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The Relationship Between Therapist Adverse Childhood Experiences, Personal Therapy, Resilience, and Treatment Outcomes

Elizabeth J. Nunez

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**The Relationship Between Therapist Adverse Childhood Experiences, Personal Therapy,
Resilience, and Treatment Outcomes**

Elizabeth J. Nunez

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**The Relationship Between Therapist Adverse Childhood Experiences, Personal Therapy,
Resilience, and Treatment Outcomes**

by

Elizabeth Nunez

has been approved

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Committee Members

Kenneth Logan, PsyD, Chair

Aundrea Paxton, PsyD, Member

Marie-Christine Goodworth, PhD, Member

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Abstract

With the development of the Adverse Childhood Experiences (ACE) questionnaire, Felitti et al. (1998) established that childhood trauma has a wide-ranging impact on adult health. Subsequent studies have identified a myriad of relationships between childhood adversity and negative physical, psychological, social, vocational, educational, and developmental outcomes in adulthood (Centers for Disease Control and Prevention, 2020; Hughes et al., 2017; Kalmakis & Chandler, 2015). New research has uncovered higher rates of ACEs among those in helping professions (Butler et al., 2018; Harris, 2019; Thomas, 2016), but it is unclear how these experiences impact their work as helpers. This study investigated the treatment outcomes of clients in simulation therapy at a university-based site in the Pacific Northwest. The researcher hypothesizes therapists would have higher rates of ACEs, that therapists with higher ACEs and high resilience would have better treatment outcomes and therapeutic alliances, and that therapists who had attended personal therapy would have higher resilience and better treatment outcomes. Results indicated therapists experience significantly higher rates of childhood emotional abuse and household mental illness and significantly lower rates of physical and sexual abuse. No significant relationship was found between therapist ACE scores, resilience, personal therapy attendance, and treatment outcomes. A small negative relationship between the quality of the therapeutic alliance and therapist resilience was found. Additionally, there was a small positive relationship between therapeutic relationships and treatment outcomes. Finally, no relationship was found between therapist personal therapy and level of resilience and better treatment outcomes. The implications of these findings are discussed.

Keywords: childhood adversity, adverse childhood experiences, therapeutic alliance, personal therapy, treatment outcomes, psychotherapy, resilience, therapist effects, therapist factors

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The Relationship Between Therapist Adverse Childhood Experiences, Personal Therapy, Resilience, and Treatment Outcomes

The impact of childhood adversity is a widely researched topic. With the development of the Adverse Childhood Experiences (ACE) questionnaire, Felitti et al. (1998) established that childhood trauma has a wide-ranging impact on adulthood health. In subsequent studies, researchers have identified a myriad of relationships between childhood adversity and negative physical, psychological, social, vocational, educational, and developmental outcomes (Centers for Disease Control and Prevention, 2020; Hughes et al., 2017; Kalmakis & Chandler, 2015). In recent years, researchers have begun to investigate the prevalence of ACEs in mental health providers, finding the rates of ACEs to be higher for those working in mental health (Butler et al., 2018; Esaki & Larkin, 2013; Harris, 2019; Keesler, 2018; Thomas, 2016). Although the impact of ACEs on adult functioning is well established, studies are only beginning to identify the effect of childhood adversity on the life and work of mental health clinicians specifically. This study seeks to determine whether therapist ACEs, resilience, and personal therapy has an impact on therapy outcomes.

Adverse Childhood Experiences

In their groundbreaking study of 9,508 adults, Felitti et al. (1998) identified ACEs, including experiences of abuse, neglect, and household dysfunction, and their relationship to health outcomes in adulthood. The researchers found that participant ACE scores are strongly related to the amount of risk behavior, health status, and disease they experience as adults. ACEs had a cumulative effect, with a greater likelihood of health risks and disease conditions occurring with higher rates of ACEs. There are a wide range of negative outcomes in adulthood for those with high ACE scores. Common outcomes include chronic health problems, mental illness,

substance abuse, increased high-risk behaviors, disruption in development, increased healthcare utilization, increased risk of violence, negative impact on educational and job opportunities, and early death (Centers for Disease Control and Prevention, 2020; Hughes et al., 2017; Kalmakis & Chandler, 2015). The Centers for Disease Control and Prevention report that Americans experience similar rates of ACEs today as reported by Felitti et al in 1998. Thirty-six percent of Americans surveyed have no history of ACEs, 26% experienced one ACE, 15.9% experienced two ACEs, 9.5% experienced three ACEs, and 12.5% experienced four or more ACEs (Centers for Disease Control and Prevention, 2021). Several studies have found higher rates of ACEs in those in the helping professions as compared to the national average, including among child service providers (Esaki & Larkin, 2013), direct support professionals (Keesler, 2018), and graduate students in the helping profession (Butler et al., 2018; Harris, 2019; Thomas, 2016). In her survey of masters of social work and doctor of clinical psychology students, Harris (2019) found a higher percentage of students (25.8%) on average endorsed four or more ACEs as compared to the general population (12.5%).

