11
Rationale and Justification for the Study ... 12
Research Question ... 12
Significance and Importance of the Study ... 12
Theoretical Framework ... 14
Definition of Terms ... 17

Self-Positioning Statement ... 18

Review of the Literature ... 20
Methods of Literature Search ... 20
Methodology Analysis ... 27
Research Paradigms Across Studies ... 27
Postpositivism ... 28
Constructivism ... 29
Sampling, Recruitment, and Participants ... 30
Sampling Size ... 32
Inclusion and Exclusion Criteria ... 33
Sampling Characteristics ... 36
Data Collection ... 37
Qualitative Data Collection ... 37
Mixed-Methods Data Collection ... 39
Quantitative Data Collection ... 40
Data Analysis ... 46
Qualitative Data Analysis ... 46
Quantitative Data Analysis ... 48

Ethical Considerations ... 50
Respect for Persons ... 51
Concern for Welfare ... 53
Justice ... 55

Findings ... 56
Therapeutic Alliance and Initial Therapy Engagement ... 57
Therapeutic Alliance and Treatment Adherence ... 58
Therapeutic Alliance and Dropout ... 60
Therapeutic Alliance and Outcome ... 61

Clinical Application and Implications for Counselling Psychology ... 65
Formation of an Attachment Bond ... 65
Mutual Understanding and Agreement on Goals ... 67
Shared Commitment and Collaboration on Tasks ... 68

Recommendations for Practice 70

Conclusions and Recommendations for Future Research 73
Conclusions....................73
Limitations....................74
Recommendations for Future Research....................75

Reflectivity....................77

References....................79

List of Tables

Table 1. Summary of Key Research Articles Reviewed..23

The Role of the Therapeutic Alliance in Trauma-Focused Cognitive Behavioral Therapy with Child and Adolescent Survivors of Complex Trauma

Introduction

The purpose of this capstone research was to gain a greater understanding of the role of the therapeutic alliance in trauma-focused cognitive behavioral therapy (TF-CBT) with child and adolescent survivors of complex trauma. Although various approaches to treating childhood trauma exist, TF-CBT is one of the best-supported evidence-based treatments for trauma in children and adolescents (Vanderzee et al., 2018). In fact, in a recent systematic review of the evidence-based psychological treatments for PTSD in young people, Bennett et al. (2020) concluded that TF-CBT is the best supported treatment for maltreated children and adolescents. TF-CBT (developed by Anthony Mannarino, Judith Cohen, and Esther Deblinger) is a family-focused, conjoint parent-child trauma-focused treatment model that requires collaboration among therapists, young people, and their nonoffending caregivers (de Arellano et al., 2014). This treatment model is grounded in the theoretical principles of cognitive, behavioral, interpersonal, family therapy and trauma theory; and the goals are to address and help clients to reregulate the affective, behavioral, biological, cognitive, and social domains of the trauma impact, which are also known as *trauma responses* (Cohen & Mannarino, 2015).

Trauma exposure is rampant, and over 70% of people worldwide will endure a traumatic event at some point in their lives (Kumar et al., 2019). Trauma is generally classified trauma into two types: (a) type I trauma, also known as *simple* or *acute* trauma, which refers to a single-incident trauma (i.e., isolated distressing experience) such as a motor vehicle accident or a natural disaster, for example, and (b) type II trauma, also known as *complex* trauma, which refers to repetitive harmful experiences that frequently occur in the interpersonal domain, most

commonly beginning during childhood and spanning over extended periods of time (Van Nieuwenhove & Meganck, 2017). Examples of complex trauma include emotional abuse, emotional neglect, physical abuse, physical neglect, sexual abuse and witnessing family violence (Lawson et al., 2013). Furthermore, those who have endured complex trauma frequently display a wider range of challenges compared to those who have endured simple or acute trauma (Kumar et al., 2019). For example, the Neuroscience Research Australia Foundation (2021) estimated the incidence of PTSD following exposure to interpersonal traumas (i.e., incidences of victimization involving other people) at 25% and the incidence of PTSD following noninterpersonal traumas (i.e., traumatic events that do not involve an interaction with other people) at 10%.

The long-term effects of childhood trauma exposure are significant and pervasive (Dye, 2018). Enduring traumatic events during childhood can result in neurological, physiological, and psychological disruptions (Dye, 2018). For example, exposure to early childhood trauma interferes with normal brain development in the brainstem, the midbrain, the limbic system, and the cortex (Dye, 2018). This obtrusion causes neurological disruptions that impact memory, damage information processing capabilities, impact one's ability to regulate their behavior and cognitive responses to future stress and interfere with one's ability to regulate high emotions (Dye, 2018). Furthermore, survivors of complex trauma frequently develop a negative self-concept that is largely influenced by feelings of shame, guilt, self-blame, hopelessness, helplessness, and vulnerability (Van Nieuwenhove & Meganck, 2017). As a result of the negative self-concept and schemas of self-blame for the abuse, survivors of complex trauma frequently perceive themselves as worthless and deserving of mistreatment (Karatzias & Cloitre, 2019; Lawson, 2017; Pearlman & Courtois, 2005; Van Nieuwenhove & Meganck, 2017), hindering their ability to allow connection and nurturance (Grossman et al., 2017; Karatzias &

Cloitre, 2019). In addition, stemming from early violations of trust, complex trauma survivors frequently perceive others and the world as dangerous, untrustworthy, and unpredictable, causing continuous doubts regarding safety (Lawson et al., 2013; Lawson, 2017; Van Nieuwenhove & Meganck, 2017).

The developers of TF-CBT argued that the therapeutic alliance plays a central role in empowering children and their nonoffending caregivers to heal effectively following exposure to trauma (J.A. Cohen et al., 2018). This is of no surprise, because researchers have frequently reported the therapeutic alliance as an essential component of the therapeutic process across various theoretical models (Accurso et al., 2013). Furthermore, the therapeutic alliance has persistently emerged as one of the most important factors in the motivation for therapy attendance and engagement and for positive outcomes of trauma treatments within adult populations (Accurso et al., 2013; Gentry et al., 2017). However, research surrounding the therapeutic alliance with child and adolescent populations has progressed much slower than with adult populations (Gergov et al., 2021; Kazdin et al., 2012; Papalia et al., 2022; Shirk et al., 2011).

Statement of the Problem

The rates of childhood victimization are alarmingly high; nationally, in the 2014 General Social Survey, one third of Canadians aged 15 and older reported having endured some form of maltreatment in childhood before age 15 (Burczycka, 2017). In the same survey, more than one quarter of Canadians reported that they endured childhood physical abuse, and nearly 10% of Canadians reported having endured sexual abuse (Burczycka, 2017). Considering the high prevalence of child maltreatment in Canada and around the world (Burczycka, 2017; Kumar et al., 2019), it is crucial that we fully understand the contributors to successful outcomes in child

and adolescent trauma treatment. In adult trauma treatment, the therapeutic alliance predicts engagement in the therapeutic tasks and successful treatment outcomes (Yasinski et al., 2018). However, research surrounding the therapeutic alliance with child and adolescent populations is limited (Gergov et al., 2021; Kazdin et al., 2012; Papalia et al., 2022; Shirk et al., 2011), and the current literature on the therapeutic alliance in the context of child and adolescent trauma therapy is alarmingly scarce (Ormhaug et al., 2014; Ormhaug & Jensen, 2016; Ovenstad et al., 2020; Zozella et al., 2015). Furthermore, although TF-CBT is a recommended first-line treatment approach with strong empirical support that improves PTSD symptomology in children and adolescents (Cohen & Mannarino, 2015), researchers have only recently begun to examine the therapeutic alliance within the context of TF-CBT in greater depth (Loos et al., 2020). Thus, because of the limited number of studies on the therapeutic alliance in TF-CBT treatment, the problem that I addressed in this study is the lack of academic knowledge about the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma.

Purpose of the Study

The purpose of this capstone research was to understand the role of the therapeutic alliance in TF-CBT and whether it is related to successful outcomes when utilized with child and adolescent survivors of complex trauma. Thus, in this paper I analyze 10 scholarly and peer-reviewed studies on the impact of the therapeutic alliance on the treatment of childhood trauma with a TF-CBT approach. I begin by synthesizing and critiquing the 10 selected studies based on their research paradigms, sampling methods, recruitment methods, participant selection, data-collection procedures, and data-analysis processes. I then conduct a traditional narrative literature review (Petticrew & Roberts, 2006) and use a narrative approach to report my findings on the role of the therapeutic alliance on the TF-CBT treatment process and outcome.

Rationale and Justification for the Study

It is important to explore the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma to gain a better understanding of the significance of the therapeutic alliance. Researchers such as J.A. Cohen et al. (2018) have proposed that the presence of a strong therapeutic alliance is necessary to facilitate healing in trauma treatment with children and adolescents. However, it has also been noted that survivors of complex trauma might perceive therapists' efforts to display warmth and compassion and to foster a safe, reliable, consistent, and trusting therapeutic relationship as a threat and experience them as primary sources of emotional dysregulation, which can then undermine the effectiveness of the therapeutic intervention (Grossman et al., 2017). Given the limited research on the role of the therapeutic alliance in trauma treatment with young people (Ormhaug et al., 2014; Ormhaug & Jensen, 2016; Ovenstad et al., 2020; Zozella et al., 2015), understanding the role of the therapeutic alliance and whether it predicts the success of TF-CBT treatment with child and adolescent survivors of complex trauma is crucial, because it will guide therapists' focus on developing and maintaining this alliance, which in turn could improve the trauma treatment of this population and ensure that they receive the best possible care.

Research Question

The following research question drove this study: *What is the role of the therapeutic alliance in trauma-focused cognitive behavioral therapy with child and adolescent survivors of complex trauma?*

Significance and Importance of the Study

I intended that my research would make a contribution at two levels. First, it will contribute to academic knowledge because it will help to fill the gap in the literature on the role

of the therapeutic alliance when using a TF-CBT treatment modality with child and adolescent survivors of complex trauma. Second, it will contribute to therapeutic practice; complex trauma impacts survivors' capacity to trust others and feel safe and can result in the perception of most relationships as potentially threatening (Cohen et al., 2012; Lawson et al., 2013; Lawson, 2017; Van Nieuwenhove & Meganck, 2017). As a result, therapists who work with childhood maltreatment face challenges in forging meaningful and effective therapeutic alliances (Cohen et al., 2012; Grossman et al., 2017; Van Nieuwenhove & Meganck, 2017). Unfortunately, facing these challenges can inadvertently cause therapists to focus more on the manualized components of TF-CBT (psychoeducation, parenting skills, relaxation skills, affective skills, trauma narration and processing, in vivo mastery, conjoint child-parent sessions, and enhancing safety; Cohen et al., 2018) than on the alliance itself. However, the findings from the 10 studies analyzed in this paper suggest that a strong therapeutic alliance facilitates initial therapy engagement and promotes overall therapy participation (Dittmann & Jensen, 2014; Eastwood et al., 2020; Okamura et al., 2020), reduces premature termination (Dittmann & Jensen, 2014; Ormhaug & Jensen, 2016; Yasinski et al., 2018), and that a relationship between the therapeutic alliance and the outcome of treatment exists (Kirsch et al., 2018; Loos et al., 2020; Ormhaug et al., 2014; Ormhaug et al., 2015; Zorzella et al., 2015). Thus, these findings may motivate therapists to shape their approaches to the therapeutic alliance, ensure that they reinforce the factors that strengthen the alliance, and address and mitigate those that interfere with the development of a strong alliance to enhance the chances of successfully treating trauma when using a TF-CBT treatment modality with child and adolescent survivors of complex trauma.

Successful treatment of trauma is vital, because when untreated, it can be costly for the survivor and the community as a whole; untreated trauma increases the risk for repeated

victimisation, acute health problems, substance use, involvement with the criminal justice system, unemployment, and homelessness (Gilad & Gutman, 2019). In addition, without the competencies necessary to establish safe and healing relationships, clients are at a higher risk for retraumatization, and therapists are at a higher risk for vicarious traumatisation and secondary traumatic stress (Kumar et al., 2019). Therefore, this research will contribute to the academic field of psychology and the well-being of child and adolescent trauma survivors and their families, their therapists, and the community.

Theoretical Framework

Edward Bordin's (1979, as cited in Muran & Barber, 2010) theory on the therapeutic alliance guided the current study. Bordin's definition of the therapeutic alliance is a narrative definition that focuses on how the alliance transpires, operates, and performs, without directly labelling the limitations and boundaries of the construct (Horvath, 2017). Researchers have used Bordin's publications in a large body of empirical investigations of the therapeutic alliance to define the idea (Horvath, 2017). Lafrenaye-Dugas et al. (2018) reported that the concept of the therapeutic alliance emerged within the psychodynamic school of thought in the early 1900s and can be traced back to Freud's theory of transference. Throughout its evolution, the concept and its defining features have shifted from analytical and orientation specific to a pan-theoretical conceptualization that applies to any therapeutic approach (Ardito & Rabellino, 2011). Moreover, what researchers once understood as a static or nondynamic part of the relationship between clients and therapists they now understand as consisting of the development of an affective therapist-client relationship, therapist-client agreement on goals of therapy, and therapist-client collaboration on therapeutic tasks (Ardito & Rabellino, 2011).

The development of an affective therapist-client relationship refers to the *bonds* construct of the therapeutic alliance, which embodies the feelings or qualities that unite clients with their therapists (Johnson & Wright, 2002). In other words, bonds refers to the relationship and interpersonal connectedness between therapists and clients (Dryden & Reeves, 2008). Examples of qualities of the bonds construct include liking, trust, a feeling of common purpose, respect, caring, and understanding in the interactions between therapists and clients (Johnson & Wright, 2002). Therapist-client agreement on goals of therapy reflects the *goals* construct of the therapeutic alliance (Johnson & Wright, 2002). Accordingly, not only mutual understanding and agreement on the goals, but also the mutual beliefs that the identified goals are achievable, as well as the mutual agreement to work towards achieving these goals, promotes the desired therapeutic outcomes (Dryden & Reeves, 2008). It is important that clients' perceptions of their therapists' investment in helping them to achieve these goals are crucial components of this construct (Johnson & Wright, 2002). Finally, therapist-client collaboration on therapeutic tasks refers to the *tasks* construct of the therapeutic alliance (Johnson & Wright, 2002). The tasks construct reflects therapists' expertise and clients' impressions of their therapists' ability to help them (Johnson & Wright, 2002). Shared commitment and collaboration on the activities that they will undertake, including the manner in which they will undertake them during therapy, are directly connected to this construct (Muran & Barber, 2010). Another important consideration within the tasks construct is the timing and pace of activities, because, regardless of therapists' skills, if the timing or pace is incorrect, clients might ultimately perceive their therapists as lacking the necessary skills to help them to reach their desired outcomes (Johnson & Wright, 2002). Furthermore, Bordin stressed the importance of enhancing clients' confidence that the therapeutic approach and accompanying interventions will result in their desired outcomes

(Muran & Barber, 2010). Thus, the development of collaboration on the tasks of therapy requires clear relevancy of the tasks and the goals of therapy (Muran & Barber, 2010).

Bordin's (1979, as cited in Muran & Barber, 2010) theory commences with the notion that therapeutic work must be goal directed and purposeful. Accordingly, his theory is founded on the idea that each therapeutic approach carries a set of expectations of the work that clients and therapists will do together, which he termed *embedded working alliances* (Muran & Barber, 2010). Bordin's theory is grounded in four main ideas. First, the therapeutic alliance is a requisite of all psychotherapies (Johnson & Wright, 2002). However, different psychotherapies require different types of alliances (Johnson & Wright, 2002). Second, the stronger the therapeutic alliance, the more successful the therapy will be (Johnson & Wright, 2002). Thus, Bordin believed that therapy effectiveness is, to a certain degree, a consequence of the development and management of the alliance (e.g., repairing and rebuilding following stresses and possible ruptures; Horvath, 2017). Third, the expectations of therapists and clients vary based on different psychotherapy approaches (Johnson & Wright, 2002). Fourth, the strength of the therapeutic alliance is a function of the compatibility between clients' and therapists' characteristics and the clients' and therapists' expectations of the therapeutic alliance (Johnson & Wright, 2002).

