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The Effects Of Childhood Physical Abuse and Gender On Adult Interpersonal Relationships and the Therapeutic Alliance

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The Effects Of Childhood Physical Abuse and Gender On Adult Interpersonal Relationships and the Therapeutic Alliance

Abstract
Millions of children are abused in this country every year. Research has shown that child abuse has many negative socio-emotional consequences in childhood. This study examined the long-term consequences of childhood physical abuse in adults. In particular, this study investigated the relationship between childhood physical abuse, interpersonal functioning and the therapeutic alliance in adult outpatients. The effects of gender were also considered as a moderating variable. Data was gathered from 392 clients seeking individual psychotherapy at a university training clinic. It was hypothesized that clients who reported childhood physical would report weaker early therapeutic alliances and greater interpersonal dysfunction than clients without histories of abuse. Additionally, it was hypothesized that abused men would report weaker therapeutic alliances and less interpersonal difficulties than abused women. Findings suggest that clients with histories of physical abuse do not form weaker therapeutic alliances early in therapy. However, clients with histories of physical abuse appear to experience greater interpersonal impairment. No significant gender differences were found. Implications for intervention and future research are discussed.

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Thesis

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THE EFFECTS OF CHILDHOOD PHYSICAL ABUSE AND GENDER ON ADULT INTERPERSONAL RELATIONSHIPS AND THE THERAPEUTIC ALLIANCE

A THESIS
SUBMITTED TO THE FACULTY
OF
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PACIFIC UNIVERSITY
FOREST GROVE, OREGON
BY
AMY ELIZABETH JENKS
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APPROVED:

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Abstract

Millions of children are abused in this country every year. Research has shown that child abuse has many negative socio-emotional consequences in childhood. This study examined the long-term consequences of childhood physical abuse in adults. In particular, this study investigated the relationship between childhood physical abuse, interpersonal functioning and the therapeutic alliance in adult outpatients. The effects of gender were also considered as a moderating variable. Data was gathered from 392 clients seeking individual psychotherapy at a university training clinic. It was hypothesized that clients who reported childhood physical would report weaker early therapeutic alliances and greater interpersonal dysfunction than clients without histories of abuse. Additionally, it was hypothesized that abused men would report weaker therapeutic alliances and less interpersonal difficulties than abused women. Findings suggest that clients with histories of physical abuse do not form weaker therapeutic alliances early in therapy. However, clients with histories of physical abuse appear to experience greater interpersonal impairment. No significant gender differences were found. Implications for intervention and future research are discussed.
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Introduction

In 2004 approximately 5.5 million children were referred to state child protective agencies for suspected abuse or neglect (United States Department of Health and Human Services, 2006). Child abuse appears to put children at risk for a host of negative outcomes (Cicchetti & Toth, 1995). In particular, child abuse appears to have a negative impact on the development of children's social and emotional regulation skills (Alessandri, 1991; Shipman & Zeman, 2001). Considerable progress has been made during the last three decades in our understanding of the socio-emotional consequences of child abuse. Developmental psychopathology, in particular, has greatly influenced our understanding of the consequences of child abuse (see Cicchetti, 2004). While a great deal is known about the socio-emotional consequences of abuse during childhood, comparably little is known about the long-term effects of abuse.

Does impaired social functioning persist into adulthood? Evidence suggests that adults with histories of child abuse also tend to have difficulties in interpersonal relationships (Colman & Widom, 2004). However, much less is known about the interpersonal functioning of adults, particularly men, physically abused in childhood. In addition to impaired interpersonal functioning, adults with histories of child abuse appear to have significantly higher rates of psychopathology than the general population (Widom, 1999). Disorders related to emotional dysregulation, such as PTSD, appear to affect this population at significantly higher rates (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). It is not surprising that a large percentage of clients seen in outpatient mental health settings have histories of child abuse (Lipschitz, 1996).
Recently, researchers have begun to pay greater attention to how interpersonal variables affect therapeutic outcomes (Cloitre, Koenen, Cohen, & Han, 2002). Research suggests that impaired social functioning interferes with the development of a strong therapeutic alliance early in therapy (Hersoug, Monsen, Havik & Hoglend, 2002). The alliance, widely considered essential to the therapeutic process, appears to predict positive therapeutic outcomes (Martin, Garske, & Davis, 2000). Previous research supports a relationship between child abuse and impairment in adult interpersonal relationships; thus, it would appear justified to link child abuse to poor alliance and worse outcomes. However, very little research has investigated the impact that child abuse has on the therapeutic alliance. To date, research in this area has been limited by small sample size and limited generalizability. The purpose of this study is to investigate the relationship between childhood physical abuse, gender, interpersonal functioning and the therapeutic alliance. The goal of this study is to add to the alliance literature and contribute to our understanding of the long-term consequences of child abuse.

*Developmental Psychopathology*

To date, many different theoretical perspectives (e.g. attachment, object relations) have conceptualized the developmental sequelae of child abuse. However, during the past several decades, developmental psychopathology has emerged as the most influential theoretical template. According to Cicchetti (1995), the goal of developmental psychopathology is to bring historically different fields (e.g. neuroscience, psychology, embryology) together in examining childhood and adult disorders. Special emphasis is placed on the interactions between continuity and discontinuity, normal and abnormal development, risk and protective factors, and the influence of factors outside the
individual (Cicchetti, 1984). Specifically, development is conceptualized as a number of stage- and age- appropriate tasks (Cicchetti & Toth, 1995). According to Stroufe and Rutter (1984), successful resolution of an early developmental task increases the probability of mastering subsequent developmental tasks. This particular perspective provides a framework for understanding the reasons why abused children are at greater risk of emotional, behavioral and interpersonal impairment as children and adults.

*Socio-emotional Consequences of Childhood Abuse*

Affect regulation is now understood as one of the primary developmental tasks of child development, which, if disrupted, can have wide-ranging developmental implications (Cicchetti, Ganiban & Barnett, 1991). Cicchetti et al. (1991) defined affect regulation as the ability of an individual to control, modulate, and modify their emotions in arousing situations. The developmental task of emotion regulation appears to occur within the caregiver-child relationship. Research has shown that caregivers guide infants in the development of affect regulation through activities such as labeling and interpreting emotions, soothing, and role modeling mood regulation (e.g. Malatesta & Haviland, 1982). Disruptions in the caregiver-child relationship appear to interfere with the development of affect regulation in infants. Gaensbauer and Hiatt (1984) found that infants who were physically abused displayed more negative affect and less positive affect compared to non-abused infants.

According to the developmental psychopathology framework, adequate emotion regulation serves as a foundation for positive peer relationships (Cicchetti & Toth, 1995). Inadequate control and modulation of emotion appears to put children at risk of interpersonal impairment. Various studies illustrate the difficulties that maltreated
children have in peer relationships. Salzinger, Feldman, Hammer, and Rosario (1993) found that peers viewed abused children as more antisocial. Abused children were more likely to be seen by peers as aggressive, disruptive and possessing fewer prosocial qualities. In addition, research has shown that abused children avoid or withdraw from social situations more often than non-abused children (Hasket & Kistner, 1991).

Children who are abused are also more likely to attribute hostile intentions towards other children (Dodge, Petit, Bates, & Valente, 1995; Ornduff, 2000). Furthermore, children with abuse histories are more likely to report less intimacy and more conflict when interacting with close friends (Parker & Herrera, 1996). In summary, difficulties with emotion regulation appear to interfere with children’s ability to maintain positive peer interactions. As a result, abused children are more likely to be seen by their peers as possessing fewer pro-social qualities.

Socio-Emotional Functioning in Adults Abused in Childhood

Do the interpersonal difficulties of abused children persist into adulthood? Substantially less is know about the long-term socio-emotional consequences of child abuse. Far fewer resources have been devoted to examining the long-term consequences of abuse. Furthermore, existing studies appear to have many limitations. For example, the majority of studies rely on individual’s perceptions of relationships instead of measures of interpersonal functioning. In fact, very few studies in this area have included measures of interpersonal functioning (Colman & Widom, 2004). In addition, the majority of studies examine the relationship between childhood sexual abuse (CSA) in women and adult interpersonal functioning. Very few studies exist on the interpersonal
functioning of adults physically abused as children. In particular, there is a lack of research on the interpersonal functioning of men abused in childhood.