Resilience

Existing research consistently finds that therapists with a history of personal trauma are at higher risk of experiencing secondary and vicarious traumatization (Baird & Jenkins, 2003; Dagan et al., 2016; Esaki & Larkin, 2013; Nelson-Gardell & Harris, 2003; Trippany et al., 2003), yet among helping professionals, higher rates of ACEs were correlated with higher compassion satisfaction and lower rates of burnout (Hiles Howard et al., 2015). These results suggested there are more factors at play than first meets the eye. One such factor is therapist resiliency, defined as successful coping with stress or adversity (Connor & Davidson, 2003). Research on resiliency suggests there is a negative correlation between resilience and posttraumatic stress symptoms

(Connor & Davidson, 2003), and resilience mediates the relationship between ACEs and the development of posttraumatic growth (Yundt, 2019). One recent pilot study found among patients with high ACE scores, those with high levels of resilience experienced significantly fewer health problems than those with low levels of resilience (Ross et al., 2020). These findings suggest resilience can mediate the impact of ACEs on therapists. The benefits of resilience in therapists go beyond therapist health, as research suggests therapists with higher resilience pass on these benefits to their clients in the form of better treatment outcomes (Green et al., 2014; Pereira et al., 2017).

The Therapeutic Alliance

The quality of the working relationship between therapist and patient is the single most significant indicator of treatment outcomes (Lambert & Barley, 2001). Therapists must be adept at creating and maintaining a robust therapeutic alliance to effectively treat their patients; Yet those who have experienced ACEs are significantly more likely to experience interpersonal difficulties (Poole et al., 2018). It is unclear whether therapist history of ACEs impact the therapeutic alliance and outcome of their patients. In their review of the personal and professional characteristics of effective therapists, Heinonen and Nissen-Lie (2020) found that therapist use of avoidant coping strategies predicted poorer patient outcomes in short-term therapy. However, therapists who experienced more subjective difficulty in providing therapy, combined with constructive coping habits, had better client outcomes. The findings of this study suggest it is not the amount of difficulty experienced by the therapist that predicts patient outcomes but rather the way the therapist copes with the difficulties they experience. Therapist resiliency may play a role in mitigating whatever impact ACEs might have on therapeutic alliance. Even though therapists with ACEs may experience more personal difficulties that could

impact their interpersonal relationships in their work, greater difficulty alone does not suggest poorer client outcomes. If therapists with ACEs developed higher levels of resilience as a result of their experiences, we would expect them to be able to cope more successfully in the face of difficulty. Resilience and associated constructive coping skills may, in turn, lead to better treatment outcomes for the client (Heinonen & Nissen-Lie, 2020; Pereira et al., 2017).

Personal Therapy

Whether or not a therapist receives personal therapy impacts the therapeutic alliances that therapists form with their patients. Therapists receiving personal therapy rated their alliances with patients higher than those not receiving personal therapy, and their patients remained in treatment twice as long as those who did not receive personal therapy (Gold & Hilsenroth, 2009). These results suggest engaging in personal therapy impacts the therapist's clinical work. In a study of student therapists, the quality of the therapist's alliance in personal therapy correlated positively with the treatment outcomes of that therapist's patients, indicating better outcomes for patients when the therapist had a strong alliance in personal therapy (Gold et al., 2015). Although there is little research that suggests a direct correlation between therapists engaging in personal therapy and their patient's treatment outcomes, the benefits of personal therapy may impact client outcomes indirectly (Wigg et al., 2011). These impacts may be explained by strong and consistent support in the literature that personal therapy leads to gains in empathy and sensitivity toward clients and a greater emphasis on the therapeutic relationship (Orlinsky et al., 2011; Wigg et al., 2011), encouraging stronger therapeutic alliances and better treatment outcomes for those patients whose therapists engaged in personal therapy.