Bordin (1979, as cited in Muran & Barber, 2010) believed that the strength of the alliance is a reflection of therapists' and clients' ability to negotiate and perform the expected work cooperatively, that clients and therapists must begin to negotiate the alliance at the onset of therapy, and that these negotiations will continue throughout the treatment (Muran & Barber, 2010). Furthermore, according to Bordin's conceptualization, the alliance is a negotiation between therapists' and clients' expectations (Muran & Barber, 2010). Accordingly, clinical theory guides therapists' expectations, which in this case is TF-CBT, and client's understanding

of the challenges that they face and the best means to deal with them guide their expectations (Muran & Barber, 2010). The three fundamental components of this negotiation are (a) the establishment of the bond, (b) mutual understanding and agreement on goals, and (c) shared commitment and collaboration on tasks (Muran & Barber, 2010). Accordingly, therapists' and clients' work is anchored in these three interrelated components.

Definition of Terms

The *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, Text Revision* [*DSM-5-TR*] (American Psychiatric Association, 2022) defines trauma as

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) Witnessing, in person, the event(s) as it occurred to others; (3) 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; (4) Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains: police officers repeatedly exposed to details of child abuse) (p. 301).

For the purpose of this study, I will use the term *complex trauma* as an umbrella term encompassing repetitive harmful experiences that frequently occur in the interpersonal domain, most commonly beginning during childhood and spanning over extended periods of time (Van Nieuwenhove & Meganck, 2017). In this study, I refer to *childhood maltreatment* as any of the following traumatic experiences: emotional abuse, emotional neglect, physical abuse, physical neglect, and sexual abuse (Mauritz et al., 2013). Finally, in this study, I define *therapeutic alliance* as the mutual understanding and agreement on the goals of therapy, the shared commitment and collaboration on the tasks of therapy, and the formation of an attachment bond between therapist and client (Muran & Barber, 2010).

Self-Positioning Statement

For as long as I can remember, I have been drawn to the topic of trauma; my interest originated in my childhood. I was born in Israel and lived there for the first 10 years of my life. Because of the deadly Israeli-Palestinian conflict, I was frequently exposed to political hostility and increased violence. In fact, one of the first things that I recall learning in school was what to do when the missile siren started. However, although my interest in trauma stems from my childhood, my interest in complex trauma stems from the various professional roles that I have held in mental health. For example, during my role as a success coach in partnership with Edmonton Public Schools, I quickly realized that early childhood maltreatment is increasingly prevalent, with adverse childhood experiences occurring much more frequently than I once thought. In this role I had the humbling opportunity to support young people who had endured physical, verbal, and sexual abuse and presented with emotional, behavioral, cognitive, and relational challenges. Furthermore, my internship placement further solidified my passion for working with complex trauma. During my internship, I provided counselling services to an inner-city population who were dealing with high levels of trauma and addiction. As a result, I witnessed the wide-ranging and long-term impacts of chronic and complex trauma exposure.

As a mental health therapist who works with trauma daily, when I think about my work with trauma survivors of various ages, I think about the need for safety, stabilisation, connection, and compassion, as well as the potential for retraumatisation and vicarious traumatisation. Concerning the therapeutic alliance, I have experienced firsthand the challenges of fostering and maintaining a therapeutic alliance with trauma survivors of various ages. Despite this, I firmly believe that developing a safe and healing alliance is critical to support trauma survivors meaningfully. Thus, my assumption in this research was that the therapeutic alliance holds a

constructive role in the clinical outcomes of TF-CBT with child and adolescent survivors of complex trauma. However, throughout the research process, I remained open to the idea that the investigation may not support my beliefs surrounding the importance of the therapeutic alliance, and that the data that I will collect may challenge my views about what is going on. As a result, it was crucial that I remain objective in conducting my research and interpreting the findings. Thus, as I engaged in this research process, I employed various strategies to minimize the impact of my biases. These strategies included continually reflecting on and acknowledging the existence of my biases, maintaining an open mind, ensuring that I did not choose only sources that supported my point of view and ignored information that did not align with my preconceived notions (confirmation bias), and engaging in ongoing consultations with my supervisors. Moreover, in reflecting on how my worldview, cultural identity, and privilege all influenced my research question, I was highly aware that, despite having had the privilege of working with trauma survivors, I have not endured childhood maltreatment and thus will never truly understand the experience of having endured this type of trauma. Therefore, I believe that clients are the experts in their lives and recognize that I cannot step into clients' worldviews; instead, I can walk alongside them on their journey. Finally, I acknowledge that I only scratched the surface regarding my knowledge and understanding of trauma treatment. I hope to continue to build the necessary skills to support clients through safe and healing relationships.

Review of the Literature

Methods of Literature Search

In this section I explain how I conducted my literature search. I initially wanted to study the impact of complex trauma on the therapeutic alliance. However, I quickly realized that this topic is too broad and that a significant amount of research in this area already exists. For example, a theme that consistently arose was that therapists who work in the realm of trauma face various intrapersonal and interpersonal factors that can create challenges to supporting complex trauma survivors meaningfully and effectively (Dye, 2018; Grossman et al., 2017; Lawson, 2017; Van Nieuwenhove & Meganck, 2017). Because the research on the therapeutic alliance in adult trauma treatment is extensive, to narrow down my topic, I decided that my population of interest would be maltreated children with PTSD, which the American Psychiatric Association (2013) defined under the criteria outlined in the *DSM-5*. My specific interest in the therapeutic alliance in the context of childhood maltreatment stems from the findings that childhood maltreatment negatively impacts early attachment relationships and disrupts the development of secure attachment between children and their caregivers, adversely transforms children's view of themselves, others, and the world (Dye, 2018), and increases the potential for the perception of interpersonal relationships as uncomfortable and scary, which in turn inhibits the capacity to build and sustain relationships with others (Lafrenaye-Dugas et al., 2018).

Once I decided on my population, I had to decide on an intervention that is conducive for exploring the topic with this population and one that aligns with my research goals. I began to research popular therapy modalities for treating childhood PTSD, and TF-CBT consistently emerged as one of the most well-supported evidence-based treatments for childhood trauma (Vanderzee et al., 2018). I searched various databases for studies on my topic of interest,

including Google Scholar, City University of Seattle Library, Research Gate, PubMed and PsycNet. In my initial search, I used specific keywords of interest: *therapeutic relationship*, *therapeutic alliance*, *working alliance*, *therapeutic working alliance*, *working therapeutic alliance*, *complex trauma*, *interpersonal trauma*, *childhood maltreatment*, *childhood PTSD*, *TF-CBT*, *trauma-focused cognitive behavioral therapy*, *TF-CBT clinical outcomes*, *therapeutic alliance in trauma-focused cognitive behavior therapy*, *therapeutic alliance TF-CBT*, and *working alliance TF-CBT.* I limited my research to scholarly, peer-reviewed studies that were published between 2012 and 2022, were written in the English language, and included samples of children with PTSD diagnoses after any of the following traumatic experiences: emotional abuse, emotional neglect, physical abuse, physical neglect, sexual abuse and witnessing family violence (Lawson et al., 2013). However, this search generated fewer than 10 studies that met my criteria and that specifically addressed the therapeutic alliance in the context of TF-CBT clinical outcomes with maltreated children who had endured interpersonal traumas such as emotional abuse/neglect, physical abuse/neglect, and sexual abuse who also met the diagnostic criteria for *DSM-5* (American Psychiatric Association, 2013).

After several failed attempts to locate at least 10 scholarly, peer-reviewed articles that matched my predetermined criteria, I realized that I had to broaden my topic. Because TF-CBT is a manualized therapy approach for young people aged 3-18 (Vanderzee et al., 2018), I decided to broaden my population to children and adolescents (young people under 18) who have endured repetitive harmful experiences occurring in the interpersonal domain (complex trauma; Van Nieuwenhove & Meganck, 2017). Furthermore, because it is not necessary to meet the full diagnostic criteria of PTSD to participate and benefit from TF-CBT (Vanderzee et al., 2018), I decided to also broaden my focus to child and adolescent survivors of complex trauma who did

not meet the full diagnostic criteria of PTSD. Over time, I was able to locate two qualitative, one-mixed methods, and seven quantitative studies on the therapeutic alliance in the context of TF-CBT with a sample of young survivors of complex trauma who presented with posttraumatic stress.

I hoped to include an equal number of qualitative and quantitative studies for this capstone research. My wish to include qualitative studies stemmed from my desire to gain a deeper understanding of participants' experiences of the therapeutic alliance in TF-CBT, and my wish to include quantitative studies arose from my desire to gain a deeper understanding of the alliance-outcome relationship in TF-CBT. However, despite having broadened my inclusion criteria, I was able to locate only two qualitative studies and one mixed-methods study with qualitative information on the participants' experiences of the therapeutic alliance in TF-CBT. Furthermore, of the seven quantitative studies available, the researchers of one study (Yasinski et al., 2018) did not explicitly refer to the concept of the therapeutic alliance; however, they discussed therapist-client relationship difficulties, which provided sufficient information for inclusion in this capstone research.

Finally, all of the participants except for those in one study's sample (Eastwood et al., 2020) were 18 or younger (ages 7-18). Eastwood et al.'s (2020) sample ranged from 17-25 years of age. Despite this, I chose to include this study because of the lack of available research with only children and adolescents and because the mean age of their participants was 20 years, which I believed was close enough to my target population. Furthermore, all of the participants except those in one study sample (Okamura et al., 2020) had been exposed to multiple traumatic experiences, including interpersonal forms of trauma. Although Okamura et al. (2020) did not include the sample's characteristics on index traumas, they noted trauma exposure in their

criteria for recruitment, which, given the limit research, I believed was sufficient to include in this capstone research.

Overall, the difficulty that I faced in locating a sufficient number of studies that met my criteria further shed light on the gap in the research on the impact of the therapeutic alliance in TF-CBT. I found this research gap particularly interesting, given that the developers of this therapeutic modality argued that the therapeutic alliance plays a central role in empowering children and their nonoffending caregivers to heal effectively following exposure to trauma (J. A. Cohen et al., 2018). Table 1 summarizes the 10 selected studies, organized by the authors, the years of publication, the titles of the articles, the research designs and paradigms, and the objectives, hypotheses, or research questions in each of the studies.

Table 1

Summary of Key Research Articles Reviewed

Authors	Year	Title	Research design and paradigm	Objective/hypothesis
Dittmann, I., & Jensen, T. K.	2014	Giving a Voice to Traumatized Youth—Experiences With Trauma-Focused Cognitive Behavioral therapy	Qualitative Constructivist	Objective: to explore traumatized youths' experiences of receiving TF-CBT
Eastwood, O. et al.	2020	"Like a Huge Weight Lifted off my Shoulders": Exploring Young Peoples' Experiences of Treatment in a Pilot Trial of Trauma-Focused Cognitive Behavioral Therapy	Qualitative Constructivist	Objective: to address research gaps surrounding young peoples' experiences of trauma-focused cognitive behavioural therapy by exploring older adolescents' and young adults' subjective experiences of TF-CBT.

(table continues)

Authors	Year	Title	Research design and paradigm	Objective/hypothesis
Kirsch, V. et al.	2018	Treatment expectancy, Working Alliance, and Outcome of Trauma-Focused Cognitive Behavioral Therapy With Children and Adolescents	Quantitative Postpositivist	Objective: to fill the gap in research on TE in children and adolescents with PTSS and their caregivers. Hypotheses: 1. The patients' as well as the caregivers' TE *directly* affects patients' treatment response to TF-CBT in terms of PTSS score, respectively PTSS reduction after treatment completion. 2. The patients' as well as the caregivers' TE *indirectly* affects treatment response in so far as 3. the patients' as well as the caregivers' TE affect patients' collaboration *and* at the same time patients' collaboration significantly affects patients' treatment response. 4. the patients' as well as the caregivers' TE affect patients' and caregivers' working alliance *and* patients' and caregivers' working alliance affects patients' treatment response.
Loos, S. et al.	2020	Do Caregivers' Perspectives Matter? Working Alliances and Treatment Outcomes in Trauma-Focused Cognitive Behavioural Therapy With Children and Adolescents	Quantitative Postpositivist	Objective: to extend previous research by investigating the working alliance among participants in a randomized controlled trial of TF-CBT including different perspectives. Hypotheses: 1. The working alliance is positive and stable. 2. Moderate agreement between the perspectives. 3. Significant main effects for both the patient and the caregiver alliance to the therapist.
Okamura, K. H. et al.	2020	Perceptions of Evidence-Based Treatment Among Youth and Caregivers Receiving Trauma Focused-Cognitive Behavioral Therapy	Mixed method Postpositivist	Objective: to explore how youth and caregivers who received trauma-focused cognitive-behavioural therapy (TF-CBT) in a public behavioural health system perceived the concept of EBT, their experience with treatment, their perceptions of TF-CBT, and whether their perceptions varied as a function of clinical improvement. Hypothesis: youth and caregivers would have little exposure to the concept "evidence-based."

(table continues)

Authors	Year	Title	Research design and paradigm	Objective/hypothesis
Ormhaug, S. M., & Jensen, T. K.	2016	Investigating Treatment Characteristics and First-Session Relationship Variables as Predictors of Dropout in the Treatment of Traumatized Youth	Quantitative Postpositivist	Objective: to investigate the relationships among treatment type, caregiver participation, and dropout. Expectations: 1. Dropout rates is higher in the exposure-based condition (TF-CBT) and in therapies without caregiver attendance. 2. The first-session caregiver–therapist alliance would predict dropout because caregivers are pivotal agents in their child's treatment. 3. Youths' alliance with the therapist in addition to the youths' perception of their caregivers' approval of treatment would predict dropout.
Ormhaug, S. M. et al.	2014	The Therapeutic Alliance in Treatment of Traumatized Youths: Relation to Outcome in a Randomized Clinical Trial	Quantitative Postpositivist	Objective: to evaluate the strength of association between alliance and outcome with a sample of referred youths presenting with PTSD symptoms and to compare whether alliance-outcome relations were significantly different in TF-CBT compared to TAU. Hypothesis: alliance is associated with outcome such that more positive alliance is associated with greater symptom reduction.
Ormhaug, S. M. et al.	2015	Therapist and Client Perspectives on the Alliance in the Treatment of Traumatized Adolescents	Quantitative Postpositivist	Objective: to investigate how therapists' ratings relate to the adolescents' perspective, how individual therapist and adolescent ratings relate to change in symptoms and treatment satisfaction, and whether discrepant alliance perspectives impact treatment outcome. Hypothesis: greater divergence between therapist and adolescent ratings of alliance signals poor therapist attunement to the adolescent's experience and represents a marker of negative therapeutic process. Expectation: lower adolescent than therapist ratings is at greater risk for poorer outcomes.

(table continues)

Authors	Year	Title	Research design and paradigm	Objective/hypothesis
Yasinski, C. et al.	2018	Treatment Processes and Demographic Variables as Predictors of Dropout From Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Youth	Quantitative Postpositivist	Objective: to address gaps in knowledge of factors that predict dropout from childhood PTSD treatments by examining the role of client and caregiver baseline variables, as well as client, caregiver, and therapist in-session process variables in the first phase (usually sessions 2–5) of TF-CBT for childhood trauma. Expectations: 1. With regard to in-session child variables, more hope expressed in sessions would predict lower dropout, whereas more avoidance would predict greater dropout. 2. With regard to in-session caregiver variables, less caregiver support of the child, more avoidance of trauma-related related issues or emotions, and more blame of the child would predict dropout. Hypothesis: therapist support of the child and the caregiver would predict less dropout, whereas difficulties in the therapeutic relationship with both the child and the caregiver would predict more dropout.

(table continues)

Authors	Year	Title	Research design and paradigm	Objective/hypothesis
Zorzella, K. P. et al.	2015	The Relationships Between Therapeutic Alliance and Internalizing and Externalizing Symptoms In Trauma-Focused Cognitive Behavioral Therapy	Quantitative Postpositivist	Objective: to investigate the relationships between child therapeutic alliance and psychopathology in an empirically supported therapy model designed to address issues related to trauma with children and their caregivers. Hypotheses: 1. Internalizing and externalizing symptoms would predict early alliance as reported by both child and therapist. While higher internalizing symptoms would predict stronger alliances, higher externalizing symptoms would predict weaker alliances. 2. Early child and therapist alliances would predict improvement in both internalizing and externalizing symptoms. Stronger early alliances would predict greater improvement in symptoms. 3. A positive correlation between change in alliance and change in symptomatology at post-treatment.