Because of a lack of research in this area, information about the interpersonal functioning of adults physically abused as children must be generalized from research on women with histories of CSA. Research indicates that women with a history of CSA are more likely to report difficulties in interpersonal relationships. Davis and Petretic-Jackson (2000) found that women with CSA tend to be more distrustful and fearful of others and are more likely than non-abused women to report feeling socially isolated and dissatisfied in relationships (Harter, Alexander, & Neimeyer, 1988; Fleming, Mullen, Sibthorpe, & Bammer, 1999). Furthermore, Callahan, Price, and Hilsenroth (2003) found that women with CSA reported feeling significantly more shy, uneasy, self-conscious and misunderstood in relationships. In sum, women with histories if CSA appear to have significantly more interpersonal difficulties than non-abused samples.

Although few studies have included adults with histories of childhood physical abuse in their samples, one study suggests that childhood physical abuse may have a similar effect on adult interpersonal relationships. In a study on child abuse and adult intimate relationships, Colman and Widom (2004) found that all types of child abuse were associated with relationship dysfunction and disruption. Child abuse, irrespective of type, was found to be associated with disruption (walking out and divorce), cohabitation, and sexual infidelity. These findings must be interpreted with caution because of the absence of replication studies. Additional research in this area is needed to further investigate the impact that physical abuse has on interpersonal functioning in adults.
There is also a lack of research on the relationships between gender, childhood physical abuse and adult interpersonal functioning. Existing studies suggest that women with histories of abuse are more vulnerable to relationship dysfunction. Colman and Widom (2004) found that women were at greater risk of experiencing difficulties related to intimacy (e.g. dissatisfaction, infidelity) in their relationships, whereas abused men were not. In another study, White and Widom (2003) found that women with histories of child abuse were more likely than men to engage in intimate partner violence. In fact, compared to men, women had 3 times the risk of perpetrating intimate partner violence. Less is known about the relationship between gender, type of child abuse and interpersonal functioning. Further research is needed to clarify the differences in interpersonal functioning between men and women who were physically abused in childhood.

*Adult Psychopathology Associated with Childhood Abuse*

In addition to interpersonal difficulties, research has demonstrated that adults with histories of child abuse have higher rates of psychopathology. In particular, early disruptions in affect regulation appear to put adults at risk of developing disorders of emotion dysregulation such as Posttraumatic Stress Disorder (PTSD). In a longitudinal study on child abuse related PTSD in adults, Widom (1999) found that 32.7% of those physically abused, 37.5% of those sexually abused and 30.6% of those neglected met lifetime criteria for PTSD. Complex PTSD (CP) has gained recent attention in the literature. Researchers have conceptualized CP as a constellation of symptoms related to self-regulation, self-definition, interpersonal functioning and adaptation (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). In a PTSD field trial for the DSM-IV, Roth
et al. found that 72% of participants with child abuse related PTSD also met lifetime criteria for CP.

In addition to PTSD, adults with histories of child abuse also appear to be at greater risk of developing other mental health problems (Horwitz, Widom, McLaughlin, & White, 2001). Men with histories of child abuse reported more dysthymia and antisocial personality disorder compared to controls; whereas women reported more dysthymia, antisocial personality disorder and alcohol use than controls. Child abuse also appears to be related to depression and anxiety (Gibb, Butler, & Beck, 2003). Given these findings, it is not surprising that approximately 34% of outpatients have childhood histories of physical abuse (Lipschitz, 1996).

The Therapeutic Alliance

The high prevalence of clients with abuse histories in outpatient mental health settings raises some important clinical questions. Research has shown that the qualities of both current and past relationships are associated with the therapeutic alliance (Moras & Strupp, 1982; Hersoug et al., 2002). Among clinicians and researchers alike, the therapeutic alliance is considered a vital ingredient to positive therapeutic outcome. Research has shown that client-therapist relationship factors (empathy, warmth, congruence) account for 30% of variance in client outcome (Lambert & Barley, 2001). Additionally, the strength of the therapeutic alliance early in treatment is predictive of outcome (Martin et al., 2000). Do clients with histories of physical abuse have more difficulty forming strong therapeutic alliances given that they appear to have difficulties with interpersonal relationships? Although there is evidence to support the relationship between interpersonal client variables and therapeutic alliance, to date, few studies have
directly investigated the relationship between childhood physical abuse, gender, interpersonal functioning and the alliance. The few studies that do address this question should be interpreted with caution.

Eltz and Shirk (1995) examined the relationship between child abuse, the therapeutic alliance and therapeutic outcome in abused adolescents. The authors found that abused adolescents formed weaker early alliances than non-abused adolescents. In addition, adolescents that were abused multiple times appeared to form weaker alliances than those that were abused once. Interestingly, abused adolescents did not appear to have more interpersonal problems than non-abused adolescents (as measured by the Interpersonal Problems Scale on the Child Behavior Checklist). Although interpersonal problems did not appear to predict early alliance strength, the severity of interpersonal problems did appear to predict alliance development over time. Although this study addressed the relationship between child abuse and the therapeutic alliance in adolescents, it did little to address the relationships between interpersonal functioning, childhood physical abuse and alliance in adults.

Paivio and Patterson (1999) conducted a study that attempted to examine these variables in adults. The researchers investigated the relationship between interpersonal functioning, type and severity of child abuse, alliance development and therapeutic outcome in adults treated with emotionally focused therapy for adult survivors of child abuse (EFT-AS). Interestingly, Paivio and Patterson did not find any differences in alliance ratings between their abused sample and a general clinical sample in similar therapy (EFT). Unexpectedly, the researchers found that their sample had comparably strong alliance ratings. However, when examining the severity of childhood abuse as
measured by the Childhood Trauma Questionnaire (CTQ) they found a significant relationship between abuse severity and early alliance difficulties. Congruent with Eltz and Shirk's results (1995), they did not find a significant relationship between current interpersonal problems, abuse history and early alliance strength. The results of this study should be interpreted with caution. First, there was considerable sampling bias. Only clients who completed treatment were included in the analysis. The exclusion of clients who terminated treatment early may have introduced several confounding variables. Similarly, clients were carefully screened and were excluded from the sample if they did not appear to be good candidates for EFT-AS. In addition, the sample was homogeneous in regards to ethnicity, gender, socio-economic status, and type of abuse history. The majority of participants were Caucasian (91%), sexually abused as children (42%), female (26 women, 7 men) and had an income less than $39,000. These factors limit the generalizability of their results. Moreover, the small number of observations in the cells for physical abuse (7) and gender (7 men) further limit their findings. Because of the study's small sample size few conclusions can be made about the interpersonal functioning and therapeutic alliance of men physically abused as children.

Callahan et al. have also examined the relationship between therapeutic alliance and childhood abuse. Unlike previous studies, the authors focused their research on adult survivors of CSA. Like Paivio and Patterson they did not find any differences between clients with and without histories of CSA on early therapeutic alliance ratings. Interestingly, the means for the CSA group were higher than the mean alliance ratings for the non-CSA group. While these results are interesting, they do not address the question of alliance differences between various types of child abuse.
Existing research on child abuse provides limited information regarding gender differences in alliance strength. However, studies on the therapeutic alliance of non-abused samples suggest that men tend to form weaker alliances than women. Thomas, Werner-Wilson, and Murphy (2005) examined the relationship between gender and ratings of working alliance in couples therapy. The researchers found that scores on the bond subscale of the Working Alliance Inventory - Client (WAI-C) were significantly higher for female clients than males. In another study, Wintersteen, Mesinger, and Diamond (2005) examined the relationship between gender matching between therapist and adolescent clients and the clients' ratings of the therapeutic alliance. The researchers found that female adolescents rated their alliance as higher, regardless of therapist gender. In non-abused samples, it appears that women tend to rate their therapeutic alliance as higher than men's. However, the results of these studies may not generalize to clients with histories of physical abuse. Additional research is needed to determine if similar gender differences are found in a physically abused sample.