Present Study

Given that mental health workers experience high rates of childhood adversity and the profound impact that adversity has on later health and functioning, it is possible that these childhood experiences may impact a therapist's ability to create a strong therapeutic alliance with their patients. In research conducted on psychotherapy outcomes, the therapeutic alliance is a consistently strong predictor of positive treatment outcomes (Lambert & Barley, 2001). If this alliance is either bolstered or compromised by the therapist's traumatic experiences, it is possible clients will demonstrate variable outcomes as a result of engaging in treatment with that therapist. The level of resilience and whether the therapist engages in personal therapy may moderate any relationship between the ACEs of the therapist and their patient's treatment outcomes.

Hypotheses

H1: Therapists will have higher rates of ACEs than the general population.

H2: There will be a positive relationship between higher ACEs, higher resilience, and higher patient outcomes in patients (both overall session rating and symptom rating). Outcomes will be poorer for high ACEs and low resilience.

H3: Therapists with higher resilience will have a better therapeutic alliance and therapeutic outcomes.

H4: Therapists who have had personal therapy will have higher resilience than those who haven't had personal therapy, and will have higher therapy outcomes.

Methods

Participants

This study uses client outcome data collected from 56 undergraduate volunteers ages 18 to 24 years volunteering to be an analogue client for credit in an introductory course for

psychology at a private university in the Pacific Northwest. Therapist data was collected from 33 first-year clinical psychology doctoral students ages 21 to 50 years attending the same university. This study was approved by the Internal Review Board at George Fox University.

Therapist Population

Therapists in this study were doctoral students in their first year of a clinical psychology program who provided ten person-centered, telehealth-based psychotherapy sessions to either one or two undergraduate volunteers between February and April 2021. Each therapist participant completed the ACEs questionnaire, the CD-RISC, and answered questions relating to personal therapy attendance using an online survey platform. Informed consent was obtained before collecting therapist data. There were 12 male and 21 female-identifying participants. Two therapists were biracial, 29 were White, one was Hispanic, and one was Asian. Five therapist participants held a masters' degree in the field of counseling, mental health, or psychology, two held masters in other fields, and 26 did not hold a masters' degree prior to this study. Fifteen participants received personal therapy prior to entering the doctoral program, six were currently receiving treatment at the time they were surveyed, six received both current and past therapy, and six never received therapy.

Patient population.

Patients in this study were undergraduate volunteers who received 10 person-centered, telehealth-based psychotherapy sessions conducted by therapist participants. Consent to participate in research was provided prior to beginning treatment. Patients completed an outcome measure at the first and last session and a session rating measure on sessions two through nine. There were 23 male and 33 female-identifying patients, four biracial, 38 White, five Latino, five Asian, three Pacific Islander, and one participant with unknown ethnic origin.

Materials

The Outcome Rating Scale (ORS; Miller et al., 2003) is a brief treatment outcome measure. It is comprised of four 10-cm visual analog scales. The patient is asked to make a hash mark on a continuum, with negative responses on the left and positive responses on the right. Scales measure overall wellbeing, individual wellbeing, interpersonal wellbeing, and social wellbeing. Miller et al. (2003) reported internal consistency with a coefficient alpha of .93, an overall correlation of .59 with the Outcome Questionnaire-45.2, a mean of 22.3 and standard deviation of 8.5 for females, and a mean of 18.9 and standard deviation of 8.7 for males. The coefficient alpha for this study's sample was .81 for Client A pre-test, .85 for Client A post-test, .75 Client B for pre-test, and .94 for Client B post-test.

The Session Rating Scale (SRS; Duncan et al., 2003) is a brief measure of alliance meant to be used in every session as a clinical tool to address problems in alliance and encourage discussion of client disagreements with the therapist. It consists of four 10-cm visual analog scales. The patient is asked to make a hash mark on a continuum, with negative responses on the left and positive responses on the right. These scales measure the therapeutic relationship, the goals and topics addressed, the approach or method used by the therapist, and the client perception of the session in total. Duncan et al. (2003) reported the internal consistency using Cronbach's coefficient alpha to be .88, and test-retest reliability using the overall Pearson correlation coefficient to be .64. When limited to the first two administrations, researchers found a Pearson correlation coefficient of .70. The SRS has a correlation of .29 with the ORS, and concurrent validity of .48 with the Revised Helping Alliance Questionnaire.