Methodology Analysis

In this section I examine the research paradigms, sampling, recruitment and participants, data-collection processes, and data-analysis procedures of the selected articles.

Research Paradigms Across Studies

In research, the term *paradigm* describes researchers' philosophical worldviews and reflects their beliefs about their world (Kivunja & Kuyini, 2017). Research paradigms shape the philosophical bases of research, provide direction for the study, and guide the way that individuals engage in the overall process of conducting research (Creswell & Poth, 2017). On the topic of the relationship between the therapeutic alliance and treatment success in TF-CBT, the postpositivist paradigm informed many of the studies that are available. However, I also believed that it was crucial that I include several studies informed by the constructivist paradigm, because

they helped me to gain a deeper understanding of the role of the therapeutic alliance in TF-CBT from the perspectives of the participants.

Postpositivism. A postpositivist paradigm informed all seven quantitative studies and one mixed-methods study reviewed in this paper. Postpositivism, sometimes referred to as the *scientific method*, is an approach that frequently guides quantitative research; it is a research methodology based on a deductive approach with the aim of testing objective theories by examining cause-and-effect relationships among measurable variables (Creswell & Creswell, 2018). Postpositivism holds the elements of determination, reductionism, empirical observation and measurement, and theory verification (Creswell & Creswell, 2018). This worldview is based on the belief that reality is observable and discoverable; however, it also acknowledges that all observation is prone to error and is thus fallible (Creswell & Creswell, 2018). Although postpositivist researchers attempt to maintain distance between themselves and their study participants, they do not believe that researchers can be independent observers of the social world (Creswell & Creswell, 2018). From a postpositivist worldview, researchers acknowledge their bias and approach objectivity by attempting to recognize and minimize it. Because postpositivism is guided by the belief that knowledge is conjectural and falsifiable, postpositivist researchers recognize that they can never completely achieve objectivity, but that they can approach it by using multiple measures and observations and triangulating across multiple fallible perspectives (Creswell & Creswell, 2018).

In the seven quantitative studies and one mixed-methods study reviewed in this paper, the researchers tested their theories by developing hypotheses and collecting data to either support or refute them. Hypotheses can either be directional or nondirectional; and, because the directional hypothesis makes a stronger claim, researchers believe that it is stronger than the nondirectional

hypothesis (L. Cohen et al., 2018). The researchers of six of the quantitative studies (Kirsch et al., 2018; Loos et al., 2020; Ormhaug et al., 2014; Ormhaug et al., 2015; Yasinski et al., 2018; Zorzella et al., 2015) all had directional hypotheses. For example, Ormhaug et al. (2014) hypothesized that the therapeutic alliance is associated with the outcome such that a more positive alliance is associated with greater symptom reduction. It is notable that, although Ormhaug and Jensen (2016; the seventh quantitative study) did not propose specific hypotheses, they phrased their expectations directionally. They expected that dropout rates would be higher in the exposure-based condition (TF-CBT) and in therapies without caregiver attendance; that the first-session caregiver-therapist alliance would predict dropout because caregivers are pivotal agents in children's treatment; and that the youths' alliances with therapists in addition to the youths' perceptions of their caregivers' approval of treatment would predict dropout. However, Ormhaug and Jensen's (2018) decision to state expectations rather than formal hypotheses suggests that their theory might not have been strong enough to support a formal hypothesis (L. Cohen et al., 2018).

Constructivism. Both qualitative studies reviewed for this paper (Dittmann & Jensen, 2014; Eastwood et al., 2020) were informed by the constructivist paradigm and aimed at exploring and understanding the participants' subjective experiences of receiving TF-CBT. Constructivism is an approach that frequently guides qualitative research; it is a research strategy that is based on an inductive approach with the aim of exploring and understanding the meaning of a phenomenon from the views of the participants (Creswell & Creswell, 2018). Constructivism holds elements of understanding, multiple participant meanings, social and historical construction, and theory generation (Creswell & Creswell, 2018). Researchers guided

by the constructivist paradigm typically believe that reality is a subjective construct of the human mind that interacts with real-world experiences (Elkind, 2005).

Sampling, Recruitment, and Participants

Sampling methods refers to the process of selecting study participants (a sample population) from a target population (Elfil & Negida, 2017). The two main methods of sampling include probability sampling, in which all members of the larger population have an equal chance of being included in the sample, and nonprobability sampling, in which not all members of the population have an equal chance of being included for participation because researchers selected them based on specific characteristics (L. Cohen et al., 2018). Because probability sampling incorporates a measure of randomness, samples selected are more representative of the wider population and thus carry a degree of generalisability (L. Cohen et al., 2018). By drawing randomly from the larger population, researchers who use probability sampling reduce the risk of bias and enhance the external validity and generalisability of their findings; it is therefore the preferred sampling method in quantitative research, in which researchers aim to investigate larger databases to obtain broader insights and generalisable results (L. Cohen et al., 2018). Although probability sampling techniques enable reliable and valid inferences from a sample, it is not always viable because of factors such as cost, availability, accessibility, complexity, and so on; as a result, researchers might choose to use nonprobability sampling such as convenience, quota, dimensional, purposive, or snowball instead (L. Cohen et al., 2018). It is unlikely that probability sampling was feasible in the research on the relationship between the therapeutic alliance and treatment success with TF-CBT, because exposure to childhood trauma is not an experience that most members of the larger population share. Accordingly, the researchers of all 10 studies that I reviewed relied on nonprobability sampling—specifically, convenience

sampling, which is a sampling strategy in which the researchers select the nearest/most readily accessible and available individuals at the time (L. Cohen et al., 2018).

In all 10 studies the researchers selected participants based on their convenient accessibility and proximity (i.e., the researchers relied on readily accessible, previously recruited samples). For example, Eastwood et al. (2020) recruited participants from a pilot trial of TF-CBT for young people who had experienced symptoms of posttraumatic stress following exposure to interpersonal trauma. The researchers reminded them of the optional qualitative component of the pilot trial in their final therapy session and gave them the name of a researcher who would contact them by phone or text message to gauge their interest. However, although the researchers of all 10 of the studies used convenience sampling, many relied on research in which the investigators had used purposive sampling to recruit participants, which enabled them to focus on specific, unique cases. For example, Dittmann and Jensen (2014), Ormhaug et al. (2014), Ormhaug et al. (2015), and Ormhaug and Jensen (2016) all recruited participants and derived data from the same study on whether TF-CBT is superior to therapy as usual (TAU) in eight community clinics for children and adolescents with trauma-related symptoms in Norway (Jensen et al., 2013). Jensen et al. (2013) selected participants who were part of a larger sample of children and adolescents with trauma-related symptoms. The original sampling was purposive, which involved recruitment through referral to one of eight community mental health outpatient clinics in Norway (Jensen et al., 2013). This indicates that many children and adolescents who had endured trauma would access these services at any of these eight locations. It is important to note that using purposive sampling in their recruitment of participants enabled Jensen et al. to focus on specific, unique cases (i.e., youth who had experienced at least one traumatizing event and suffered from significant PTS reactions; (L. Cohen et al., 2018).

Sampling Size. Quantitative researchers are tasked with ensuring their investigations' external and internal validity (Efron & Ravid, 2018). Validity is a crucial aspect of meaningful research. If research is invalid, then it is meaningless (L. Cohen et al., 2018). The sample size is a crucial factor in determining the external and internal validity (Efron & Ravid, 2018). The sample must be representative of the selected population, and larger sample sizes are more representative of the larger population meaningless (L. Cohen et al., 2018). Thus, the sample size must not only be large enough, but also sufficiently representative of the population to generalize the findings (Vogt et al., 2012). A larger sample also ensures greater reliability and enables the use of more sophisticated statistics (L. Cohen et al., 2018). According to L. Cohen et al. (2018), a sample size of 30 is the minimum number of participants required for inclusion to employ statistical analyses of the data. Accordingly, the rule of thumb is a minimum of 30 cases per variable (L. Cohen et al., 2018). All of the quantitative studies that I reviewed for this paper included a sample size larger than 30. However, the one mixed-methods study that I reviewed (Okamura et al., 2020) had a sample size of only eight, which limited the generalisability of their findings.

Because the sample size establishes the statistical power, to determine the appropriate target sample size, quantitative researchers conduct a statistical power analysis, which encompasses four parameters, including the effect size, the sample size, the alpha significance level, and the power of the statistical test (L. Cohen et al., 2018). Conducting a power analysis can also help researchers avoid type I and type II error rates. A type I error refers to a false positive effect; that is, the researchers conclude that the findings are statistically significant despite the fact that they are a result of chance or because of unrelated factors (Creswell & Creswell, 2018). A type II error refers to a false negative effect; that is, the researchers conclude

that the results are not statistically significant despite the presence of a significant association (Creswell & Creswell, 2018). None of the researchers of the quantitative studies that I reviewed indicated whether they conducted a power analysis. This raises a concern, because this hinders the reader's ability to conclude whether the sample was adequate to avoid type I and type II errors. However, Kirsch et al. (2018) and Loos et al. (2020) recruited participants from Goldbeck et al.'s (2016) study and conducted a power analysis to determine the appropriate target sample size, which they determined to be at least 150 patients. Despite this, it is not possible to conclude that their samples were adequate to avoid type I and type II errors. This is because Kirsch et al. conducted their analysis with a sample size of only 65 (TF-CBT completers), and Loos et al.'s (2020) sample size was only 76 (this included all participants in the TF-CBT group, not only the completers).

Conversely, qualitative researchers often gather data from smaller samples, which makes the data richer (Creswell & Creswell, 2018). Gathering richer sets of data from a smaller number of participants in qualitative research promotes a deeper understanding of the social world from the perspectives of the participants (Creswell & Creswell, 2018). Small sample sizes are evident in the two qualitative studies that I reviewed: Dittmann and Jensen's (2014) sample size was 30, and Eastwood et al.'s (2020) was 13. However, despite the small sample sizes, qualitative researchers establish validity and reliability by determining the trustworthiness of the findings: They assess the credibility, transferability, dependability, and confirmability of their studies (Efron & Ravid, 2018).

Inclusion and Exclusion Criteria. Researchers create inclusion and exclusion criteria to ensure that the data that they collect are applicable to the topic under investigation (Yale University, 2022). Inclusion criteria are the characteristics that prospective participants must

have to be included in a study. In contrast, exclusion criteria are characteristics that disqualify prospective participants from inclusion in the study (Yale University, 2022). Inclusion and exclusion criteria influence the external validity (generalisability) of a study. When researchers clearly define their inclusion and exclusion criteria, they enhance the chances of generating reliable results and lessen the possibility that vulnerable persons will be exploited or that prospective participants will be harmed (Yale University, 2022).

Of the 10 studies that I reviewed, the researchers of seven explicitly stated the criteria for inclusion and exclusion (Dittmann & Jensen, 2014; Eastwood et al., 2020; Kirsch et al., 2018; Ormhaug & Jensen, 2016; Ormhaug et al., 2014; Ormhaug et al., 2015; Yasinski et al., 2018). For example, Dittmann and Jensen (2014) identified their inclusion criteria as exposure to at least one traumatic event and the presence of posttraumatic stress symptom scores of 15 or higher on the Child Posttraumatic Symptom Scale; and the exclusion criteria as acute suicidal behavior, psychosis, or the need for an interpreter. In contrast, Loos et al. (2020) explicitly stated only their inclusion criteria but not their exclusion criteria. However, in their design section they noted that further details were available in Goldbeck et al.'s (2016) research (the original study from which Loos et al. recruited their participants). Furthermore, although Okamura et al. (2020) did not clearly define their inclusion and exclusion criteria, they indicated that they limited the selection of study participants to youth and/or their caregivers who had experienced a traumatic event (e.g., witnessed a murder, was sexually abused) and received TF-CBT through community mental health clinics that participated in the Philadelphia Alliance on Child Trauma Services. However, although they referred to the original study from which they recruited their participants from, because this study was not freely accessible, I was unable to determine whether the original sample was based on clearly defined inclusion and exclusion criteria. It is interesting

that Zorzella et al. (2015) grouped their inclusion and exclusion criteria and that, although the characteristics that prospective participants were required to have to be included in the study and those that would disqualify them from inclusion are apparent in their inclusion criteria, combining them creates confusion and minimizes the distinctiveness of the criteria.

Overall, all of the researchers who explicitly stated their criteria for inclusion and exclusion defined exposure to at least one traumatic event as an inclusion criterion, and most also included the presence of posttraumatic stress symptoms (PTSS). This ensured that the participants would be able to provide information on their experience of trauma exposure and impact. The researchers used varying measures to evaluate the presence of PTSS, including the Child Posttraumatic Symptom Scale (CPSS), the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA), and the UCLA PTSD Reaction Index for DSM-IV (UPID)–Abbreviated. Only Zorzella et al. (2015) defined their inclusion and exclusion criteria but did not include a measurement of PTSS.

Frequent commonalities among exclusion criteria were (a) acute suicidal behavior/high risk for suicidality, (b) untreated psychosis/a psychotic disorder, and (c) insufficient understanding of the language/need for an interpreter. It is notable that most of the researchers of the remaining studies defined sufficient knowledge/speaking of the language as part of the inclusion criteria, possibly to reduce the likelihood of harm to prospective participants or the exploitation of vulnerable persons (Yale University, 2022). It is surprising that the researchers of only four studies (Kirsch et al., 2018; Loos et al., 2020; Yasinski et al., 2018; Zorzella et al., 2015) included the availability/co-operation of a nonoffending caregiver to participate in treatment as an inclusion criterion, because TF-CBT is a conjoint parent-child trauma-focused

treatment model that requires collaboration among therapists, children, and their caregivers (de Arellano et al., 2014).

Sampling Characteristics. The characteristics of the samples in the 10 selected studies reflect the participants' exposure to multiple traumatic events, which often involved interpersonal victimisation. For example, Dittmann and Jensen (2014), Ormhaug and Jensen (2016), Ormhaug et al. (2014), and Ormhaug et al. (2015) all recruited their participants from the same randomized effectiveness study in which the researchers compared TF-CBT to TAU for traumatized youth (Jensen et al., 2013). The participants in Jensen et al.'s (2013) randomized effectiveness study reported having been exposed to an average of 3.6 different types of traumatizing events. When the researchers asked them at intake to specify which event they perceived as the worst, 32.5% reported exposure to domestic violence and physical abuse, 29.1% reported sexual abuse, 18.0% reported violent attacks outside the family context, 16.6% reported traumatic loss (i.e., the sudden death of a caregiver or a close person), and 4.0% reported exposure to accidents or other forms of noninterpersonal traumas (Jensen et al., 2013). Of this sample, 66.7% met the diagnostic criteria for PTSD on the CAPS-CA (Jensen et al., 2013).

It is interesting that Dittmann and Jensen's (2014), Ormhaug and Jensen's (2016), Ormhaug et al.'s (2014), and Ormhaug et al.'s (2015) inclusion criteria all defined the characteristics of the sample in Jensen et al.'s (2013) original study. This is concerning, because Jensen et al. used a sample of 156 participants in their study, whereas Dittmann and Jensen included only 30 participants from this sample in their study. Therefore, it is unclear how applicable the sampling characteristics of 156 participants are to those of the 30 youths who participated in Dittmann and Jensen's interview study. In contrast, although Kirsch et al. (2018) and Loos et al. (2020) recruited participants from the same effectiveness study on whether

TF-CBT is superior to the waitlist condition (Goldbeck et al., 2016), because Kirsch et al. included only participants who had completed the TF-CBT intervention, and Loos et al. included all of the participants in the TF-CBT group. Kirsch et al. and Loos et al. included only sampling characteristics that matched their specific sample.