Summary

According to the developmental psychopathology literature, affect dysregulation appears to put children and adults at greater risk of interpersonal discord (Cicchetti et al., 1991). Numerous studies suggest that children and adults with abuse histories have greater levels of interpersonal impairment (Parker & Herrera, 1996; Fleming et al., 1999). While there is clear evidence of a relationship between CSA and interpersonal impairment, much less is known about the long-term socio-emotional consequences of physical abuse. Moreover, even less is known about the ways in which gender influences interpersonal functioning in adults with histories of physical abuse.
Adults with histories of abuse also appear to have greater levels of psychopathology. In particular, child abuse related PTSD appears to occur at especially high rates in this population (Widom, 1999). Although clients with abuse histories are commonly seen in outpatient mental health settings, very little is known about the relationship between childhood physical abuse and the therapeutic alliance.

A large number of studies have demonstrated a relationship between alliance strength early in treatment and clinical outcomes (e.g. Martin et al., 2000). Additionally, numerous studies support a relationship between client interpersonal functioning and the strength of the therapeutic alliance (e.g. Moras & Strupp, 1982). In studies with non-abused samples, compared to men, women appear to rate their therapeutic alliance as stronger (Wintersteen et al., 2005). However, a gap in the literature exists regarding gender differences in the alliance for a physically abused sample.

Not surprisingly, researchers have hypothesized that clients with histories of abuse will report lower levels of interpersonal functioning and weaker early therapeutic alliances. Previous research has produced mixed results. While a study on inpatient adolescents showed a negative relationship between abuse and alliance strength, other studies on adults have not found significant differences on alliance measures (Eltz & Shirk, 1995; Paivio & Patterson, 1999; Callahan et al., 2003). Surprisingly, these studies did not find a relationship between interpersonal functioning and the therapeutic alliance in abused samples. However, these results should be interpreted with caution due to small sample size, limited generalizability, and possible insufficient power. Furthermore, these studies have not been replicated. Therefore, the purpose of this study is to address a
gap in the literature related to childhood physical abuse, adult interpersonal functioning, the therapeutic alliance and gender.

Research Questions and Hypotheses

1. Do clients who were physically abused as children report more interpersonal difficulties and a decreased ability to form a strong therapeutic alliance compared to clients without histories of physical abuse? It is hypothesized that clients with histories of physical abuse will report greater amounts of interpersonal dysfunction and weaker therapeutic alliances than clients without histories of childhood physical abuse.

2. Does gender moderate the relationship between childhood physical abuse, adult interpersonal functioning and the therapeutic alliance? It is hypothesized that men who were physically abused as children will report weaker early therapeutic alliances and less interpersonal dysfunction compared to abused woman.

Method

Participants

The participants in this study were drawn from a database consisting of information collected from psychotherapy clients seen at a student training outpatient mental health clinic in Portland, Oregon, between the years of 2002 and 2006. Participants were included in the study if they (a) attended the intake and at least 3 sessions of individual psychotherapy at the clinic, (b) completed the Personal Data Form (PDF) and the OQ-45 (Lambert & Burlingame, 1996) at intake, and (c) completed the Working Alliance Inventory-Client (WAI-C; Kokotovic & Tracey, 1990) at either sessions 3, 4 or 5 (for purposes of this paper this administration will be referred to as Session 4). The total sample of clients who met these criteria included 392 individuals.
The range of ages for the total sample was 19 - 63. The total sample was comprised of 248 females (63.3%) and 144 males (36.7%). The ethnicity of participants included 340 Caucasians (86.7%), 13 Asians (3.3%), 5 Blacks (1.3%), 10 Hispanics (2.6%), 1 Native American (.3%), and 21 multi-ethnic/other individuals (5.4%). Regarding relationship status, 174 participants had never been married (44.4%), 45 were divorced (11.5%), 29 were separated (7.4%), 2 were widowed (.5%), and 65 were cohabiting with their partner (16.6%). Of the total sample, 334 clients (85.2%) indicated that they were not injured from the discipline used by their parents during their childhood while 58 clients (14.4%) reported that they were injured from the discipline used by their parents during childhood. Of the abused group, 19 men (32.7%) and 39 (67.2%) reported that they were physically abused during their childhood.

**Procedure**

Clients were administered the OQ-45 and the PDF by a student therapist before their intake interview at the training clinic. During the intake interview clients gave written consent for treatment and consent for the use of their information in research. After the intake interview clients were usually assigned to a different student therapist who acted as their primary therapist. At sessions 3, 4, or 5 clients and their therapist separately completed the WAI and therapists reviewed the client’s WAI after completion. Only the client version of the WAI was included in this study due to research that found it to be the most reliable predictor of treatment outcome (e.g. Martin et al., 2000). All information was entered into the clinic’s database by the student therapist at the time of administration. Before beginning this study the University IRB approved this research and any identifying information was removed from the database.
Measures

**Personal Information.** The Personal Data Form (PDF) is a questionnaire used to obtain information about incoming clients. Information gathered on the PDF includes clients' background (i.e., sex, ethnicity, work status, and childhood experiences), relationship and parental status, mental health history, drug/alcohol use, and a description of the current problem. The following questions were used as the independent variables in this study (a) “What is your sex?” and (b) “during your childhood were you ever injured from the discipline used by your parents?” (Leitenberg, Gibson & Novy, 2004). The question on childhood physical abuse originated from a study by Leitenberg et al. (2004) in which undergraduate women were asked about childhood physical abuse. Past research suggests that questions that use operational definitions of childhood physical abuse are more valid than simply asking clients if they were physically abused (Berger, Knutson, Mehm, & Perkins, 1988).

**Interpersonal Relationships**

The OQ-45 is a 45 item self-report questionnaire that uses a Likert scale ranging from 0 (never) to 4 (always) (Wells, Burlingame, Lambert, Hoag, 1996). The measure was developed for use as a baseline psychotherapy screening instrument. Lambert (1983) suggested that three areas of client’s lives should be monitored throughout therapy. These areas include (a) subjective discomfort, (b) interpersonal relationships, and (c) social role performance. The OQ-45 consists of three subscales that represent each of these domains.

The subscale of Interpersonal Relations (IR) was used in this study to measure interpersonal functioning. The subscale consists of 11 items designed to measure
satisfaction with, as well as problems in interpersonal relationships. Items related to friendships, family and marriage were included in the subscale. In addition, items were included that measure friction, conflict, isolation, inadequacy and withdrawal in relationships. The range of score for the IR scale is 0 – 44 with higher scores indicating more interpersonal problems and less satisfaction with intimate relationships. A sample item from the interpersonal relations subscale is “I am concerned about family troubles.” The Cronbach alpha for IR was found to be 0.74 ($N = 294$) for a subset of patients at an Employee Assistance Program. The test-retest reliability was found to be 0.80 ($N = 157$). The IR subscale has concurrent validity with the Inventory of Interpersonal Problems (IIP) and the SF-36 Medical Outcome Questionnaire (Social Functioning subscale). The mean score for the IR at a university outpatient clinic was 17.86 ($SD = 6.42$) for men and 17.80 ($SD = 6.17$) for women (Wells et al., 1996). For the sample population in this study the IR subscale remained a valid measure with the Cronbach’s alpha of .78 for the 11 items.

**Working Alliance**

The Working Alliance Inventory, Short Form- Client version (WAI-C) was used to measure the strength of the therapeutic alliance (Kokotovic & Tracey, 1990). The WAI-C is a self-report measure consisting of 12 items. The short form was created using the four highest loading items from each of the three subscales of Bond, Goal, and Task. These subscales reflect the personal bond between the client and clinician, the agreement on therapeutic goals, and the agreement on tasks needed to reach these goals, respectively. The items on the WAI-C are scored using a 7-point Likert scale from 1
(never) to 7 (always). Total scores can range from 12 to 84, with higher scores indicating a stronger therapeutic alliance.

Kokotovic and Tracey (1989) found Cronbach alpha scores of 0.91 for Task, 0.88 for Bond, and 0.93 for Goal on the clients’ scale. The test-retest reliability of the full scale is 0.80 across a three-week interval. The test-retest ranges between 0.74 and 0.66 for the full scale score (Cecero, Fenton, Nich, Frankforter, & Carroll, 2001). The WAI-C has concurrent validity with the California Psychotherapy Alliance Scale and the Vanderbilt Therapeutic Alliance Scale (Cecero et al., 2001). For the sample population in this study, the WAI-C remained a valid measure with the Cronbach’s alpha of .83 for the 12 items.