Additionally, aside from exposure to various interpersonal forms of trauma such as physical and sexual abuse, as well as clinical diagnoses, another prominent commonality amongst the sampling characteristics is the gender of the participants; in all 10 of the studies that I reviewed, females were the majority of the sample. For example, of Eastwood et al.'s (2020) 13 participants, nine identified as female; of Kirsch et al.'s (2018) 65 participants, 44 identified as female; and of Loos et al.'s (2020) 76 participants, 53 identified as female. The reason is that females are more likely to be exposed to interpersonal trauma, are at a higher risk for trauma exposure at a younger age and are two to three times more likely to develop PTSD compared to males (Olff, 2017). However, the uneven gender distribution in these samples could have limited the generalisability of the researchers' findings.

Data Collection

Data collection is the process of gathering and measuring information on variables of interest (L. Cohen et al., 2018). Accurate and meaningful data collection is vital to preserve the integrity of the research, because it enables researchers to answer research questions and test hypotheses (L. Cohen et al., 2018). In the following subsections I discuss qualitative, mixed-methods, and quantitative data collection and evaluate the data-collection methods that the researchers used in the studies that I reviewed for this paper.

Qualitative Data Collection. Researchers collect qualitative data mainly through observations, in-depth interviews, document analysis, and analysis of audiovisual and digital

material, which help to uncover the underlying meaning of a phenomenon for those involved (Creswell & Creswell, 2018). In both of the qualitative studies that I reviewed (Dittmann & Jensen, 2014; Eastwood et al., 2020), the researchers collected data by conducting semistructured interviews. Dittmann and Jensen (2014) gathered data on their participants' therapy expectations and perceived help, information on working with the trauma narrative, and views on confidentiality and parents' involvement in therapy. They also asked their participants to offer advice to children and therapists. Examples of the interview questions include the following: "Tell me about how you experienced coming to the clinic?"; "Did you and your therapist talk much about the difficult things that have happened to you? What was that like?"; "Do you think it is different talking to a therapist than to your parents or other adults? What is different?"; and "If you met another boy/girl at your own age who had experienced something difficult and who was struggling, what would you recommend they do?" (p. 1224). Similarly, Eastwood et al. (2020) explored their participants' experiences of TF-CBT. More specifically, they collected data on the participants' perspectives on what was helpful and unhelpful and on the change processes and asked them for recommendations for change. Examples of the questions that the interviewer asked include the following: "Tell me about your experience of the study"; "What were some of the things you and [therapist] did in your sessions?"; "What was it like working with [therapist]?"; and "What would you say to other young people who are just starting out at headspace and are receiving treatment for their trauma symptoms?" (p. 740).

It is interesting that, although the researchers of both studies conducted semistructured interviews, their approaches to the interviews differed. For example, Dittmann and Jensen (2014) interviewed their participants over the phone and justified their selection of telephone interviews with the reasons that it is easy and convenient to contact youth, and they enhance the likelihood

of participation. Some additional benefits of telephone interviewing include the reduced cost, the reduced interviewer effects, and the neutralisation of power (L. Cohen et al., 2018). However, some significant drawbacks of telephone interviewing include the limited visual, nonverbal, and contextual cues; the lack of emotional feedback; and shorter concentration spans (L. Cohen et al., 2018). It is important that Dittmann and Jensen highlighted the use of phone interviews as a possible limitation of their research.

Mixed-Methods Data Collection. Mixed-methods research incorporates qualitative and quantitative data (Creswell & Creswell, 2018). The core assumption of a mixed methods approach to inquiry is that integrating these two forms of data will yield additional data that surpass the data that result from either approach on its own (Creswell & Creswell, 2018). The three primary mixed-methods designs in the social health sciences are convergent mixed methods (researchers converge quantitative and qualitative data), explanatory sequential mixed methods (researchers begin by conducting and analysing quantitative research and then conduct qualitative research to explain the results), and exploratory sequential mixed methods (researchers begin by conducting and analysing qualitative research and then conduct quantitative research; Creswell & Creswell, 2018).

The one mixed-methods research study that I reviewed for this paper (Okamura et al., 2020) is based on an explanatory sequential mixed methods design, in which the qualitative phase followed the initial quantitative phase (Creswell & Creswell, 2018); the participants completed the CPSS (Foa et al., 2001; it is a quantitative measure of PTSD symptoms) at pretreatment, every six months, and at posttreatment or termination. Then those who agreed to participate completed a semistructured interview (qualitative measures) on their broad impressions of evidence-based treatments, their thoughts on strategies to market specific

evidence-based approaches, and their impressions of receiving TF-CBT at posttreatment and/or termination. Integrating quantitative and qualitative data has a number of strengths: Because mixed-methods researchers are not confined to using one method, they can incorporate both open-ended and closed-ended questions, answer a broader range of research questions, access more data, and provide additional insight and knowledge (Creswell & Creswell, 2018).

Quantitative Data Collection. Quantitative researchers commonly measure variables by using instruments (standardized measurement tools) to support their analyses of numeric data through statistical procedures (Creswell & Creswell, 2018). Utilizing standardized measurement tools to gather data on their participants' experiences better enables researchers to assume a neutral, objective, and detached stance and maintain distance between themselves and the study participants, thus minimizing the influence of their biases on the outcome and interpretation of the data (Creswell & Creswell, 2018). The researchers of six of the quantitative studies that I reviewed used standardized measurement tools to measure the therapeutic alliance; they used instruments such as the Working Alliance Inventory Short Version (WAI-S), the Therapeutic Alliance Scale for Children (TASC) and the Therapeutic Alliance Scale for Children–Revised (TASC-R). In the remaining quantitative study, Yasinski et al. (2018) used an observational coding system to identify difficulties in the therapeutic relationship. Similarly, the researchers of six of the quantitative studies that I reviewed used standardized tools to measure PTSD symptoms as measures of the primary outcome. They used instruments such as the CAPS-CA, the CPSS, and the UPID to measure PTSS. The researchers of the remaining quantitative study (Zorzella et al., 2015) used the Child Behavior Checklist 6–18 (CBCL 6–18) to measure internalizing and externalizing symptoms as a measure of the primary outcome. Although distinct from the other six quantitative studies, given the association between internalizing and

externalizing symptoms and children's maltreatment (Zorzella et al., 2015), the CBCL was an appropriate measure of the primary outcome.

The use of standardized measures enabled the researchers to compare the alliance ratings and posttraumatic stress ratings over time and then to investigate the role of the alliance in the therapy process and the outcome and arrive at an objective conclusion. For example, using the client and therapist versions of the TASC-R and the CPSS enabled Ormhaug et al. (2015) to arrive at the finding that, although both the clients' and the therapists' perspectives on the alliance (which the TASC-R gathered) were moderately related and predicted adolescent-treatment satisfaction, only the clients' perspective on the alliance (the client scale) was significantly related to changes in the PTSS. This finding led Ormhaug et al. to conclude that adolescents' and therapists' perspectives on the therapeutic alliance are not interchangeable and are differently associated with changes in PTSS.

Quantitative researchers are concerned with the reliability and validity of the instruments that they use to gather their data (L. Cohen et al., 2018). The reliability of a data-collection tool indicates the degree to which the instrument yields consistent results with uniform values (Mohajan, 2017). The coefficient of reliability can lie between 0 and 1, where 0 signifies *no reliability* and 1 signifies *perfect reliability* (Mohajan, 2017). A value of 0.8 is commonly recognized as an acceptable level of reliability (L. Cohen et al., 2018). Prevalent strategies that researchers use to evaluate the reliability of their data-collection tools include test-retest, alternate forms, and measures of internal consistency reliability (Efron & Ravid, 2018). The test-retest and alternate forms methods are measures of stability and requires that researchers administer the same instrument to the same group of respondents at two different points in time (Mohajan, 2017). Calculating the correlation coefficient between the two sets of data determines

the external consistency of an instrument (Mohajan, 2017). A high reliability coefficient indicates that the instrument is relatively free of measurement errors (Mohajan, 2017). An example of an instrument with high test-retest reliability is the UPID which Yasinski et al. (2018) used. It has a test-retest reliability of 0.84 (Yasinski et al., 2018), which implies that it yield consistent results after being administered to the same group of examinees at two different points in time (Efron & Ravid, 2018).

Measures of internal consistency are concerned with the homogeneity of the items within an instrument (Mohajan, 2017); unlike test-retest and alternate forms, measures of internal consistency reveal scores from a single testing situation to evaluate the reliability of an instrument (Efron & Ravid, 2018). The Cronbach's alpha (α) and the split-half coefficient are common measures of internal consistency (L. Cohen et al., 2018). The Cronbach's alpha provides a coefficient of interitem correlations (L. Cohen et al., 2018). An example of a measure with a high alpha value is the German version of the CAPS-CA ($\alpha = .91$), which Kirsch et al. (2018) and Loos et al. (2020) used. A Cronbach's alpha of .91 implies that the items that the CAPS-CA measured are all closely related to each other. Because the CAPS-CA assesses the frequency and intensity of the 17 *DSM-IV* PTSD symptoms, using the Cronbach's alpha to establish the internal consistency of the CAPS-CA is appropriate because it is a useful measure of the internal consistency and reliability of multiitem scales (L. Cohen et al., 2018).

The validity of a measurement tool indicates the degree to which it measures what it claims to measure (Efron & Ravid, 2018). In other words, the validity of a measurement tool specifies its accuracy. Researchers use three major types of validity—construct, content, and criterion-related—to evaluate the validity of their data-collection tools (Efron & Ravid, 2018). To establish construct validity, the instrument must demonstrate that it genuinely measures the

construct that it is intended to measure (Mohajan, 2017). Convergent and discriminant validity are both facets of construct validity (L. Cohen et al., 2018). Researchers establish convergent validity when the scores that they obtain from two different instruments that measure the same concept are highly correlated (Mohajan, 2017). For example, the CPSS, which Okamura et al. (2020), Ormhaug and Jensen (2016), Ormhaug et al. (2014), and Ormhaug et al. (2015) all used, had very good convergent validity, which the researchers established by comparing the total-scale score of the CPSS with the severity rating from the Child PTSD-Reaction Index; this produced a Pearson product-moment correlation coefficient of .80 ($p < .001$), which indicates statistical significance (Foa at al., 2001).

To establish content validity, the instrument must show that the items fairly and comprehensively measure the content that researchers design them to measure (Efron & Ravid, 2018). The TASC-R that Ormhaug and Jensen (2016), Ormhaug et al. (2014), and Ormhaug et al. (2015) used has good content validity, which means that the 12 items in the TASC-R actually measure the contents that the researchers designed them to measure, which in this case are emotional aspects (affective bond) and the degree of client-therapist collaboration on tasks and goals (Accurso et al., 2013). Last, to establish criterion-related validity, the results of an instrument must correlate with another criterion of interest (Mohajan, 2017). Researchers establish criterion-related validity by measuring the concurrent validity (the degree of agreement between two different instruments that measure the same or related constructs) or predictive validity (whether the results of the instrument at the first round of research correlate with the results at a future date; L. Cohen et al., 2018). For example, the Mood and Feelings Questionnaire, which Ormhaug et al. (2014) used, has high concurrent validity, because it significantly and strongly correlates with the Children's Depression Rating Scale–Revised and

the Reynolds Adolescent Depression Scale 2, which are measures that researchers have previously validated (Thabrew et al., 2018).

Furthermore, it is important to point out that many of the researchers of the studies that I reviewed for this paper relied on instruments that others had developed, tested, and validated in North America but that researchers used in other countries such as Norway and Germany. One technique to address the validity of the instruments that researchers use in cross-cultural research is *back-translation* (L. Cohen et al., 2018). During the process of back-translation, researchers translate the original version of the instrument into the required language, which they then give to a third party, who translates it back into the original version (L. Cohen et al., 2018). They compare the two versions to determine whether the meanings have remained the same and are deemed the same; they then consider the translated version acceptable. Examples of back-translation are in Kirsch et al. (2018)'s study, in which the researchers adapted the patient (WAI-S-P) measure by translating and back-translating from German to English; and in Loos et al.'s (2020) study, in which they translated and back-translated from German into English both the patient (WAI-S-P) and therapist (WAI-S-T) measures. It is important to note that both Kirsch et al. and Loos et al. used systematic processes based on recommendations for good practice to translate and back-translate the instruments. Another example of back-translation is in Ormhaug et al. (2014)'s study, in which the researchers translated and back-translated the TASC-R, the CPSS, the CAPS-CA, the Mood and Feelings Questionnaire, and the Screen for Child Anxiety Related Disorders from Norwegian into English.

Using existing instruments that other researchers had previously developed enables researchers to bypass the step of constructing and validating the instruments (Efron & Ravid, 2018). The use of existing instruments was appropriate in the studies that reviewed for this

paper, because the researchers measured the same concepts that the existing tool had measured (Efron & Ravid, 2018). For example, Okamura et al. (2020), Ormhaug and Jensen (2016), Ormhaug et al. (2014), and Ormhaug et al. (2015) all used the CPSS (Foa et al. 2001) to assess clinical improvement of PTSD symptomology. Using the CPSS was appropriate, because it was designed for the purpose of assessing symptom severity and diagnosing PTSD in children aged 8 to 18 following exposure to a traumatic event (Foa et al., 2001).

In modifying/adapting an existing instrument, researchers are responsible for indicating the reasons for the modifications and demonstrating that they do not reduce the instrument's reliability and validity (Efron & Ravid, 2018). An example of modified instruments is in Kirsch et al.'s (2018) study; they adapted the patient (WAI-S-P) version to use it with children and adolescents and the caregiver-therapist version (WAI-S-CT) with the same items reworded to use it with caregivers. Kirsch et al. explained their reasons for the modification and demonstrated its reliability by showing that the Cronbach's alpha for the adapted versions total scores was 0.88 for the WAI-S-P and 0.86 for the WAI-S-CT. Likewise, in addition to adapting the patient (WAI-S-P) and caregiver-therapist (WAI-S-CT) versions of the WAI-S (Tracey & Kokotovic, 1989), Loos et al. (2020), also adapted the therapist (WAI-S-T) and the therapist-caregiver (WAI- S-TC) versions. They explained that they reworded these versions for use with the target population and that the changes did not negatively impact the tool's reliability, which they proved by showing that the Cronbach's alpha for the adapted versions' total scores were .88 for the WAI-S-P, .95 for the WAI-S-T, .86 for the WAI-S-CT, and .96 for the WAI-S-TC.

In addition to collecting data with existing or modified instruments, some researchers design new instruments specifically for their studies, because they tend to be most closely related to the study's objectives (Efron & Ravid, 2018). Ormhaug et al. (2015) designed a new

instrument specifically for their study composed of three-item self-report measure to assess adolescents' satisfaction with their therapy. Accordingly, this measure was closely related to Ormhaug et al.'s objective of investigating how adolescent ratings are related to changes in treatment satisfaction.

Data Analysis

In the following section I discuss qualitative and quantitative data analysis, which refers to the process that researchers use to convert collected data into meaningful findings.

Qualitative Data Analysis. In qualitative data analysis, researchers interpret the meaning of in-depth subjective data (L. Cohen et al., 2018). Depending on the approach that researchers choose, qualitative data analysis typically involves preparing and organizing, describing and presenting, analysing, and interpreting the data; drawing conclusions; reporting the findings; and ensuring accuracy, reliability, coherence, corroboration, validity, and reliability (L. Cohen et al., 2018). In qualitative data analysis, the researcher becomes the principal research instrument and must thus be alert to personal bias (L. Cohen et al., 2018). Various ways to reduce researcher bias in qualitative research include respondents' validation, constant comparisons across participants' accounts, representation of deviant cases and outliers, prolonged involvement in or persistent observation of participants, other researchers' independent analysis of the data, and triangulation (Smith & Noble, 2014). It is notable that Dittmann and Jensen (2014) conducted an independent data analysis as a strategy to minimize researcher bias in their qualitative study; both authors analyzed the data separately before discussing their interpretations of the meaning of the data. Conversely, although Eastwood et al. (2020), who conducted the other qualitative study that I reviewed for this paper, used a reflexive research diary, conducted a negative case analysis, and engaged in ongoing peer review to increase the rigour of their analysis, primarily

one researcher coded their data, which, unfortunately, increased the risk of researcher bias. Eastwood et al. noted that the risk of researcher bias was a limitation in their study, which demonstrates their commitment to transparency.