Results

A two-way multivariate analysis of variance (MANOVA) was conducted to determine if gender moderates the relationship between being physically abused as a child and the outcomes of interpersonal functioning and the therapeutic alliance. The independent variables used were the IR scale of the OQ-45 at session 1 (Lambert et al., 1996) and the client WAI-C at session 4 (Kokotovic & Tracey, 1990). The dependent variables used were gender (male/female) and history of childhood physical abuse (yes/no). It was hypothesized that clients who were physically abused as children would demonstrate more interpersonal difficulties and weaker early therapeutic alliances than clients who were not abused as children. Additionally, it was hypothesized that there would be gender differences between men and women in interpersonal functioning and therapeutic alliance. It was anticipated that abused women would demonstrate more
difficulties in interpersonal relationships and stronger therapeutic alliances compared to men with histories of abuse.

Preliminary assumption testing was conducted to check for linearity, normality, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity. For normality, it was found that the WAI-C was slightly negatively skewed. According to Tabachnick and Fidell (2001), skewness is common with large samples and it does not generally make a difference in the analysis. Besides this consideration, no other serious violations were found. Using the significance criteria of $p < .001$ suggested by Tabachnick and Fidell, Box's M was not violated (Box's $M = 11.33$, $p = .27$), meaning that the data did not violate the assumption of homogeneity of variance-covariance matrices.

The MANOVA revealed no significant interaction between gender and abuse status on either the WAI-C or the IR scale ($Wilk's A = .99$, $F(2, 387) = 2.6$, $p = .07$, $partial \eta^2 = .01$). The MANOVA also did not reveal a significant gender difference on either the IR scale or the WAI-C ($Wilk's A = .99$, $F(2, 387) = 1.08$, $p = .34$, $partial \eta^2 = .00$). However, the MANOVA did reveal a significant difference between abused and non-abused clients on either the IR scale or the WAI-C ($Wilk's A = .96$, $F(2, 387) = 7.44$, $p = .001$, $partial \eta^2 = .04$).

When considering the abuse independent variable only the assumption of Equality of Variances was not violated (IR scale: $F(3, 388) = 1.65$, $p = .18$; WAI: $F(3, 388) = .96$, $p = .41$). When the dependent variables were considered separately, results indicated statistically significant differences between abused and non-abused clients on the IR scale ($F(1, 398) = 10.13$, $p = .002$, $partial \eta^2 = .02$). No significant differences were found for
abused and non-abused clients on the WAI-C scale. As can be seen in Table 1, clients who were physically abused as children reported higher levels of interpersonal difficulties on the IR scale than clients who were not abused. There did not appear to be statistically significant differences between men and women on either the WAI-C or the IR scale depending on abuse status.

Table 1.
Means and Standard Deviations for Working Alliance Inventory (WAI-C) and Interpersonal Relations subscale of the OQ-45 (IR subscale) for Females and Males With and Without an Abuse History

<table>
<thead>
<tr>
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</tbody>
</table>

Note: WAI-C = Working Alliance Inventory, IR Subscale = Interpersonal Relations subscale of OQ-45

Discussion

Description of Results and Limitations

The goals of this study were to investigate the relationship between childhood physical abuse, early alliance strength and interpersonal functioning in adult outpatients. Furthermore, this study extended previous research and examined gender differences in interpersonal functioning and the therapeutic alliance. It was hypothesized that clients who reported childhood physical abuse would report weaker early alliances and greater interpersonal dysfunction than clients without histories of abuse. Additionally, it was
hypothesized that abused men would report weaker therapeutic alliances and less interpersonal difficulties than abused women.

The hypotheses of this study were only partially supported by the data. Unlike past studies on abused adolescents (Eltz & Shirk, 1995) this study failed to find a relationship between abuse status and alliance strength. However, these non-significant findings are not surprising due to the limitations of this study and previous research findings. Previous research on adults with histories of child abuse have not found a relationship between reported abuse and a weak early therapeutic alliance; however, these studies did find a relationship between childhood abuse severity and alliance strength (Paivio & Patterson, 1999; Callahan et al., 2003). Paivio and Patterson also hypothesized that the early alliance would be weaker for clients with abuse histories. Like the current study, their hypothesis was based on an inferential link between child abuse, interpersonal dysfunction and alliance quality. These inferred relationships were based on research findings that indicate a relationship between poor interpersonal functioning and weak alliance strength in non-abused samples (Moras & Strupp, 1982; Hersoug et al., 2002). Although the present study produced insignificant results, these findings do contribute to a fuller understanding of alliance strength in abused samples.

According to the results of this study, reported childhood physical abuse is not associated with weaker early alliances in therapy. These results can be interpreted in several ways. First, the mere presence of an abuse history may not influence the ability of an individual to form a strong relationship with a therapist. Nevertheless, abuse severity may moderate the strength of the alliance. In the present study, abuse was measured dichotomously verses continuously. A limitation to this study was that abuse
severity was not measured using a continuous variable. The dichotomous question that was used ("During your childhood were you ever injured from the discipline used by your parents?") to report childhood physical abuse was limiting in that it did not account for abuse frequency, duration or severity. In addition, the question used to screen for abuse was subjective in nature and therefore open to interpretation. Specifically, the word "injured" could have been interpreted by clients in various ways. If a questionnaire such as the Childhood Trauma Questionnaire (Bernstein et al., 1994) had been used the results may have been more consistent with previous research that showed a relationship between abuse severity and alliance strength. While the relationship between physical abuse severity and alliance strength remains unknown, the results of this study suggest that the mere presence of childhood physical abuse history does not predict a weak alliance early in treatment.

Another limitation that may have contributed to the non-significant results between alliance strength and physical abuse status is the restricted range and negative skew of the WAI-C. In general, the majority of clients at this particular outpatient clinic rated their alliance as strong. At this clinic the mean score for the total sample was 70.67 (SD= 9.19) indicating a strong alliance. The negatively skewed results may have resulted from several factors. At this particular clinic clients fill out the WAI-C and give it directly to their therapist to review. This method of administration may contribute to higher scores due to the effects of social desirability. In other words, clients may feel compelled to give their therapist high scores because of a desire to be liked. Another possible explanation for the negative skew is that clients treated at this client do indeed have strong alliances with their therapists. Although Tabachnick and Fidell (2001) state
that skewness does not generally affect the analysis, it is worth noting that these scores may lack validity due to the method of administration.

Despite these findings, the hypothesis that clients with histories of childhood abuse will report more interpersonal dysfunction was supported. Past research on the interpersonal functioning of adults abused as children has primarily focused on women with reported CSA (Davis & Petretic-Jackson, 2000). Previous studies have found that women with reported CSA tend to have significantly more interpersonal problems: these problems include feeling socially isolated, shy, uneasy, self-conscious, misunderstood and dissatisfied in relationships (Harter et al., 1988; Fleming et al., 1999; Callahan et al., 2003). In addition, research has found that all types of child abuse have detrimental effects on adult intimate relationships (Colman & Widom, 2004); however, this study had not been replicated. The results of the present study provide further evidence that childhood physical abuse has detrimental effects on adult interpersonal relationships. These findings are consistent with previous research in developmental psychopathology. From a developmental psychopathology perspective, the developmental task of affect regulation prepares children to successfully negotiate and engage in peer relationships. Child abuse appears to put children at risk of inadequate emotional regulation. As an adult, inadequate emotional regulation can contribute to interpersonal dysfunction (Cicchetti & Toth, 1995). The current study provides further evidence that child abuse, irrespective of type, contributes to long-term socio-emotional consequences in adulthood.

As for gender effects, the hypothesis that physically abused men would report weaker therapeutic alliances and less interpersonal dysfunction than physically abused women was not supported by the data. These results are surprising due to previous
studies that found main effects for gender on measures of alliance and interpersonal functioning. Previous researchers found that women were at greater risk of experiencing difficulties related to intimacy (e.g. dissatisfaction, infidelity) and were more likely to engage in intimate partner violence in their relationships (Colman & Widom, 2004; White & Widom, 2003). Additionally, research on non-abused samples suggests that men tend to form weaker alliances than woman (Thomas et al., 2005). Specifically, men tend to score significantly lower on the Bond subscale of the WAI-C (Thomas et al.).