Researchers can take various approaches to qualitative data analysis. A common approach is to use thematic analysis to transcribe and analyze qualitative data (L. Cohen et al., 2018). Dittmann and Jensen (2014) used this approach. First, they familiarized themselves with the data by reading and rereading the transcripts and making notes. They then generated preliminary codes to identify seemingly significant data and systematically reviewed the interviews and assigned codes to sentences with significant meanings. Following this, they searched for salient themes that represented patterns in the data and then organized the codes into four different themes. Dittmann and Jensen then reviewed the themes and examined their applicability to the cases; they also used additional codes to expand the themes. Finally, they defined and labelled the final themes as (a) changing expectations, (b) talking to the therapist and sharing information, (c) working through the trauma narrative, and (d) change and change processes.

Once Dittmann and Jensen (2014) had defined and labelled the themes, they reread all of the interviews to assess the consistency between the interview content and their four main superordinate themes. Conversely, Eastwood et al. (2020) in their qualitative study and Okamura et al. (2020) in their mixed-methods study used NVivo to manage their qualitative data. NVivo is qualitative data-analysis computer software that enables the organisation and storage of various kinds of data by category (L. Cohen et al., 2018). Researchers have repeatedly noted that computer software such as NVivo is a helpful tool to organize and structure data for qualitative and mixed-methods data analysis (L. Cohen et al., 2018).

Quantitative Data Analysis. During quantitative data analysis, researchers use statistical tests and computer programs as aids. The researchers of all of the quantitative studies that I reviewed utilized statistical tests. To advance towards statistical processing and analysis, quantitative researchers need to determine the scales (categorical, ordinal, interval, and ratio) of the data, the types of data (parametric, nonparametric), and the variables (categorical, discrete, continuous, independent, dependent, moderator, and mediator) that they will analyze and the types of statistics that they will calculate (L. Cohen et al., 2018). Researchers can choose descriptive or inferential statistics (L. Cohen et al., 2018). The researchers of the seven quantitative studies that I reviewed used both descriptive and inferential statistics. Descriptive statistics enable researchers to describe and present details of a dataset (L. Cohen et al., 2018). For example, the researchers of all 10 studies that I reviewed reported descriptive statistics such as age, gender, ethnicity, average exposure to different traumatic events, index trauma, mean posttraumatic stress level, and so on (see Table 1). In contrast, inferential statistics enable researchers to make inferences and predictions about the wider population based on their derived data (L. Cohen et al., 2018).

The researchers of four studies that I reviewed for this paper (Kirsch et al., 2018; Loos et al., 2020; Ormhaug & Jensen, 2016; Ormhaug et al., 2014) used the t-test, which is an inferential statistic that researchers use to discover the presence of statistically significant differences either between the means of the same group under two conditions or between the means of two separate groups (L. Cohen et al., 2018). The two variants of the t-test are the t-test for independent samples and the t-test for paired samples (L. Cohen et al., 2018). Kirsch et al. (2018) and Ormhaug et al. (2014) used the t-test for independent samples to determine the difference between two groups of respondents, Kirsch et al. (2018) used the t-test for

independent samples to test differences between the TF-CBT completers and dropouts in the group, and Ormhaug et al. used the t-test for independent samples to test the differences between the TF-CBT and the TAU therapists in the group. The use of the t-test for independent samples in both studies was appropriate, because the two groups in Kirsch et al.'s study (completers and drop-outs) and in Ormhaug et al.'s study (TF-CBT and TAU therapists) were unrelated to each other. Similarly, Ormhaug and Jensen (2016) used independent-sample t-tests for group comparisons. Conversely, Loos et al. (2020) used the t-test for paired samples to determine differences in the same group of respondents on two occasions; they used the paired t-test to compare the means of the alliance reports from different rater perspectives at two measurement points. Their use of the paired t-test was appropriate, because Loos et al. measured the same group of informants on two different occasions (at mid- and posttreatment). However, although the t-test is helpful in investigating the differences between two groups, some research requires the investigation of differences among more than two groups. In these cases, researchers can use analysis of variance (L. Cohen et al., 2018), as Zorzella et al. (2015) did, to investigate gender, age, ethnicity, family income, and type of trauma in relation to early child-and-therapist alliance, as well as both internalizing and externalizing symptoms at preassessment and improvement in internalizing and externalizing symptoms following treatment.

Another type of inferential statistics that the quantitative researchers used is regression analysis, which is a form of predictive inferential statistics that enables researchers to make predictions about an outcome variable based on their knowledge of a predictor variable (L. Cohen et al., 2018). The researchers of five studies (Loos et al., 2020; Ormhaug & Jensen 2016; Ormhaug et al., 2014; Ormhaug et al., 2015; Zorzella et al., 2015) used regression models to analyze their data. Loos et al. (2020), Ormhaug et al. (2014), and Ormhaug et al. (2015) all used

linear regression to analyze the relationships between the alliance scores and the outcomes. In other words, they used predictive statistics to determine whether changes in the therapeutic alliance predict changes in the clinical outcomes. In linear regression researchers assume a linear connection between an independent (explanatory) variable and a dependent (explained) variable (L. Cohen et al., 2018). In addition to using linear regression to analyze relationships between alliance scores and outcomes, Ormhaug et al. (2014) used linear regression analysis to investigate whether early symptom reduction influenced the alliance ratings. This was part of their control analysis, which is important because control variables strengthen the internal validity of a research study. When researchers control for variables that are not of primary interest to them, they increase the likelihood that they will actually investigate what they have set out to investigate (L. Cohen et al., 2018).

Finally, statistical tests operate under specific assumptions (safety checks) to ensure the suitability of the data prior to proceeding with the test (L. Cohen et al., 2018). It is interesting that none of the researchers mentioned whether they had completed these safety checks (i.e., whether they verified the assumptions of each statistical test prior to use). The failure to note verified faithfulness to the assumptions that underpinned the statistical tests that the researchers used is concerning, because it could have influenced the validity of the findings (L. Cohen et al., 2018).

Ethical Considerations

In this section I analyze the ethical considerations of the 10 selected studies by referring to the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research [CIHR] et al., 2018). Ethical principles and guidelines are pivotal in protecting participants and advancing the pursuit and expansion of knowledge (CIHR et al.,

2018). Because all 10 of the studies that I reviewed for this paper involved human participants, the researchers' commitment to ethical practices was vital. The fundamental value of the *Tri-Council Policy Statement* is respect for human dignity. Accordingly, "respect for human dignity requires that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that they are due" (p. 6). The three core principles in the policy include respect for persons, concern for welfare, and justice. They convey the value of human dignity and help ensure the conduct of research in an ethical manner (CIHR et al., 2018)

Respect for Persons

The principle of respect for persons acknowledges the intrinsic value of human beings and the need to respect their autonomy (CIHR et al., 2018). Researchers have a moral obligation to respect the autonomy of all human beings, including persons with developing, impaired, or diminished autonomy (CIHR et al., 2018). Respecting individuals' autonomy is particularly crucial in the study of trauma, especially complex trauma, because those who have endured complex trauma are highly vulnerable and at a higher risk of retraumatization and repeat victimisation (Gilad & Gutman, 2019). Respect for persons in this policy aligns with Principle I: Respect for the Dignity of Persons and Peoples in the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). According to the CPA (2017), psychologists must ensure that they protect people's rights, dignity, privacy, and confidentiality as much as possible. In line with this principle, researchers respect participants' autonomy by providing as much information as reasonable and prudent individuals need to know before they consent to participate and by ensuring that they clearly understand and freely give consent and that it is

ongoing (CIHR et al., 2018; CPA, 2017). Consent is not a static entity; thus, it must be ongoing throughout the research process.

In ensuring that individuals can make an informed decision, researchers must inform them of the purpose of the research and what it entails, as well as the anticipated risks and likely benefits (CIHR et al., 2018). Although the researchers of all but two studies that I reviewed (Yasinski et al., 2018; Zorzella et al., 2015) reported that the potential participants offered consent prior to their participation, their consent statements were very broad. For example, the researchers of only three studies (Loos et al., 2020; Ormhaug & Jensen, 2016; Ormhaug et al., 2014) specifically mentioned that they offered the potential participants written and verbal information about the study prior to asking them to consent. The researchers of the remaining five studies (Dittmann & Jensen, 2014; Eastwood et al., 2020; Kirsch et al., 2018; Okamura et al., 2020; Ormhaug et al., 2015) did not state whether they explained the purpose of the research, what it entailed, or the anticipated risks and likely benefits. Furthermore, the researchers of only six studies (Kirsch et al., 2018; Loos et al., 2020; Okamura et al., 2020; Ormhaug & Jensen, 2016; Ormhaug et al., 2014; Ormhaug et al., 2015) reported that they obtained informed consent from the parents/legal guardians and informed assent from the children and adolescents. The failure of the researchers of the other four studies to do so is concerning, because obtaining informed consent from parents/caregivers and informed assent from young persons is a measure that protects children and adolescents (CPA, 2017).

Moreover, Dittmann and Jensen's (2014) and Yasinski et al.'s (2018) consent statements were concerning. For example, Dittmann and Jensen declared that their potential participants provided informed consent as part of the effectiveness study. However, they also noted that they did not ask them to take part in the qualitative component (interview) until 1-3 weeks after the

completion of treatment. This shows a lack of transparency about whether the participants actually consented to the qualitative component when they originally provided consent and whether they fully understood what their consent involved and how their participation in the qualitative interview could impact them. Similarly concerning was Yasinski et al.'s consent statement. They reported that they audio-recorded all of the sessions except when a technological malfunction occurred, or a child or caregiver requested that a particular session not be recorded. However, they also noted that they did not record the baseline session because the participants did not give their consent to record it until the end of that session. It is therefore unclear whether the participants provided any consent prior to their participation in the study. Moreover, Zorzella et al. (2015) simply wrote that their project received university ethics approval and ethics approval from each participating agency. They did not mention informed consent at all.

Researchers often ask their participants to complete questionnaires on their traumatic experiences and the resulting symptoms. However, describing traumatic experiences can be retraumatizing. Thus, it is crucial to ensure that the participants know how their participation could impact their well-being. Despite this, Loos et al. (2020) did not give the children and caregivers in their study information on the study or ask them to provide consent until the researchers had completed a comprehensive clinical assessment. This is problematic, because the clinical assessment could have triggered reactions to the trauma and resulted in significant harm. It is notable that, although the children and caregivers might have provided informed consent for the clinical assessment, Loos et al. did not mention this.

Concern for Welfare

The principle of concern for welfare protects and promotes the welfare of human beings (CIHR et al., 2018). Welfare encompasses the impact on individuals' physical, mental, and

spiritual health and their physical, financial, and social circumstances (CIHR et al., 2018). Because the goal of research is to fundamentally understand something not yet known, research poses diverse risks to participants and others (CIHR et al., 2018). Thus, researchers have a duty to protect their participants from research-related harms (CIHR et al., 2018). Moreover, because the long-term effects of complex trauma exposure make the population of interest more vulnerable (Dye, 2018), researchers who work with them must do everything in their power to decrease the likelihood that the research will harm the study participants.

In line with Principle II: Responsible Caring in the *Canadian Code of Ethics for Psychologists* (CPA, 2017), researchers must protect and promote the well-being and best interests of their participants. Furthermore, researchers must complete a risk/benefit analysis, maximize benefit, and minimize harm (CPA, 2017). Unfortunately, only Eastwood et al. (2020) described the steps that they took to mitigate risk and enhance the participants' safety. These steps included offering the interviewer dedicated training in rapport building and the management of participant distress from a researcher with extensive clinical experience, informing the participants that they did not have to answer any question that they did not want to answer and that they could take a break or cease the interview at any time of their choosing without penalty, and ensuring that a team of trained clinicians was present for immediate debriefing or in case of emergency (Eastwood et al., 2020).

In addition, the researchers of only two studies (Dittmann & Jensen, 2014; Eastwood et al., 2020) discussed the steps that they took to safeguard their participants' privacy and confidentiality. For example, Dittmann and Jensen (2014) initially asked the youths if they were in a place where they could talk privately; if not, they made arrangements to contact the youth again. Similarly, Eastwood et al. (2020) noted that the addition of individual identifying

variables comprises confidentiality, so they did not include a demographic table that listed the participants' characteristics line by line. The fact that only the researchers of these two studies discussed privacy and confidentiality is concerning, because measures of privacy and confidentiality contribute to the participants' welfare (CIHR et al., 2018). Moreover, the researchers of three studies (Okamura et al., 2020; Ormhaug et al., 2014; Zorzella et al., 2015) described the compensation that they offered their participants. For example, Okamura et al. (2020) gave their participants $50 gift cards for their time, Ormhaug et al.'s (2014) participants received a small gift card (e.g., a movie pass) after they completed the posttreatment assessment, and Zorzella et al.'s (2015) participants received $20 for each of the first four rounds of data collection and $30 for the final data collection.

Justice

The principle of justice concerns the fair and equitable treatment of people (CIHR et al., 2018). Fairness means that researchers must treat everyone equally and with concern (CIHR et al., 2018). To ensure equity, they must disperse the benefits and costs of the research participation so that no group of people is unfairly burdened by any harm or denied the advantages of the knowledge that they study produces (CIHR et al., 2018). With regard to the principle of justice, it is crucial that researchers reflect on the power relationship and consider power imbalances, which are a significant threat to justice and can result in harm to the participants (CIHR et al., 2018). Because individuals who have endured complex traumas frequently perceive interpersonal relationships as uncomfortable and frightening, which in turn inhibits their capacity to develop and maintain relationships with others (Lafrenaye-Dugas et al., 2018), adhering to these aspects of justice ensures that the researchers will behave in ways that signify safety and trustworthiness.

Furthermore, in accordance with the principle of justice, researchers must maintain accuracy and honesty, avoid incomplete disclosure, and avoid conflict of interest (CPA, 2017). The researchers of all of the studies declared that they had received approval from their respective ethics committees. However, the researchers of only three studies (Loos et al., 2020; Okamura et al., 2020; Ormhaug et al., 2015) declared that there was no conflict of interest in their research. This is a concern, because failure to disclose conflicts of interest can hinder the research participants' ability to make informed and autonomous choices (CIHR et al., 2018). It is notable that the researchers who received external funding (Dittmann & Jensen, 2014; Loos et al., 2020; Yasinski et al., 2018) declared their donors. However, of the remaining studies, only Kirsch et al. (2018) declared that their investigation was not funded; the remaining researchers (Eastwood et al., 2020; Okamura et al., 2020; Ormhaug & Jensen, 2016; Ormhaug et al., 2014; Ormhaug et al., 2015; Zorzella et al., 2015) did not declare whether their research was funded.

Furthermore, the researchers of only two studies (Okamura et al., 2020; Ormhaug et al., 2015) declared that there was no conflict of interest in their research, and the researchers of the remaining four studies (Eastwood et al., 2020; Ormhaug & Jensen, 2016; Ormhaug et al., 2014; Zorzella et al., 2015) made no funding or conflict-of-interest declaration. Not only does the failure to disclose conflict of interest impact the participants' ability to make informed and autonomous choices, but it can also jeopardize the overall integrity of the research (CIHR et al., 2018). Future researchers in this area should address ethical considerations beyond the need for consent and institutional review board approval.

Findings

In this section I analyze and organize the findings of the 10 selected studies into themes to understand the role of the therapeutic alliance in TF-CBT with child and adolescent survivors

of complex trauma. To develop these themes, I read and reread the findings section of each article, summarized the findings into bullet points, and then organized them into themes. I relied heavily on Bordin's (1979, as cited in Muran & Barber, 2010) conceptualization of the therapeutic alliance to identify the overarching themes, because Bordin focused less on what the alliance is and more on what it does (Horvath, 2017). The themes that emerged were therapeutic alliance and initial therapy engagement, therapeutic alliance and treatment adherence, therapeutic alliance and dropout, and therapeutic alliance and outcome. In addition, these themes reflected the formation of attachment bonds and a shared commitment to tasks and goals, which are the three constructs that make up the therapeutic alliance, according to Bordin (as cited in Muran & Barber, 2010). For consistency purposes, children and adolescents will be referred to as *young persons* for the remainder of the study.