Several explanations may shed light on these insignificant findings for gender differences. One explanation for these results is the small number of abused men \(N = 19\) included in this study. The small sample of men may have led to insufficient statistical power that produced a null result for alliance and interpersonal functioning differences. Another explanation is that previous research on gender differences and alliance strength in non-abused samples may not generalize to physically abused samples. While gender appears to moderate alliance strength in non-abused samples, gender may not have the same moderating effect for men that have experienced abuse. In effect, child abuse may even the playing ground for alliance strength. In addition, there may be an unknown mediational variable that explains the relationship between childhood physical abuse and alliance strength in men.

**Implications**

Although the results of this study were only partially supported by the data, the clinical and policy implications are numerous. This study contradicted widely held clinical assumptions that clients with histories of abuse have greater difficulties forming strong therapeutic alliances early in therapy. Clients with physical abuse histories appear
to form equally strong alliances with therapists compared to non-abused clients. Although this study did not address the relationship between abuse severity and alliance, other studies have shown that greater levels of abuse severity negatively affect the therapeutic alliance. The results of this study suggest that simply screening for a history of child abuse is not enough to predict alliance difficulties. In order to more accurately predict alliance difficulties clinicians should use measures that determine child abuse severity. These types of measures may provide much richer information about a client's ability to form close therapeutic bonds and have a positive therapeutic outcome. This information is extremely pertinent due to the widespread use of intake measures that use dichotomous questions to screen for abuse history.

Furthermore, this study showed that abused clients with severe interpersonal problems can form strong therapeutic alliances despite their current relationship difficulties. This is positive news for clients and therapists alike. Research has indicated that the strength of the therapeutic alliance early in treatment is predictive of positive therapeutic outcomes (Martin et al., 2000). Among outpatients, approximately 34% have reported childhood physical abuse; of those, 32.7% have child abuse related PTSD (Lipschitz, 1996; Widom, 1999). The current study suggests that, despite more severe interpersonal problems, these clients can form alliances that are comparable to clients without abuse histories.

The results of this study indicate that child physical abuse does have long-ranging socio-emotional consequences that persist into adulthood. The data from this study provides further evidence that the effects of child abuse significantly interfere with the lives of adult survivors. Besides individual costs, dysfunctional relationships harm
families and further burden the mental health system. This study supports the call for improved child welfare systems that focus on prevention and early intervention in order to reduce the incidence and severity of child abuse.

**Future Research**

Because of the limitations of this study many questions remain unanswered. Future research on childhood physical abuse should further explore the relationship between abuse severity, alliance strength, gender and interpersonal impairment. In future research child abuse should be measured using a continuous variable to assess for abuse severity. In addition, other comparable alliance measures with normal distribution and less range restriction should be considered for use. The small number of men included in this study may have contributed to insufficient power. In future studies larger numbers of men with physical abuse histories should be included in the sample. Like most research in this area, the study sample was homogeneous in regard to ethnicity (86.7% Caucasian). This factor may have limited the generalizability of this research to samples with greater ethnic diversity. Future research should include a sample that has greater diversity and is more representative of the ethnic make-up of the country.

The findings of this study brought up several interesting questions that may warrant future research. To date, most research on alliance strength among adults with reported abuse histories has been surprising and incompatible with past research on non-abused samples. For example, Hersoug et al. (2002) found that impaired social functioning in non-abused samples was significantly associated with poor alliance quality (Hersoug et al.). Why do clients with abuse histories and impaired interpersonal functioning tend to develop strong alliances? How do variables such as abuse frequency,
severity, duration and type of perpetrator moderate alliance strength? Are there mediating variables that explain the tendency for clients with interpersonal impairment and abuse histories to form strong alliances? Are clients with abuse histories more likely to form therapeutic bonds too quickly and too strongly? Why doesn't gender moderate alliance strength and interpersonal functioning in abuse samples? How is alliance strength in abuse samples related to resiliency? Further research should attempt to further our knowledge of the long-term consequences of abuse and their effects on the therapeutic relationship.

Conclusions

Every year in this country millions of children experience child abuse and neglect (United States Department of Health and Human Services, 2006). While much is known about the socio-emotional consequences of abuse in childhood, much less is known about the long-term effects of abuse. Previous research suggests that adults who report histories of child abuse have greater incidences of mental health problems and interpersonal impairment (Horwitz et al., 2001; Colman & Widom, 2004). Various researchers have shown that interpersonal problems negatively influence the development of a strong therapeutic alliance (e.g. Moras & Strupp, 1982). While some studies have explored the relationship between child abuse, interpersonal relationships and the alliance, few have included childhood physical abuse and gender in their research. This study sought to explore the relationships between gender, childhood physical abuse, interpersonal relationships and the alliance. The hypothesis that reported childhood physical abuse was associated with a weaker alliance was not supported by the data. Although, the hypothesis that clients with reported childhood physical abuse would report
more interpersonal dysfunction was supported. This study did not find that gender moderated the strength of the alliance or the severity if interpersonal functioning. These findings support the argument that increased resources should be allocated to programs that seek to decrease the incidence and impact of child abuse. Future research should further explore the relationship between abuse severity, alliance strength, gender and interpersonal relationships.
References


Appendix A: Consent Form
AGREEMENT AND INFORMED CONSENT FOR TREATMENT

TREATMENT AGREEMENT
This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), the federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is included with this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the start of treatment. Although these documents are long and sometimes complex, it is very important that you read them carefully. You will also receive a copy of this information to keep. We can discuss any questions you have about them after you have read them and please make sure to let us know if there is any part you do not understand. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

DESCRIPTION OF SERVICES
The Psychological Service Center of the School of Professional Psychology at Pacific University is a private, non-profit, outpatient mental health treatment/training clinic, which provides a wide range of affordable psychological services to children and adults. All persons are eligible for services, regardless of ethnicity, color, age, sex, sexual orientation, disability, religion, creed, or national origin.
The Psychological Service Center provides training for doctoral clinical psychology graduate students. The Center is under the direction of a licensed psychologist, and clinicians receive weekly individual and group supervision from licensed psychologists. You may, therefore, benefit from having several PSC clinical staff members help to understand your situation.
PSYCHOLOGICAL SERVICES

INTAKE

All clients go through a 90 minute intake assessment interview to determine if we are able to provide treatment for you. This interview is not a guarantee, we will ultimately be able to provide services to you if you go through one; however, if you go complete the interview and we determine the PSC is not a suitable treatment setting for you, we will be happy to provide you with a copy of the findings. We can mail (after you give us an authorization to disclose protected health information to do so) this information to another agency of your choosing or we could recommend based on the interview findings.

If additional meetings are necessary to complete the intake interview, then additional fees will be incurred, and would be charged at the rate of a therapy session. It usually takes between 7 to 10 days from the time of the completed intake interview before you and a therapist can meet if the PSC is found to have the appropriate services for you.

RIGHTS AND RESPONSIBILITIES

You have the right to be informed about your psychological services, any risks it might entail, and to be involved in planning your treatment and what alternatives might be considered. You have the right to request or refuse any particular approach; to withdraw from treatment at any time, and to be informed about the possible time frame your treatment may require. You may request referral to another agency. If needed, your progress will be reviewed after 90 days and new goals or approaches may be recommended.

Psychological services involve close collaboration between clinician and client. If you have questions, feel free to ask. If there are problems, please let your clinician know right away. Most problems have solutions when people feel free to discuss the issue. If you are not happy with the person who will be your clinician, please tell him/her right away and see if you can resolve your concerns. If problems persist and your clinician and supervisor agree that another clinician would be better able to help you, we may be able to offer you a different clinician or a referral to another agency.

You have the right to know the name of your clinician's supervisor and if you wish to speak with him/her, leave a message with the receptionist as to how you may be contacted. You may also speak to the Center Director or other supervisory staff about filing a written grievance or about other services that are available to you.