Therapeutic Alliance and Initial Therapy Engagement

The researchers of the two qualitative studies (Dittmann & Jensen, 2014; Eastwood et al., 2020) and the mixed-methods study (Okamura et al., 2020) aimed to better understand their participants' subjective experiences of receiving TF-CBT. For example, with regard to their experiences during the initial therapy engagement, Dittmann and Jensen (2014) found that their participants' initial anxiety and reluctance to engage in therapy decreased as a result of their perceptions of their therapist as kind, caring, empathetic, and knowledgeable and that this positively contributed to their engagement in the initial treatment. Similarly, the participants in Eastwood et al.'s (2020) study reported that their perceptions of their therapist as understanding and empathetic made it easier for them to talk to the therapist than to other adults in their lives. In addition, the participants in the Okamura et al. (2020) study reported that receiving encouragement from the therapist facilitated their felt sense of trust in the relationship with the

therapist and elevated their confidence during the initial therapy engagement. For example, one youth recalled her conversation with the therapist: "Expressing my feeling to [my therapist], she's like 'You can do this; you can do that'; so me expressing my feelings, . . . it built up how confident I could be" (p. 1717).

Furthermore, once in treatment, Okamura et al.'s (2020) participants and caregivers stressed the importance of the therapeutic relationship and trust in their therapist to engage in TF-CBT. For example, in a dialogue with her child's therapist, one mother said, "She was like, 'I really think this would be a great thing for [your child].' So I said, 'Okay, I trust your judgment" (p. 1717). In addition, therapists' transparency and authenticity also played a vital role in developing trust and facilitating engagement in the initial therapy. For example, Eastwood et al. (2020) reported that transparency about the content and direction of therapy from the beginning empowered their participants to recognize their autonomy and reclaim their sense of agency and control in their recovery. Furthermore, Dittmann and Jensen (2014) found that the therapist's clarification of what would happen and why further enhanced the participants' perceptions of therapy as safe and meaningful. In addition, Okamura et al. found that the therapists gained the participants' trust by offering them choices of treatment and that this trust increased the participants' collaboration from the onset of treatment. These findings adhere to Bordin's (1979, as cited in Muran & Barber, 2010) ideas that clients' level of trust conditions the therapeutic alliance and that to improve collaboration on the tasks of therapy, clients must be confident that the therapeutic approach and accompanying tasks will result in their desired outcomes.

Therapeutic Alliance and Treatment Adherence

The participants in the two qualitative studies (Dittmann & Jensen, 2014; Eastwood et al., 2020) that I reviewed, repeatedly described trauma as challenging and emotionally upsetting to

discuss. For example, in study, one participant reported, “I started crying even when we only talked about doing it because I felt so scared” (p. 1226). However, despite the initial significant fear of talking about their trauma, Dittmann and Jensen’s (2014) participants described the importance of talking about their trauma to enhance their recovery. In addition, they considered the therapist’s sensitivity to their needs essential to facilitate their engagement in the trauma narrative and processing phase. For example, one participant stated, “She [the therapist] said that if it was difficult we could stop and do some breathing exercises, and that helped very much” (p. 1226). Similarly, the participants in Eastwood et al.’s (2020) study reported that perceiving that the therapist genuinely cared and wanted to help also made them feel safe, comfortable, and motivated to engage in the trauma narrative and processing phase.

Furthermore, Eastwood et al.’s (2020) participants believed that the therapist not only was committed to understanding their experiences but also genuinely wanted to understand, validated their story, and helped them to recognize the importance of working through their trauma for their recovery. For example, one participant said:

> So like I felt she [therapist] really wanted to get my story. . . . It made me feel like my story or my trauma was valued kind of, that it made me feel like it was important; my story was important; it was important for me to get over that. (p. 6)

The participants’ demonstrated understanding of the importance of talking about their trauma and their perception of the therapist’s investment in helping them to achieve their desired goals reflect the task-and-goals components of the alliance (Johnson & Wright, 2002). Thus, these findings reveal that the three constructs of the therapeutic alliance facilitated the participants’ confidence in the utility of talking about their trauma, which in turn promoted their engagement in the trauma narrative and processing phase.

In addition, the findings from the research suggest that timing and pace, which are part of the tasks construct, significantly impact adherence to treatment. For example, Eastwood et al.’s

(2020) participants emphasized the importance of the therapist's not forcing or rushing them into talking about their trauma. This finding is consistent with those of Okamura et al. (2020), whose participants who experienced positive clinical change described the trauma narrative with the therapists as guiding them at a comfortable pace.

Therapeutic Alliance and Dropout

The findings from this research indicate a relationship between the therapeutic alliance and dropout. For example, Dittmann and Jensen (2014) noted that several participants who dropped out of therapy reported the feeling that they were not heard and were pressured to talk. For example, a 17-year-old girl said:

> It was the fact that I had to drag up the things that had happened and that I didn't have time to think about it and that I felt pressured to talk about it when I didn't feel ready. I wished we could have done it another time when I was more ready and that I could have decided when, but I felt that I couldn't, . . . that I had to say it right away. And when I said "No" many times and that I couldn't do it, she didn't listen to me, so at the end I had to say it to her. That was difficult for me. (p. 1226)

It is notable that this finding further reinforces Bordin's (1979, as cited in Muran & Barber, 2010) suggestion that appropriate timing and pace of activities are critical to collaboration between therapists and clients.

Moreover, several researchers demonstrated the relationship between the formation of attachment bonds (or lack thereof) and dropout. For example, several of Dittmann and Jensen's (2014) participants who dropped out of TF-CBT reported that they did so because they did not have rapport with their therapist. These findings are consistent with those of Yasinski et al. (2018), who found that greater observed relationship difficulties between children and therapists predict dropout. For example, a 1-point increase in peak therapeutic relationship difficulty is associated with a 2.40 times greater likelihood that children will drop out of treatment (Yasinski et al., 2018). The role of the therapeutic alliance in predicting dropout is also evident in Ormhaug

and Jensen's (2016) study. However, in investigating therapist-, youth-, and caregiver-rated alliances, Ormhaug and Jensen (2016) found that only a weaker therapist-rated youth alliance predicts dropout. The use of different measures might explain the heterogeneity of these findings. For example, Dittmann and Jensen used client self-reports (qualitative interviews), Yasinski et al. used an observational coding system, and Ormhaug and Jensen used a standardized measure of alliance (TASC-R).

Therapeutic Alliance and Outcome

Although Ormhaug et al. (2014) were the only authors of a quantitative study with the primary purpose of investigating the alliance-outcome relationship in TF-CBT, their findings and those of the other researchers of quantitative studies that I reviewed for this paper suggest a relationship between the therapeutic alliance and outcome. However, the findings on the relationship between the two variables are heterogenous, and the results vary depending on the rater of the alliance (i.e., young person's, therapist's, and caregiver's perspective). For example, Ormhaug et al. found that young persons' alliance ratings are significant predictors of reduced PTSS and that young persons with stronger alliances have better outcomes than those with weaker alliances. However, Ormhaug et al. found only a trend-level relationship between the alliance ratings in session 6 and the reduction of PTSS. In other words, only young persons' midtreatment alliance ratings are significant predictors of outcome. Furthermore, all of the significant correlations between alliance and outcome were only in the medium range ($r = -.35$; $p = .013$; Ormhaug et al., 2014).

It is interesting to note that, compared to Ormhaug et al.'s (2014) finding of no relationship between early alliances or changes in alliance during treatment and outcome and their conclusion that changes in alliance do not predict the outcome, Zorzella et al. (2015) found

that a strong early young person-reported alliance significantly predicts improvements in the internalizing symptoms at the end of treatment. Similarly to Ormhaug et al.'s (2014) statistics, Zorzella et al. reported that the strength of this relationship was in the medium range ($r = .32$). However, this finding applies only to internalizing symptoms, because early alliance does not predict improvements in the externalizing symptoms at the end of treatment. In interpreting the findings from these two studies, it is essential to note that Ormhaug et al. and Zorzella et al. used different alliance and symptom-improvement measures. For example, although they used the TASC, only Ormhaug et al. used the revised version (TASC-R). Furthermore, Ormhaug et al. measured their participants' PTSS (by using the CPSS and the clinician-administered PTSD interview), whereas Zorzella et al. measured their participants' internalizing and externalizing symptoms (by using the CBCL). Measuring PTSS compared to internalizing and externalizing symptoms might further explain the heterogeneity of the findings.

Furthermore, although Ormhaug et al. (2014) found no relationships between early alliance or changes in alliance during early treatment and the outcomes and Zorzella et al. (2015) found no significant association between changes in alliance and improvement in symptomatology, but Loos et al. (2020) reported that the alliance increased throughout therapy and that the improvement in the young persons' evaluations of their alliances with the therapist and the therapist's evaluations of the alliances with the caregivers was associated with a reduction in the PTSS over time. One potential explanation for these inconsistent findings is the time span over which the researchers measured the alliance. For example, Ormhaug et al. collected the alliance ratings after sessions 1 and 6, Zorzella et al. reported the alliance ratings at sessions 3, 8, and posttreatment, and Loos et al. noted their alliance ratings after session 6 and at least two weeks after the last session. In addition, the researchers used different measures for

alliance and outcome: Ormhaug et al. used the TASC-R to measure the alliance and the CPSS and CAPS-CA to measure the outcome, Zorzella et al. used the TASC to measure the alliance and the CBCL to measure the outcome, and Loos et al. used the WAI-S to measure the alliance and the CAPS-CA to measure the outcome.

Loos et al. (2020) and Ormhaug et al. (2015) further demonstrated the significance of the young persons' alliance ratings in predicting outcomes. For example, Loos et al. found that the young persons' perceptions of their alliance with the therapist were stronger predictors of clinical outcomes than the therapist's perception of the alliances with the young persons. Similarly, Ormhaug et al. found that the young persons' alliance ratings predicted self-reported PTSS posttreatment and were marginally associated with the clinician-rated PTSS after controlling for pretreatment symptoms. In contrast, the therapist's ratings of the alliances were not significantly related to either the young persons' or clinical reports of posttreatment symptoms (Ormhaug et al., 2015). In comparison, although Kirsch et al. (2018) hypothesized that the young persons', and caregivers' alliances with the therapist would impact the young persons' treatment response, they found that only the caregivers' ratings of their alliance with the therapist were significantly associated with the young persons' posttreatment outcome and that the young persons' ratings of their alliance with the therapist were not related to the posttreatment outcome.

It is notable that, although Loos et al. (2020) and Kirsch et al. (2018) used the same measures of alliance (WAI-S) and outcome (CAPS-CA), their findings are not consistent. One potential explanation is that Loos et al. reported the alliance ratings from young persons, their caregivers, and the therapists. In contrast, Kirsch et al. only reported the alliance ratings from young persons and their caregivers. However, the therapists in Kirsch et al.'s study rated treatment collaboration, which reflects the tasks component of the therapeutic alliance (Muran &

Barber, 2010). Despite this, their findings do not indicate any significant relationship between the therapists' ratings of treatment collaboration and outcome (Kirsch et al., 2018).

Moreover, this research yielded interesting findings on the levels of raters' agreements on the therapeutic alliance. For example, Kirsch et al. (2018) and Loos et al. (2020) found that alliance ratings of young persons and their caregivers were significantly correlated. Furthermore, Loos et al. also found a moderate level of young person-therapist agreement, and a low but significant level of caregiver-therapist agreement. However, it is important to interpret the similarly of the initial finding with caution because Loos et al. and Kirsch et al. recruited their participants from the same study, with the only distinction being that Loos et al. recruited all of their participants from the TF-CBT group, and, in contrast, Kirsch et al. recruited only TF-CBT completers. Despite this, similar results are evident in Ormhaug and Jensen's (2016), Ormhaug et al.'s (2015), and Zorzella et al.'s (2015) studies: Ormhaug and Jensen and Ormhaug et al. found a moderate level of young person-therapist agreement, and Zorzella et al. found a high level of young person-therapist agreement.

However, Ormhaug et al. (2015) also found that, for the most part, young persons rated their alliance higher than the therapists did. Similarly, Loos et al. (2020) reported that the therapists rated the alliance lower than the young persons and caregivers did and that the caregivers rated the alliance the highest. It is interesting to note that Ormhaug et al. also found that the young persons whose therapists rated the alliance as relatively more positive than they did showed less symptom reduction at the end of treatment compared to the young persons who rated the alliance similarly or more positively. In the following section I discuss the influence of these findings on the counselling profession.

Clinical Application and Implications for Counselling Psychology

The problem that I addressed is this study is the lack of academic knowledge about the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma. The findings from this study yield important clinical applications and implications for counselling psychology, which I discuss in this section with respect to the study's findings in relation to Bordin's (1979, as cited in Muran & Barber, 2010) conceptualization of the therapeutic alliance. As I discussed previously in the Theoretical Framework section of this paper, Bordin conceptualized the therapeutic alliance as a negotiation between therapists' and clients' expectations, beginning at the onset of therapy and continuing throughout treatment (Muran & Barber, 2010). The three key interrelated elements of this negotiation are the formation of an attachment bond, mutual understanding agreement on the goals of treatment, and shared commitment and collaboration on the tasks (Ardito & Rabellino, 2011).

Formation of an Attachment Bond

The findings from the research highlight the role of the formation of an effective therapist-client relationship, also referred to as the *bond* between therapist and client. Non-specific therapist characteristics such as kindness, caring, genuineness, and and empathetic understanding can facilitate the development of a strong therapeutic alliance and positively contribute to initial therapeutic engagement (Dittmann & Jensen, 2014; Eastwood et al., 2020; Okamura et al., 2020). These qualities can also be used to reduce initial anxiety and reluctance to engage in therapy (Dittmann & Jensen, 2014) while also increasing comfortability in the therapy room (Eastwood et al., 2020) and making it easier for young people to talk to the therapist (Okamura et al., 2020). In line with the first principle of trauma-informed care, the physical environment must be safe, and the interpersonal interactions must promote a sense of safety for

both clinicians and clients (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). Accordingly, the researchers of the two qualitative studies that I reviewed for this paper (Dittmann & Jensen, 2014; Eastwood et al., 2020) clearly demonstrated that the formation of the bond between the therapist and young person plays a key role in fostering a therapeutic environment that promotes feelings of safety and trust. This is crucial, as child and adolescent complex-trauma survivors commonly perceive interpersonal relationships as uncomfortable and frightening and find it difficult to feel safe in the presence of others (Lafrenaye-Dugas et al., 2018). Furthermore, the bond between therapist and young person also has the capacity to help the young person feel like the therapist genuinely cares for them (Eastwood et al., 2020). This is important given that as a result of the negative self-concept and schemas of self-blame for the abuse, survivors of complex trauma frequently perceive themselves as worthless and deserving of mistreatment (Karatzias & Cloitre, 2019; Lawson, 2017; Pearlman & Courtois, 2005; Van Nieuwenhove & Meganck, 2017).

The significant role of this bond is further highlighted during examination of dropout; observed relationship difficulties and the perceptions of not getting along with therapists increase the likelihood of dropout (Dittmann & Jensen, 2014; Yasinski et al., 2018). Given that dropout rates range from 18% to 72% in evidence-based treatments for PTSD (DeViva, 2014; Kehle-Forbes et al., 2016; Mott et al. 2014, Zayfert et al., 2005; as cited in Sijercic et al., 2021), paying attention to relationship difficulties, or ruptures in the bond can reduce the likelihood of premature termination (Dittmann & Jensen, 2014; Yasinski et al., 2018). Moreover, given caregivers' perceptions of the importance of developing trust with therapists from the onset of treatment (Eastwood et al., 2020), combined with Kirsch et al.'s (2018) finding of an association between caregivers' ratings of alliance and young persons' posttreatment outcomes, it is crucial

that the bond extend to therapists' relationships with caregivers. Thus, the establishment of a strong bond among therapists, young persons, and caregivers is essential to therapeutic work, especially during the more challenging times, such as during the trauma narrative and processing phase.

Mutual Understanding and Agreement on Goals

The goals of TF-CBT centre on addressing and helping to reregulate trauma survivors' affective (e.g., anxiety, affective dysregulation), behavioral (e.g., avoidance of trauma reminders, severe behavioral dysregulation), biological (e.g., hypervigilance, poor sleep), cognitive (e.g., intrusive trauma-related thoughts and memories, maladaptive trauma-related beliefs), and social (e.g., impaired relationships, social withdrawal, impaired attachment and/or trust) domains of trauma impact, which are also known as *trauma responses* (Cohen & Mannarino, 2015). Ultimately, the primary goal of TF-CBT is recovery from trauma (Cohen & Mannarino, 2015). The mutual understanding and agreement on goals can be fostered during the psychoeducation component, where helping young people understand the importance of utility of talking about trauma can reduce initial fear and increase compliance (Dittmann & Jensen, 2014). This is important, because enduring multiple expected but unavoidable traumatic events during childhood (complex trauma) produces a shift from the learning brain to the survival brain, leading to extreme responses to perceived danger (Lawson, 2017). Accordingly, survival-based coping skills are grounded in avoidance, dissociation, withdrawal, and hypervigilance (Lawson, 2017). This in turn can also enhance participants' perceptions of therapy as safe and meaningful (Dittmann & Jensen, 2014) which is crucial when working with survivors of trauma (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014). Furthermore, the mutual understanding and agreement on the goals of

therapy has the capacity increase the young person's perception of the therapist's investment in helping them achieve the identified goals, provide hope surrounding the possibility of recovery, and facilitate the desire to address trauma in order to heal (Dittmann & Jensen, 2014; Eastwood et al., 2020). This is crucial given that feelings of hopelessness and helplessness are common amongst survivors of complex trauma (Van Nieuwenhove & Meganck, 2017).

Shared Commitment and Collaboration on Tasks

Once the goals are clearly understood and agreed upon, clarifying what will happen and why has the capacity to further enhance participants' confidence that the therapeutic approach and accompanying tasks will result in their desired outcomes (Dittmann & Jensen, 2014). Accordingly, the three phases of TF-CBT are (a) stabilisation skills, (b) trauma narrative and processing, and (c) integration and consolidation. During the stabilisation phase, therapists offer psychoeducation on the impact of trauma, common trauma responses, reminders, and triggers; and caregivers learn the necessary skills to improve their responses to behavioral and emotional dysregulation (Cohen & Mannarino, 2015). Young people and caregivers also learn relaxation skills to reregulate their stress systems, and young people learn effective modulation skills to help them to express a multitude of feelings safely and develop the skills to regulate their negative-feeling states. Caregivers become familiar with the ways in which they can support young people in gaining these skills (Cohen & Mannarino, 2015). Last, young people and caregivers learn cognitive-processing skills to help them to recognize the mutual interactions among thoughts, feelings, and behaviors and identify and restructure their maladaptive thoughts (Cohen & Mannarino, 2015).

The focus of the trauma narrative and processing phase is on helping young people to describe the increasingly challenging details of their trauma experiences, which enables them to

respond to their trauma memories with a sense of mastery rather than avoidance (Cohen & Mannarino, 2015). It is important that as young people gradually develops their trauma narratives, they share the contents with their caregivers to help them to process and prepare for the final phase (Cohen & Mannarino, 2015). Finally, the last phase, integration and consolidation, is comprised of conjoint child/adolescent-parent sessions, with a strong focus on enhancing safety (Cohen & Mannarino, 2015). During this phase, young people share their trauma narratives with their caregivers, and they collaboratively develop practical strategies to enhance the young persons' safety and internal sense of trust and security (Cohen & Mannarino, 2015).

Bordin (1979, as cited in Muran & Barber, 2010) argued that collaboration on the tasks of therapy requires awareness of the apparent relevancy between the tasks and the goals of therapy (Muran & Barber, 2010). In line with this, the findings from the research demonstrate that an agreement on the means of achieving the goals (i.e., the tasks of therapy) play a significant role in increasing trust, fostering initial treatment engagement, and promoting active and collaborative involvement (Dittmann & Jensen, 2014; Eastwood et al., 2020; Okamura et al., 2020). Accordingly, therapists can achieve such collaboration and mutuality by providing the space for shared decision making during treatment (Okamura et al., 2020). In addition, transparency and authenticity further foster feelings of trust, help young people to understand the importance of engaging in the process, and empower them to reclaim their sense of agency and control in their recovery (Dittmann & Jensen, 2014; Eastwood et al., 2020). Given that survivors of complex trauma frequently develop a negative self-concept mainly from the feelings of shame, guilt, self-blame, hopelessness, helplessness, and vulnerability (Van Nieuwenhove & Meganck, 2017), empowerment is pivotal to their recovery from trauma. Thus, the demonstrated

capacity of the therapeutic alliance to empower clients during treatment is an essential consideration for therapists who work with this population.

Finally, a crucial consideration within the tasks construct is the timing and pace of the activities. Exposure to early childhood trauma interferes with normal brain development, which causes neurological disruptions that impact memory, damage information-processing capabilities, impact the ability to regulate behavior and cognitive responses to future stress, and interfere with the ability to regulate high emotions (Dye, 2018). It is notable that, although gradual exposure, a process during which therapists carefully and methodically expose young people to more and more trauma reminders, is incorporated into all nine components of TF-CBT (Cohen & Mannarino, 2015), the findings demonstrate that prematurely intervening or proceeding before clients are ready places them at a higher risk of premature termination (Dittmann & Jensen, 2014). Furthermore, a key objective of trauma-informed care is to actively prevent retraumatization (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2014), and prematurely intervening or proceeding before clients are ready also increases the chances that retraumatization will occur in the therapy room. Thus, although TF-CBT is a manualized treatment plan, the findings of this study demonstrate that clinicians must remain sensitive to each client's unique needs and demonstrate flexibility when they work on the tasks of TF-CBT (Dittmann & Jensen, 2014; Eastwood et al., 2020; Okamura et al., 2020).

Recommendations for Practice

This study was driven by my desire to better understand the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma. Consequently, the findings from this study yield important recommendations for practice. I hope these

recommendations will motivate clinicians to shape their approaches to the therapeutic alliance to enhance the chances of successfully treating trauma when using a TF-CBT treatment modality with this population. Thus, as a result of the findings, I recommend that clinicians recognize that the therapeutic alliance is not a single entity but comprises three interrelated constructs (bonds, tasks, and goals), which should be carefully considered in approaching the therapeutic alliance with young people and their caregivers.

When considering the bonds construct, I first recommend that clinicians recognize that initial therapy engagement can be highly anxiety-provoking (Dittmann & Jensen, 2014; Eastwood et al., 2020) and do their best to foster a therapeutic environment that promotes feelings of safety. Fostering such an environment can be done by demonstrating qualities such as kindness, caring, genuineness, and empathetic understanding (qualities encompassed in the bonds construct), which can help reduce initial anxiety and reluctance to engage in therapy (Dittmann & Jensen, 2014) and increase comfort in talking with the therapist (Eastwood et al., 2020). My second recommendation is that clinicians seek ongoing feedback on the alliance from both young persons and caregivers and reflect on their own ratings of the alliance, as young persons whose therapists rated the alliance as relatively more positive than they did showed less symptom reduction at the end of treatment compared to the young persons who rated the alliance similarly or more positively (Ormhaug et al., 2015). My third recommendation is that clinicians attend to relationship difficulties and ruptures in the alliance, as relationship difficulties and the perceptions of not getting along with therapists can increase the likelihood of premature termination (Dittmann & Jensen, 2014; Yasinski et al., 2018). My final recommendation is for clinicians to ensure that the development of an attachment bond is not sacrificed for the manualized components of TF-CBT.

When considering the goals construct, I first recommend that clinicians demonstrate a commitment and a genuine desire to understand the participants' experiences, as this can help participants recognize the importance of working through their trauma for their recovery while further validating their story (Eastwood et al., 2020). My second recommendation is that clinicians provide a high degree of encouragement, starting at the onset of therapy and continuing throughout, as this can enhance participants' felt sense of trust in the relationship with the therapist and increase overall confidence in participating in the therapeutic approach and accompanying tasks (Okamura et al., 2020). My third recommendation is that clinicians demonstrate transparency and authenticity, as this can enhance participants' perception of therapy as safe and meaningful (Dittmann & Jensen, 2014) and empower participants to take charge of their healing (Eastwood et al., 2020). My final recommendation is that clinicians create room for shared decision-making and collaboration by offering choices in treatment, as this can help gain participants' trust and increase collaboration on therapy tasks (Okamura et al., 2020).

When considering the tasks construct, once therapeutic goals are clearly understood and agreed upon, my first recommendation is that clinicians clearly explain what participants can expect over the course of therapy and why, as this can enhance perceptions of therapy as safe and meaningful and further enhance participants' confidence that the therapeutic approach and accompanying tasks will result in their desired outcomes (Dittmann & Jensen, 2014). My second recommendation is that clinicians recognize that the trauma narrative and processing phase is challenging and emotionally upsetting and carefully monitor the timing and pace of the activities to ensure that participants' unique needs are met. Consequently, if faced with avoidance, dissociation, withdrawal, and hypervigilance, which are common survival-based coping skills seen in survivors of complex trauma (Lawson, 2017); demonstrate flexibility, remain sensitive to

participants' needs and guide them through the trauma narrative at a comfortable pace (Eastwood et al., 2020; Okamura et al., 2020). For example, if a participant asks to slow down or take a break, accommodate their needs to reduce the likelihood that they feel unheard or pressured to talk, as these can lead to premature termination (Dittmann & Jensen, 2014). My final recommendation is that if faced with avoidance, take things slow and further help participants understand the importance of talking about their trauma, as this can reduce initial fear of talking about trauma, increase compliance with therapy tasks, enhance confidence, and facilitate overall engagement (Dittmann & Jensen, 2014).

Conclusions and Recommendations for Future Research

Conclusions

The purpose of this capstone research was to extend the knowledge base of the therapeutic alliance in TF-CBT treatment with child and adolescent survivors of complex trauma in order to inform best treatment practices. To understand the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma, I analyzed 10 peer-reviewed studies, which revealed the significance of the therapeutic alliance and the correlation between the therapeutic alliance and treatment outcomes with this population. The findings of this study suggest that Bordin's (1979, as cited in Muran & Barber, 2010) conceptualization of the therapeutic alliance as encompassing an affective therapist-client bond, mutual understanding and agreement on the goals, and commitment and collaboration on the tasks of treatment can be a helpful framework for therapists to develop strong therapeutic alliances to treat young survivors of complex trauma and their caregivers meaningfully. This is crucial, given that untreated trauma increases the risk for repeated victimization, acute health problems, substance use, involvement with the criminal justice system, unemployment, and homelessness (Gilad &

Gutman, 2019). Overall, the findings of this study suggest that the therapeutic alliance plays a key role in fostering initial therapy engagement and promoting participation in the overall therapy by (a) reducing anxiety and mitigating reluctance, (b) enhancing the feelings of safety and trust, (c) empowering clients to take charge of their recovery, and (d) promoting active and collaborative involvement, especially during the more challenging components, such as during the trauma narration and processing phase. Thus, these findings show that initial therapy engagement and ongoing treatment participation are, to a degree, a consequence of the alliance and that young people and caregivers who develop strong therapeutic alliances with their therapists and have a shared sense of goals and tasks benefit more from TF-CBT.

Limitations

However, it is important to note several significant limitations. First, in this capstone paper I have not differentiated between children and adolescents but grouped them into “young people” because of the limited available research. Second, the researchers of all 10 studies used nonprobability and convenience sampling, which could have limited the generalisability of their findings (L. Cohen et al., 2018). Third, the researchers of multiple studies relied on the same sample: Kirsch et al. (2018) and Loos et al. (2020) recruited participants from the same effectiveness study on whether TF-CBT is superior to the waitlist condition. Similarly, Dittmann and Jensen (2014), Ormhaug and Jensen (2016), Ormhaug et al. (2014), and Ormhaug et al. (2015) all recruited their participants from the same randomized effectiveness study in which the researchers compared TF-CBT to TAU. Fourth, the researchers of all of the studies that I reviewed included a predominantly female sample. Although the prevalence of PTSD is higher in females than in males (Olff, 2017), the uneven gender distribution in all of these samples could have further limited the generalisability of the researchers’ findings (L. Cohen et al.,

2018). Fifth, although all of the quantitative studies that I reviewed for this paper included sample sizes larger than 30, which L. Cohen et al., (2018) considered the minimum number of participants required for inclusion to analyze the data statistically, the small sample sizes in Kirsch et al.'s (n = 65) and Loos et al.'s (n = 76) studies increase the possibility that these studies were underpowered and that the researchers could potentially have missed information (L. Cohen et al., 2018). Sixth, the researchers measured the alliances at two points in time instead of at multiple points, which limits the understanding of the alliance-outcome relationships. Finally, only Zorzella et al. (2015) conducted their study in Canada, which questions the applicability and transferability of the findings.

Recommendations for Future Research

Based on the review of the 10 studies included in this paper to answer the question of the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma, evidence shows several gaps resulting from the extensive use of different alliance measures, different measurement time points, and exclusion of different raters of the alliance. For example, although the findings from Ormhaug et al. (2014) and Zorzella et al. (2015) demonstrate that a stronger alliance is related to a better outcome, the relationships between the therapeutic alliance and successful outcomes of treatment were only in the medium range, and these findings do not imply any causal relationships. Given the heterogeneous results surrounding the correlation between early alliance and changes in alliance with the outcome of treatment (Loos et al., 2020; Ormhaug et al., 2014; Zorzella et al., 2015), the recommendation is that future research should measure alliances at multiple points in time. In their investigation of the dependability of alliance scores, Crits-Christoph et al. (2011) concluded that the accumulation of alliance scores from a minimum of four sessions is required to fully understand

the alliance-outcome relationship. Thus, because TF CBT is typically conducted in 12-16 sessions (J. A. Cohen et al., 2018), the recommendation is for future research to measure the alliance at a minimum of four points in time in order to provide a more accurate picture of the alliance-outcome relationships. In addition, given the heterogeneous findings on the significance of different informants' perspectives on the treatment outcomes (Kirsche et al., 2018; Loos et al., 2020; Ormhaug et al., 2014; Ormhaug et al., 2015; Ormhaug & Jensen, 2016; Zorzella et al., 2015), the recommendation is that future research should collect alliance ratings from everyone involved in the treatment process, including therapists, young people, and their caregivers. Importantly, these recommendations align with Kirsch et al.'s (2018) recommendations, which state that future research should measure the alliance repeatedly throughout therapy and from different informant perspectives to better understand this impact on treatment outcomes.

Notably, the postpositivist paradigm, which is quantitative in nature, informed most of the current research. However, the current quantitative research makes it difficult to clearly detect the effect of the alliance on the process and successful treatment outcome. Given that the researchers of the two qualitative studies that I reviewed for this paper (Dittmann & Jensen, 2014; Eastwood et al., 2020) provided the most information about the role of the therapeutic alliance, and in line with Eastwood et al.'s (2020) suggestion that more qualitative work would provide a greater understanding of the change processes in TF-CBT, the recommendation is that more qualitative research should be conducted to better understand the participants' (including young persons and caregivers) subjective perspectives on the therapeutic alliance and its role in TF CBT treatment.

Furthermore, because childhood and adolescent development involve different stages (Scheck, 2005), the recommendation is for future research to examine the role of the therapeutic

alliance in the TF CBT separately for each age group of complex trauma survivors (children and adolescents). Finally, given the high rates of childhood maltreatment in Canada (Burczycka, 2017), because the researchers of nine of the 10 studies that I reviewed conducted them in countries such as Norway, Australia, Germany, and the United States, the recommendation is that future research be conducted in Canada to develop a clearer picture of the role of the therapeutic alliance in TF CBT with child and adolescent survivors of complex trauma.

Reflectivity

I began this capstone research assuming that the therapeutic alliance holds a constructive role in TF-CBT with child and adolescent survivors of complex trauma. Although the findings from this research demonstrated that a strong therapeutic alliance facilitates initial therapy engagement and promotes overall therapy participation, reduces premature termination and that a relationship between the therapeutic alliance and the outcome of treatment exists, I was surprized by the inconsistency of the findings surrounding the correlation between early alliance and changes in alliance with the outcome of treatment, as well as by the inconsistency of the findings surrounding the correlation between different informants' alliance ratings and the treatment outcomes. However, I was most surprised by the lack of research conducted in Canada, given the high rates of childhood maltreatment occurring in this country. Given that this study had several significant limitations, I am hopeful that more research focusing on the role of the therapeutic alliance in child and adolescent trauma treatment will further explore the role of the therapeutic alliance and its relationship to treatment outcome.