Psychological services have helped many people, but success is not guaranteed. In fact, there are some risks in treatment and testing. It is important to know that as problems are faced they sometimes may seem to get worse. We work to make personal relationships stronger, but as you learn new ways of thinking or doing, you may make choices that may lead to conflict with others in your life. We try to limit these risks and help you be aware of them. We believe the benefits of psychological services are worth such risks, but there may be other risks that cannot be anticipated. Please talk about this with your clinician, since you must be the judge about these benefits and risks psychological services hold for you.
PSYCHOLOGICAL SERVICE CENTER
511 SW 10th, Suite 400
Portland, OR 97205
(503) 352-2400, FAX (503) 228-7120

STATEMENT OF INFORMED AGREEMENT TO TREATMENT

I have carefully read, or have had read to me, the PSC's Agreement and Informed Consent for Treatment. I acknowledge I have received the HIPAA Notice Form described above. I have also had a chance to ask questions and discuss this further with PSC staff and I fully understand this information. In particular, I understand that my sessions may be observed or video/audio taped, and that information I provide may be used in research, with appropriate steps taken to preserve confidentiality. I also understand that PSC staff and supervisors may observe or discuss my care in order to provide me with the best possible service. I understand that I may be contacted by mail or phone by PSC staff during or after my treatment has ended to inquire about my satisfaction with service and progress. I now freely give my informed agreement for myself and/or minor child or legal dependent to receive treatment or other services at the Psychological Service Center.

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Psychological Service Center.

My signature below means that I was given a copy of the Agreement and Informed Consent for Treatment and Oregon Notice Form.

NAME OF CLIENT (or Legal Guardian):

(Print Name) (Signature) (Date)

NAME OF MINOR CHILD OR LEGAL DEPENDENT:

(Print Name) (Signature or Mark) (Date)

Relationship of Guardian, Above:

I certify that I have reviewed Agreement and Informed Consent for Treatment and Oregon Notice Form with the person named above, and that it was signed in my presence.*

(Witness Name and Title)

(Signature) (Date)

*NOTE: If the client is unable, or chooses not to sign, the witness certifies that efforts were made in good faith to inform client of all rights and responsibilities.

INFORMED AGREEMENT TO TREATMENT 12/01/01
PRIVACY AND CONFIDENTIALITY

Confidentiality means that it is necessary for us to obtain your written consent even to acknowledge to someone outside the clinic that you are being seen at the Psychological Service Center. As with other agencies, information about your case will frequently need to be discussed with other members of the PSC staff in order to provide you effective services. Your records and the clinician’s notes, treatment plans, etc., are kept in a locked file. Because this is a training clinic and to ensure you receive the best possible treatment, your interviews will be audio or video recorded and/or observed by supervisors or qualified students. Tapes are erased automatically within 60 days, unless we receive written permission from you to make other use of them. On occasion, your case may also be discussed in a classroom situation or information you have provided may be used in a research project. Whenever such use is made of information about you, your name will not be used, nor will any other information be used which might identify you.

HIPAA allows this training clinic to use or disclose confidential information (including but not limited to PHI) for purposes of treatment, payment, and health care operations (see Notice for definitions) with informed written consent, signed by signing this document. In most other situations, in other words, for purposes outside of treatment, payment, and healthcare operations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by state law and/or HIPAA. However, there are some additional important legal and ethical exceptions to complete confidentiality that you should be aware of and some situations in which we are permitted or required to disclose information without either your consent or Authorization. In all cases we will try to disclose only the information that is minimally necessary to meet the needs of the situation.

1) Serious Threat to Health or Safety: If we learn that you intend to kill or seriously harm either yourself or another person(s), and we judge that there is a clear and substantial risk of imminent danger of that happening, we may breach confidentiality to the extent necessary to protect you or others and take actions which could include seeking hospitalization for you or contacting family members or others who can help to provide protection. This could also include notifying the potential victim(s) or contacting the police.

2) Child Abuse: If we have reasonable cause to believe that a child with whom we have had contact has been abused we may be required to report the abuse. Additionally, if we have reasonable cause to believe that an adult with whom we have had contact has abused a child, we may be required to report the abuse. In any child abuse investigation, we may be compelled to turn over PHI. Regardless of whether we are required to disclose PHI or to release documents, we also have an ethical obligation to prevent harm to our clients and others. We will use our professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

3) Mentally Ill or Developmentally Disabled Adult: If we have reasonable cause to believe that a mentally ill or developmentally disabled adult, who receives services from a community program or facility has been abused, we may be required to report the abuse. Additionally, if we have reasonable cause to believe that any person with whom we come into contact has abused a mentally ill or developmentally disabled adult, we
may be required to report the abuse. Regardless of whether we are required to disclose PHI or to release documents, we also have an ethical obligation to prevent harm to our clients and others. We will use our professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

4) Other Abuse: We may have an ethical obligation to disclose your PHI to prevent harm to you or others.

5) Medical: We may disclose information that would facilitate treatment of a medical emergency.

6) Court Proceedings/Subpoena: If you are involved in or anticipate becoming involved in any legal or court-related proceedings, please notify us as soon as possible. It is important for us to understand how, if at all, your involvement in these proceedings might affect our work together. Your PHI may become subject to disclosure if any of the following occur: if you become involved in a lawsuit, and your mental or emotional condition is an element of your claim, or if a court orders your PHI to be released, or orders your mental evaluation. We may have to release your records when ordered to do so by the court after being served with a valid subpoena. However, we will make every effort to discuss this with you beforehand. If our treatment involves more than one family member please be aware that our treatment record may contain information about more than one person in the family.

7) Government Health Oversight: If a government agency or the Oregon State Board of Psychologist Examiners is requesting the information for health oversight activities, we may be required to provide it for them.

8) Legal Defense: If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

9) Workers Compensation Claim: If you file a Worker's Compensation claim, this constitutes authorization for us to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

10) Insurance or Fee Collection: As discussed elsewhere in this Agreement, if you ask us to utilize your health insurance, we will probably have to release information regarding your diagnosis or treatment in order to complete your claim. Most insurance companies also retain the right to conduct periodic audit reviews of records. Similarly we may pursue collection of overdue fees without further Authorization.

11) Consultation: At times we may find it helpful, on your behalf, to consult with other health and mental health professionals, who are not involved in your case, to ensure that you receive the best treatment possible. During a consultation, we make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. We will assume that this is acceptable to you unless you notify us in writing and we will not tell you about these consultations unless we feel that it is important to our work together. If significant treatment decisions are affected by a consultation, we will note that in your Clinical Record. If any of these situations arise, however possible, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosures to what is minimally necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite
complex and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

**PROFESSIONAL RECORDS**

You should be aware that, pursuant to HIPAA, we sometimes keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others (for which we will provide you with an accurate and representative summary of your Record if you request it), you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $10 per page. If we refuse your request for access to your Clinical Record, you have a right of review, which we will discuss with you upon request.

In addition, we sometimes also keep a set of Psychotherapy Notes. These Notes are for our own use and are designed to assist us in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they may include the contents of our conversations, analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to us that is not required to be included in your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may request to examine and/or receive a copy of your Psychotherapy Notes unless we determine that such disclosure would be injurious to you.

**CLIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include:
- requesting that we amend your record;
- requesting restrictions on what information from your Clinical Record is disclosed to others;
- requesting an accounting of most disclosures of protected health information that you have neither requested nor authorized;
- determining the location in which protected health information disclosures are sent;
- having any complaints you make about our policies and procedures recorded in your records; and
- the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you. Should you wish to utilize any of these rights, please request them in writing and we can provide you with the proper form or procedure.
MINORS & PARENTS

Clients under 14 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, for children between 14 and 18, it is sometimes our policy to request an agreement from parents that they cannot give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with either a verbal or written summary of their child's treatment when it is complete, if they request it. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections the child may have. If a child is a minor, both custodial and non-custodial parents have access to treatment records.

FEES AND PAYMENT

Fees are to be paid by you at the time of each appointment. The initial intake appointment costs $45.00 and is designed both to determine exactly what the problem is, and whether we would be able to help or should refer you to another community resource. Couples seeking therapy pay $45 per partner for separate intake appointments (a total of $90) for an initial 90 minute intake interview. The clinic rate for individual, marital, or family therapy is $45.00 per session. Your payment responsibility may be offset by insurance benefits or by subsidy. Subsidies are available because the PSC is a training clinic.

At your initial session, you will receive full information regarding fee rates and policies. Your fee may be subsidized, as determined by income level and family size if you bring proof of household monthly income (pay stub, etc.). If you feel that your fee is still beyond your means, you may ask your clinician to help you complete a subsidy incomes form. After review, your clinician's supervisor will determine if further subsidy is possible. Other service fees, such as for psychological evaluations, depend upon the type of evaluation requested. You should provide any insurance information at the time of your first intake appointment.

MISSED APPOINTMENTS

Missed sessions are billed at 50% of your assigned rate (no less than $10.00) unless the PSC receives 24-hour notice except in cases of emergency that we both agree was such. Charges for missed appointments for psychological assessments reflect the number of hours scheduled for your appointment (usually 3 hours). Unlike medical offices, we do not overbook clients. Thus, a missed appointment has very real impact upon your clinician and the PSC's ability to provide subsidies. If you fail behind more than one payment, your clinician will discuss this with you and after two or more missed payments, your clinician may advise you that further services can no longer be provided. Extended payment plans may be negotiated with the PSC's Office Manager. If you are no longer able to pay for services, your clinician will assist you in locating another community resource, or she/he may suggest you request a subsidy increase.
ADDITIONAL SERVICE CHARGES
Fees may also be charged on a pro-rated basis for other professional activities necessary for good clinical care or for professional services you may need or request of us. These include time spent in telephone consultation time initiated by you that is longer than 10 minutes, and consultation time with others on your behalf, (e.g., schools, other providers of care to you). If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party.

HEALTH INSURANCE
If you are using a health insurance benefit by paying for psychotherapy services, you need to be aware of what it means. Your health plan requires cooperation between client, provider and insurance company to provide services as efficiently as possible. Health insurance companies usually limit mental health coverage to:

1) Services that are determined to be "medically necessary" for an individual. Medical necessity is usually defined as qualifying for a covered DSM IV Axis I or ICD diagnosis (acute symptoms). Most insurance companies do not cover couples treatment.

2) Conditions that are able to be treated by short-term, goal-oriented approaches whenever possible. This means that your insurance company will cover a limited number of office sessions to work on your problem as intensely as possible with the focus of eliminating acute problems. Your case may be reviewed by a utilization review/quality assurance group set up by the insurance company and in many cases we will be required to provide information about your treatment as well as a diagnosis. They may even refuse to cover your sessions or limit the number of sessions they will authorize. Some insurance plans require preauthorization or they will not cover even your first meeting, and many require periodic reauthorization of a block of sessions for ongoing treatment. You are responsible for obtaining the initial preauthorization if it is necessary. It would be very helpful if you would check the specifics of your insurance benefits, if any, prior to our first meeting. If you need help with this, you may call us and we would be happy to help.

You remain responsible for your entire bill regardless of whether insurance covers treatment costs, or whether you are the primary insured person. Co-payments or subsidized fees are payable at the time of your visit.

Please voice any concerns you may have at our first meeting so that we can further discuss if this arrangement meets your needs. You always have the choice to pay for our services out-of-pocket rather than utilize insurance. While much can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. If you exhaust your insurance benefits but you wish to continue seeing us for therapy, we will need to see whether or how we can negotiate that arrangement. If not, we would help you to find treatment that you can afford.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. If you have no Oregon insurance policy with the state law requirement that by accepting policy benefits, you are deemed to have consented to examination of your Clinical Record for purposes of utilization review, quality assurance and peer review by
the insurance company, then we may provide clinical information to your insurer for such purposes. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information database. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

PHONE ACCESS AND EMERGENCIES

The best person to help in an emergency is your primary clinician. Please call this person at the Psychological Service Center at (503) 352-3400. Use this number and not your clinician's voice mail number to ensure immediate attention. We will try to locate and ask your clinician to call you. If your clinician is not available, you may consult with another PSC clinician. After business hours, and on weekends and holidays, emergency calls from PSC clients are taken by our answering service. The answering service will either try to reach your clinician, have another clinician call, or advise you to call the Multnomah County Health Crisis Line at (503) 988-4888.

HOURS

The Psychological Service Center is open from 9 a.m. to 9 p.m., Monday through Thursday; 9 a.m. to 5 p.m., Fridays; and 8:30 a.m. to 5:30 p.m., Saturdays. The Center is closed on major holidays and occasionally for other events. You will be notified in advance if your scheduled time coincides with PSC closure.

OUR COMMITMENT

Please give us any suggestions to improve our delivery of services. We hope this information helps you to understand the PSC, our services, and your rights and responsibilities as a client. We believe very strongly in the rights of people to direct their own lives as much as possible. We pledge to assist you and your loved ones to improve your life through psychological help. We will probably contact you after therapy to ask you to comment on the services you received and progress you made.

Jennifer (Alecke, Ph.D.)
PSC Director

Lisa Christiansen, PsyD
PSC Associate Director

INFORMED AGREEMENT AND INFORMED CONSENT FOR TREATMENT-PSA-REVISED-10-06
Appendix B: Personal Data Form
PSYCHOLOGICAL SERVICES CENTER (PSC)
Personal Data Form – Individual Clients

INSTRUCTIONS
Please take a few minutes to complete this form by writing your answers in the spaces provided or by checking boxes with an X mark like this: ☑. The information you provide will help the therapist you meet with today to better understand why you are here.

WHAT IS YOUR NAME AND DATE OF BIRTH?

<table>
<thead>
<tr>
<th>Your Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

HOW CAN WE REACH YOU IF NEEDED?

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>Is it OK to leave a message here? ☑ No ☑ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td>Is it OK to leave a message here? ☑ No ☑ Yes</td>
</tr>
<tr>
<td>Other Phone/Email</td>
<td>Is it OK to leave a message here? ☑ No ☑ Yes</td>
</tr>
</tbody>
</table>

What are the best times to reach you?

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
</table>

WHO SHOULD WE CALL IF THERE IS AN EMERGENCY?

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>How is this person related to you?</th>
</tr>
</thead>
</table>

Address

<table>
<thead>
<tr>
<th>Street/PO Box</th>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Work Phone</th>
<th>Home Phone</th>
<th>Other Phone</th>
</tr>
</thead>
</table>

WHO IS YOUR FAMILY PHYSICIAN/WHERE DO YOU GO FOR MEDICAL TREATMENT?

<table>
<thead>
<tr>
<th>Doctor's Name/Agency</th>
<th>Phone</th>
</tr>
</thead>
</table>

HOW DID YOU HEAR ABOUT THIS CLINIC/HOW DID YOU FIND US?

☐ I found this on my own → How did you hear?
☐ Someone referred me here

*Name of person who referred you
How is this person related to you?
| BACKGROUND |
|-------------|-----------------|
| 1. What is your sex? | ☐ Male ☐ Female |
| 2. What is your ethnicity/race? | ☐ Caucasian/White ☐ Hispanic ☐ Native American ☐ African-American/Black ☐ Multi-ethnic/Other |
| 3. How far did you go in school (highest grade)? | ☐ Less than 7th grade ☐ Partial college ☐ High school/9th or less ☐ 4-year college ☐ Graduate work ☐ High school graduate/GED |
| 4. What is your current work status? | ☐ Unemployed ☐ Part-time ☐ Full-time ❁ Job type? |
| 5. Who did you live with mostly when you were a child (under age 16)? | ☐ Biological parents ☐ Mother only ☐ Father only ☐ Parent and stepparent ☐ Other relative ❁ Why? ☐ Foster care ❁ Why? ☐ Other |
| 6. During your childhood were you ever injured from the discipline used by your parents? | ☐ Yes ☐ No |
| 7. During your childhood did you ever see your parents have physical fights with each other? | ☐ Yes ☐ No |
| 8. Did either of your parents ever abuse alcohol or drugs? | ☐ Yes ☐ No |
| 9. Were you ever arrested by the police before you turned age 18? | ☐ Yes ☐ No ❁ Describe: |
| 10. Have you ever been arrested by the police since turning age 18? | ☐ Yes ☐ No ❁ Describe: |
| 11. Are you currently involved in any kind of legal case or lawsuit? | ☐ Yes ☐ No ❁ Describe: |
### Relationship Status & Parenting