One of the motivating factors for undertaking this research was to better inform myself for future clinical practice. I used to use the terms "rapport building" and "developing a therapeutic alliance" interchangeably and would spend a great deal of time solely focusing on

developing the affective client-therapist relationship. However, my biggest takeaway from this research is that the therapeutic alliance is not a single entity but comprises three interrelated constructs (bonds, tasks, and goals) that must be carefully considered in approaching the therapeutic alliance with young people and their caregivers. Given that caregivers play a significant role in TF-CBT, I now understand that these three interrelated constructs of the therapeutic alliance must also extend fully to the therapist-caregiver relationship and not just the therapist's relationship with the young person. Furthermore, while writing the recommendations for clinical practice, I spent some time reflecting on my own practice and recognized that I have already begun focusing more on the tasks and goals than just the bond construct. Notably, the findings from this research on how the therapeutic alliance's bonds, tasks, and goals constructs impact the therapy process and outcomes helped me better understand the process underlying therapeutic change with young persons exposed to complex trauma. Accordingly, I believe this has already begun to improve my ability to establish safety, empower trauma survivors and minimize the likelihood of re-traumatization and vicarious traumatization. I am honoured to continue to be able to support trauma survivors who have endured significant levels of trauma in their lives, including the direct experience of early childhood trauma, trauma in young adulthood, recent traumatic stress, and ongoing trauma exposure. Overall, this capstone research was both challenging and rewarding. Throughout this research process, I quickly realized that demonstrating self-compassion and setting realistic expectations for myself would be crucial to my success. Furthermore, I believe that these realizations helped me grow as a researcher and clinician, and I am honored to have had the opportunity to engage in this humbling process and contribute to the academic knowledge about the role of the therapeutic alliance in TF-CBT with child and adolescent survivors of complex trauma.

References

Accurso, E. C., Hawley, K. M., & Garland, A. F. (2013). Psychometric properties of the Therapeutic Alliance Scale for Caregivers and Parents. *Psychological Assessment*, *25*(1), 244–252. https://doi.org/10.1037/a0030551

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: Fifth edition*. https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Ardito, R. B., & Rabellino, D. (2011). therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*. https://doi.org/10.3389/fpsyg.2011.00270

Bennett, R., Denne, M., McGuire, R., & Hiller, R. (2020). A systematic review of controlled-trials for PTSD in maltreated children and adolescents. *Child Maltreatment*. https://doi.org/10.1177/1077559520961176

Burczycka, M. (2017, February 16). *Section 1: Profile of Canadian adults who experienced childhood maltreatment*. Statistics Canada. https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/14698/01-eng.html

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council. (2018). *Tri-Council policy statement: Ethical conduct for research involving humans*. https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf

Canadian Psychological Association. (2017). *Canadian code of ethics for psychologists* (4th ed.). https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2018). Trauma-focused cognitive behavioral therapy for children and families. *Psychotherapy Research*, *28*(1), 47–57. https://doi.org/10.1080/10503307.2016.1208375

Cohen, L., Manion, L., & Morrison, K. (2018). *Research methods in education* (8th ed.). Routledge.

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics of North America*, *24*(3), 557–570. https://doi.org/10.1016/j.chc.2015.02.005

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect*, *36*(6), 528–541. https://doi.org/10.1016/j.chiabu.2012.03.007

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches.* Sage publications.

Crits-Christoph, P., Gibbons, M. B. C., Hamilton, J., Ring-Kurtz, S., & Gallop, R. (2011). The dependability of alliance assessments: The alliance–outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology*, *79*(3), 267–278. https://doi.org/10.1037/a0023668

Dalenberg, C. J. (2004). Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 438–447. https://doi.org/10.1037/0033-3204.41.4.438

de Arellano, M. A. R., Lyman, D. R., Jobe-Shields, L., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Huang, L., & Delphin-Rittmon, M. E. (2014). Trauma-focused cognitive-behavioral therapy for children and adolescents: Assessing the evidence. *Psychiatric Services*, *65*(5), 591–602. https://doi.org/10.1176/appi.ps.201300255

Dittmann, I., & Jensen, T. K. (2014). Giving a voice to traumatized youth—Experiences with trauma-focused cognitive behavioral therapy. *Child Abuse & Neglect*, *38*(7), 1221–1230. https://doi.org/10.1016/j.chiabu.2013.11.008

Dryden, W., & Reeves, A. (Eds.). (2008). *Key issues for counselling in action* (2nd ed). Sage.

Dye, H. (2018). The impact and long-term effects of childhood trauma. *Journal of Human Behavior in the Social Environment*, *28*(3), 381–392. https://doi.org/10.1080/10911359.2018.1435328

Dyer, K. F. W., & Corrigan, J.-P. (2021). Psychological treatments for complex PTSD: A commentary on the clinical and empirical impasse dividing unimodal and phase-oriented therapy positions. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(8), 869–876. https://doi.org/10.1037/tra0001080

Eastwood, O., Peters, W., Cohen, J., Murray, L., Rice, S., Alvarez-Jimenez, M., & Bendall, S. (2020). “Like a huge weight lifted off my shoulders”: Exploring young people’s experiences of treatment in a pilot trial of trauma-focused cognitive behavioral therapy. *Psychotherapy Research, 31*(6), 737–751. https://doi.org/10.1080/10503307.2020.1851794

Efron, S. E., & Ravid, R. (2018). *Writing the literature review: A practical guide*. Guilford Press.

Elfil, M., & Negida, A. (2017). Sampling methods in clinical research: An educational review. *Emergency*, *5*(1), e52.

Elkind, D. (2005). Response to objectivism and Education. *The Educational Forum*, *69*(4), 328–334. https://doi.org/10.1080/00131720508984706

Fidyk, A. (2019). Trauma-sensitive practice for new teacher standards: addressing the epidemic of our times. *Education*, *25*(1), 51–76. https://doi.org/10.37119/ojs2019.v25i1.431

Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child & Adolescent Psychology*, *30*(3), 376–384. https://doi.org/10.1207/S15374424JCCP3003_9

Gentry, J. E., Baranowsky, A. B., & Rhoton, R. (2017). Trauma competency: An active ingredients approach to treating posttraumatic stress disorder. *Journal of Counseling & Development*, *95*(3), 279–287. https://doi.org/10.1002/jcad.12142

Gergov, V., Marttunen, M., Lindberg, N., Lipsanen, J., & Lahti, J. (2021). Therapeutic Alliance: A Comparison Study between Adolescent Patients and Their Therapists. *International Journal of Environmental Research and Public Health*, *18*(21). https://doi.org/10.3390/ijerph182111238

Gilad, M., & Gutman, A. (2019). The tragedy of wasted funds and broken dreams: An economic analysis of childhood exposure to crime and violence. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3458626

Goldbeck, L., Muche, R., Sachser, C., Tutus, D., & Rosner, R. (2016). Effectiveness of trauma-focused cognitive behavioral therapy for children and adolescents: A randomized controlled trial in eight German mental health clinics. *Psychotherapy and Psychosomatics*, *85*(3), 159–170. https://doi.org/10.1159/000442824

Grossman, F. K., Spinazzola, J., Zucker, M., & Hopper, E. (2017). Treating adult survivors of childhood emotional abuse and neglect: A new framework. *American Journal of Orthopsychiatry*, *87*(1), 86–93. https://doi.org/10.1037/ort0000225

Horvath, A. O. (2017). Research on the alliance: Knowledge in search of a theory. *Psychotherapy Research*, *28*(4), 499–516. https://doi.org/10.1080/10503307.2017.1373204

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., Hukkelberg, S. S., Indregard, T., Stormyren, S. D., & Wentzel-Larsen, T. (2013). A randomized effectiveness study comparing trauma-focused cognitive behavioral therapy with therapy as usual for youth. *Journal of Clinical Child & Adolescent Psychology*, *43*(3), 356–369. https://doi.org/10.1080/15374416.2013.822307

Johnson, L. N., & Wright, D. W. (2002). Revisiting Bordin’s theory on the therapeutic alliance: Implications for family therapy. *Contemporary Family Therapy*, *24*(2), 257–269. https://doi.org/10.1023/A:1015395223978

Karatzias, T., & Cloitre, M. (2019). Treating adults with complex posttraumatic stress disorder using a modular approach to treatment: Rationale, evidence, and directions for future research. *Journal of Traumatic Stress*, *32*(6), 870–876. https://doi.org/10.1002/jts.22457

Kazdin, A. E., & Durbin, K. A. (2012). Predictors of child–therapist alliance in cognitive–behavioral treatment of children referred for oppositional and antisocial behavior. *Psychotherapy*, *49*(2), 202–217. https://doi.org/10.1037/a0027933

Kirsch, V., Keller, F., Tutus, D., & Goldbeck, L. (2018). Treatment expectancy, working alliance, and outcome of trauma-focused cognitive behavioral therapy with children and adolescents. Ch*ild and Adolescent Psychiatry and Mental Health, 12*(1). https://doi.org/10.1186/s13034-018-0223-6

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education*, *6*(5), 26. https://doi.org/10.5430/ijhe.v6n5p26

Kumar, S. A., Brand, B. L., & Courtois, C. A. (2019). The need for trauma training: Clinicians' reactions to training on complex trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0000515

Lafrenaye-Dugas, A.-J., Godbout, N., & Hébert, M. (2018). Cumulative childhood trauma and therapeutic alliance: The moderator role of attachment in adult patients consulting in sex therapy. *Journal of Sex & Marital Therapy*, *44*(7), 667–678. https://doi.org/10.1080/0092623X.2018.1447057

Lawson, D. M. (2017). Treating adults with complex trauma: An evidence-based case study. *Journal of Counseling & Development*, *95*(3), 288–298. https://doi.org/10.1002/jcad.12143

Lawson, D. M., Davis, D., & Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy*, *50*(3), 331–335. https://doi.org/10.1037/a0032677

Loos, S., Tutus, D., Kilian, R., & Goldbeck, L. (2020). Do caregivers' perspectives matter? Working alliances and treatment outcomes in trauma-focused cognitive behavioural therapy with children and adolescents. *European Journal of Psychotraumatology, 11*(1), 1753939. https://doi.org/10.1080/20008198.2020.1753939

Mohajan, H. K. (2017). Two criteria for good measurements in research: Validity and reliability. *Annals of Spiru Haret University. Economic Series*, *17*(4), 59–82. https://doi.org/10.26458/1746

Muran, J. C., & Barber, J. P. (Eds.). (2010). *The therapeutic alliance: An evidence-based guide to practice*. Guilford Press.

Neuroscience Research Australia Foundation. (2021). *Post-traumatic stress disorder factsheet.* https://library.neura.edu.au/wp-content/uploads/sites/3/2021/07/Factsheet_interpersonal-vs-noninterpersonal-exposure.pdf

Okamura, K. H., Skriner, L. C., Becker-Haimes, E. M., Adams, D. R., Becker, S., Kratz, H. E., Jackson, K., Berkowitz, S., Zinny, A., Cliggitt, L., & Beidas, R. S. (2020). Perceptions of evidence-based treatment among youth and caregivers receiving trauma focused-cognitive behavioral therapy. *Journal of Child and Family Studies, 29*(6), 1712–1722. https://doi.org/10.1007/s10826-020-01708-2

Olff, M. (2017). Sex and gender differences in post-traumatic stress disorder: An update. *European Journal of Psychotraumatology*, *8*(Supp. 4), 1351204. https://doi.org/10.1080/20008198.2017.1351204

Ormhaug, S. M., & Jensen, T. K. (2016). Investigating treatment characteristics and first-session relationship variables as predictors of dropout in the treatment of traumatized youth. *Psychotherapy Research, 28*(2), 235–249. https://doi.org/10.1080/10503307.2016.1189617

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The therapeutic alliance in treatment of traumatized youths: Relation to outcome in a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 82*(1), 52–64. https://doi.org/10.1037/a0033884

Ormhaug, S. M., Shirk, S. R., & Wentzel-Larsen, T. (2015). Therapist and client perspectives on the alliance in the treatment of traumatized adolescents. *European Journal of Psychotraumatology, 6*(1), 27705. https://doi.org/10.3402/ejpt.v6.27705

Ovenstad, K. S., Ormhaug, S. M., Shirk, S. R., & Jensen, T. K. (2020). Therapists' behaviors and youths' therapeutic alliance during trauma-focused cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology*, *88*(4), 350–361. https://doi.org/10.1037/ccp0000465

Papalia, N., Dunne, A., Maharaj, N., Fortunato, E., Luebbers, S., & Ogloff, J. R. P. (2022). Correction: Determinants and Outcomes of the Therapeutic Alliance in Treating Justice-Involved Youth: A Systematic Review of Quantitative and Qualitative Research. *Clinical Child and Family Psychology Review*. https://doi.org/10.1007/s10567-022-00410-7

Pearlman, L. A., & Courtois, C. A. (2005). Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of Traumatic Stress*, *18*(5), 449–459. https://doi.org/10.1002/jts.20052

Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences: a practical guide*. Blackwell

Scheck, S. (2005). *Stages of psychosocial development according to Erik H. Erikson*. Grin Publishing.

Shirk, S. R., Karver, M. S., & Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy*, *48*(1), 17–24. https://doi.org/10.1037/a0022181

Sijercic, I., Liebman, R. E., Stirman, S. W., & Monson, C. M. (2021). The Effect of Therapeutic Alliance on Dropout in Cognitive Processing Therapy for Posttraumatic Stress Disorder. *Journal of Traumatic Stress*. https://doi.org/10.1002/jts.22676

Smith, J., & Noble, H. (2014). Bias in research: Table 1. *Evidence Based Nursing*, *17*(4), 100–101. https://doi.org/10.1136/eb-2014-101946

Thabrew, H., Stasiak, K., Bavin, L., Frampton, C., & Merry, S. (2018). Validation of the Mood and Feelings Questionnaire (MFQ) and Short Mood and Feelings Questionnaire (SMFQ) in New Zealand help-seeking adolescents. *International Journal of Methods in Psychiatric Research*, *27*(3). https://doi.org/10.1002/mpr.1610

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(3), 207–210. https://doi.org/10.1037/1040-3590.1.3.207

U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Policy, Planning and Innovation. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Van Nieuwenhove, K., & Meganck, R. (2017). Interpersonal features in complex trauma etiology, consequences, and treatment: A literature review. *Journal of Aggression, Maltreatment & Trauma*, *28*(8), 903–928. https://doi.org/10.1080/10926771.2017.1405316

Vanderzee, K. L., Sigel, B. A., Pemberton, J. R., & John, S. G. (2018). Treatments for early childhood trauma: Decision considerations for clinicians. *Journal of Child & Adolescent Trauma*, *12*(4), 515–528. https://doi.org/10.1007/s40653-018-0244-6

Vogt, W. P., Gardner, D. C., & Haeffele, L. M. (2012). *When to use what research design*. Guilford Press.

Yale University. (2022). *Human subjects protection: Protocol design—Inclusion and exclusion criteria*. https://assessment-module.yale.edu/human-subjects-protection/protocol-design-inclusion-and-exclusion-criteria

Yasinski, C., Hayes, A. M., Alpert, E., McCauley, T., Ready, C. B., Webb, C., & Deblinger, E. (2018). Treatment processes and demographic variables as predictors of dropout from trauma-focused cognitive behavioral therapy (TF-CBT) for youth. *Behaviour Research and Therapy, 107*, 10-18. https://doi.org/10.1016/j.brat.2018.05.008

Zorzella, K. P. M., Muller, R. T., & Cribbie, R. A. (2015). The relationships between therapeutic alliance and internalizing and externalizing symptoms in trauma-focused cognitive behavioral therapy. *Child Abuse & Neglect*, *50*, 171–181. https://doi.org/10.1016/j.chiabu.2015.08.002