12. What is your current marital/relationship status (choose one)?
   - Never Married
   - Separated
   - Divorced
   - Widowed
   - Married
   - Dating
   - Engaged
   - Cohabiting with partner

13. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?  
   - Yes
   - No

14. Do you feel safe in your current relationship?  
   - Yes
   - No

15. Is there a partner from a previous relationship who is making you feel unsafe now?  
   - Yes
   - No

16. Are you currently in an intimate relationship?  
   - Yes
   - No

   a. How satisfied are you with your marriage/relationship? (circle #)  
      - Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

   b. How satisfied are you with your relationship with your spouse/partner?  
      - Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

   c. How satisfied are you with your partner as a spouse/significant other?  
      - Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

17. Do you have any children under the age of 18 living with you in your home?  
   - Yes
   - No
   - Child #1: Age: Sex: Male Female
   - Child #2: Age: Sex: Male Female
   - Child #3: Age: Sex: Male Female
   - Child #4: Age: Sex: Male Female
   - Child #5: Age: Sex: Male Female

### Medical History

18. Do you have any chronic medical conditions or disabilities?  
   - Yes
   - No

   a. Describe the problem(s) below:

   b. Do you receive disability/SSI for this condition?  
      - Yes
      - No
19. Have you ever had a head injury or concussion from a fall, crash, or other kind of accident?  
   + Describe the injuries(s) below:

20. Are you currently taking any kind of medication?  
   + Describe medication(s) below & doctor's name:

21. Have previously been prescribed medication for your nerves, depression, anxiety, sleep, etc.?  
   + Describe the medication(s) below:

22. Have you ever been hospitalized or received in-patient treatment for a mental health problem?  
   + Describe what happened below (dates & places):

23. Have you ever participated in any kind of outpatient counseling or psychotherapy?  
   + Describe this counseling below (dates, problems):

24. Have you ever attempted suicide?  
   + Describe what happened below (include dates):

25. Have you ever been in counseling or support groups related to your alcohol or drug use?  
   + Describe what happened below (include dates):
26. In the past year have you used street drugs (like marijuana, heroin, cocaine, amphetamines, party drugs) or taken prescription drugs without a doctor's order? 

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

List drugs you used in last 12 months and how often.

<table>
<thead>
<tr>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

27. How often do you have a drink containing alcohol (including beer, wine, and liquor)?

<table>
<thead>
<tr>
<th>Never</th>
<th>Monthly or less</th>
<th>2 to 5 times a month</th>
<th>2 to 3 times a week</th>
<th>4 or more times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

28. How many drinks of alcohol do you have on a typical day when you are drinking?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>1 or 2</th>
<th>3 or 4</th>
<th>5 or more</th>
<th>7 to 9</th>
<th>10 or more</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

29. How often do you have six or more drinks on one occasion?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
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<tbody>
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</tbody>
</table>

30. How often during the last year have you found that you were not able to stop drinking once you started?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

31. How often during the last year have you failed to do what was normally expected of you because of drinking?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

32. How often in the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

33. How often in the last year have you had a feeling of guilt or remorse after drinking?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

34. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>Never</th>
<th>Less than monthly</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or almost daily</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

35. Have you or someone else been injured as a result of your drinking?

<table>
<thead>
<tr>
<th>Never Drink</th>
<th>No</th>
<th>Yes, but not in last year</th>
<th>Yes, in last year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
36. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested that you should cut down?  
☐ Never Drink  ☐ Yes, but not in last year  ☐ Yes, in last year  

**DESCRIPTION OF CURRENT PROBLEM**

37. Please use the space provided below to describe your reason(s) for coming to the clinic.

38. Have you sought treatment for this problem before?... ☐ Yes  ☐ No  
   ✴ Describe prior treatment (include dates & therapist):

39. What do you hope to get out of therapy, what would you like to see change?

40. I expect therapy for this problem(s) to last ___ sessions:  
   ☐ 1 to 5 sessions  ☐ 6 to 10 sessions  ☐ 11 to 20 sessions  ☐ 21 to 50 sessions  ☐ Over 50 sessions

41. After therapy, I expect my problem(s) to be:
   ☐ No Better  ☐ Slightly Better  ☐ Moderately Better  ☐ Mostly Better  ☐ Completely Better

42. The pain and distress caused by my problem(s) is:
   ☐ Very Mild  ☐ Mild  ☐ Moderate  ☐ Severe  ☐ Very Severe

43. The pain and distress caused for others by my problem(s) is:
   ☐ Very Mild  ☐ Mild  ☐ Moderate  ☐ Severe  ☐ Very Severe

Thank you for providing us with this important information.

Please bring this form to the front desk staff person who will give it to the therapist seeing you today.

endorse
Appendix C: Working Alliance Inventory Short Form - Client
# Working Alliance Inventory

## Clients

### Identification

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Day</th>
<th>Session</th>
</tr>
</thead>
</table>

### Instructions

Listed below are sentences that describe some of the different ways a person might think or feel about his/her therapist. As you read each sentence mentally insert the name of your FGC therapist in place of the blank space. If the statement describes the way you always feel or think, circle the number 1. If it never applies to you circle the number 7. Use the numbers in between to describe the variations between these extremes. This information will be shared with your therapist to help him/her provide you with the best treatment possible.

1. _______ and I agree about the things I will need to do in therapy to improve my situation.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

2. What I am doing in therapy gives me new ways of looking at my problem.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

3. I believe _______ likes me.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

4. _______ does not understand what I am trying to accomplish in therapy.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

5. I am confident in _______'s ability to help me.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

6. _______ and I are working towards mutually agreed upon goals.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

7. I feel that _______ appreciates me.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

PLEASE CONTINUE ON BACK SIDE
9. We agree on what is important for me to work on.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

9. .... and I trust one another.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

10. .... and I have different ideas on what my problems are.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

11. We have established a good understanding of the kind of changes that would be good for me.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
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<tr>
<td></td>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

12. I believe the way we are working with my problem is correct.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td></td>
<td>Never</td>
<td>Rarely</td>
<td>Occasionally</td>
<td>Sometimes</td>
<td>Often</td>
<td>Very Often</td>
<td>Always</td>
</tr>
</tbody>
</table>
Appendix D: Outcome Questionnaire 45
## Outcome Questionnaire (OQ⁺-45.2)

**Instructions:** Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any entries in the shaded area.

<table>
<thead>
<tr>
<th>Session #</th>
<th>Date</th>
<th>Name:</th>
<th>Age:</th>
<th>ID#</th>
<th>Sex</th>
<th>SD</th>
<th>IR</th>
<th>SR</th>
<th>BR</th>
<th>PR</th>
<th>RW</th>
</tr>
</thead>
</table>

### Questions

1. I got along well with others.
2. I ate quickly.
3. I felt no interest in things.
4. I felt stressed at work/school.
5. I blame myself for things.
6. I feel isolated.
7. I feel unhappy in my marriage/significant relationship.
8. I have thought of ending my life.
9. I feel weak.
10. I feel fearful.
11. After heavy drinking, I need to drink the next morning to get going. (If you do not drink, mark "never").
12. I find my work/school satisfying.
13. I am a happy person.
14. Work/study too much.
15. I feel worthless.
16. I am concerned about family troubles.
17. I have an unsatisfying sex life.
18. I feel lonely.
19. I have frequent arguments.
20. I get lost often.
21. I enjoy my spare time.
22. I have difficulty concentrating.
23. I feel happy about the future.
24. I like myself.
25. Disturbing thoughts come into my mind that I cannot get rid of.
26. I feel annoyed by people who criticize my drinking or drug use.
27. I have an unclean mouth.
28. I am not working/studying as well as I used to.
29. My heart pounds too much.
30. I have trouble getting along with friends and close relationships.
31. I am satisfied with my life.
32. I am usually in work/school because of drinking or drug use.
33. I feel that something bad is going to happen.
34. I have very much.
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
36. I feel nervous.
37. I feel my love relationship is full and complete.
38. I feel that I am doing well at work/school.
39. I have too many disagreements at work/school.
40. I feel something is wrong with my body.
41. I have a problem tolerating or avoiding sexual.
42. I feel hopeless.
43. I am satisfied with my relationships with others.
44. I am afraid enough at work/school to do something I might regret.
45. I have hallucinations.

**Total:**