The Adverse Childhood Experiences Questionnaire (ACE; Felitti et al., 1998) comprises 10 "yes"/"no" questions assessing childhood adversity in categories including household issues

and experiences of abuse and neglect. Scores range from 0–10, with higher scores indicating higher levels of adversity occurring before age 18 years. Higher scores are correlated with poorer health outcomes and increased risk of engaging in risky health behaviors (Felitti et al., 1998). Harris (2019) reported internal consistency with a coefficient alpha of .754, Esaki and Larkin (2013) reported with .734, and Keesler (2018) with .783. Dube et al. (2004) calculated the test-retest reliability, finding the kappa coefficient for emotional abuse to be .66, for physical abuse to be .55, for sexual abuse to be .69, for household substance abuse to be .75, for witnessing interpersonal violence to be .077, and the weighted kappa coefficient for the ACE score to be .64. The coefficient alpha from the original ACEs study ranges between .73 and .78 and for this study was .71.

The Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) consists of 25 items on a 5-point Likert scale (*not true at all, rarely true, sometimes true, often true, true nearly all of the time*) used to measure participant resiliency. The internal consistency reliability coefficient is .89 and the test-retest reliability coefficient is .87 (Connor & Davidson, 2003). Connor & Davidson report a mean of 77.1 and standard deviation of 16.3 for women and a mean of 77.2 and standard deviation of 14.2 for men across all study groups. The coefficient alpha for this study was .83.

Procedure

Therapists were recruited from a first-year clinical foundations course and analogue clients were recruited from an undergraduate introductory psychology course. Therapists completed 10, person-centered therapy sessions using telehealth technology. Patient ORS and SRS data were collected from clients by each therapist at the time of treatment. ORS data was collected at the first and last session and SRS data was collected from the second session through

the ninth session. Therapist ACE scores, CD-RISC scores, and personal therapy data were collected using Survey Monkey prior to sessions beginning. Therapists were asked to create a four-digit number in the survey to associate with the ORS and SRS patient data. The outcome data with the therapist generated code were collected by the course instructor who deidentified the data, leaving the code for this author to match the therapist survey data and client outcome data. One therapist provided client outcome data without the four-digit code and two therapists did not provide client outcome data to the course instructor. We were unable to match client data for these participants and removed this paired data from the study. Data for two 17-year-old patient participants were removed prior to analysis.

Results

Hypothesis 1

It was hypothesized that therapists in this study would have higher rates of ACEs than the general population. Therapist responses ranged from zero to seven total ACEs, with 22 participants reporting at least one ACE. Using the norm reference group from the original study, *z*-tests were completed to compare each of the 10 categories. Assumptions of normality were met. Therapists reported significantly higher rates of childhood emotional abuse and household mental illness, and significantly lower rates of childhood physical and sexual abuse, compared to general population. Therapist reports of childhood emotional or physical neglect, parental separation or divorce, mother treated violently, household substance use, and incarcerated household members were not significantly different from the general population (see Table 1).

Table 1

Percentages of Endorsed ACE Items From the PsyD Student Therapist Sample and the Kaiser ACE Study, and Group Differences (z-ratio)

ACE item	<i>n</i>	% of PsyD students	% Kaiser ACE study	<i>z</i> -ratio
1. Emotional abuse	10	30.3%	10.6%	3.667*
2. Physical abuse	4	12.1%	28.3%	-2.0617*
3. Sexual abuse	2	6.1%	20.7%	-2.0749*
4. Emotional neglect	7	21.2%	14.8%	1.0348
5. Physical neglect	5	15.2%	9.9%	1.008
6. Parental separation or divorce	8	24.2%	23.3%	0.1276
7. Mother treated violently	4	12.1%	12.7%	-0.1
8. Household substance abuse	11	33.3%	26.9%	0.8322
9. Household mental illness	15	45.5%	19.4%	3.7783*
10. Incarcerated household member	3	9.1%	4.7%	1.1893

* Indicates significance level of $p < .05$

Hypothesis 2

It was hypothesized there would be a positive relationship between higher therapist ACE scores, higher resilience, and better patient outcomes in patients. It was conversely hypothesized that outcomes would be poorer for therapists with higher ACEs and low resilience. The pre and post total scores of the ORS were calculated for each client. The difference between the post-ORS and the pre-ORS totals was then calculated for each client. Then the difference score for client A and B was averaged, resulting in one ORS change score per therapist. The ORS change score was used as an indicator of client outcomes for that therapist. The SRS scores for sessions 2 through 9 were totaled separately for Client A and Client B and then a mean was calculated using the total SRS scores of each client (see Table 2). The assumption of normal distribution has not been met for either ACE scores, Kolmogorov-Smirnov (27) = .22, $p = .002$, or resilience,

Kolmogorov-Smirnov (27) = .21, $p = .005$., both of which were positively skewed (ACEs skew = 1.05, Standard error of skew = .45; Resilience skew = .86, Standard error of skew = .45). The assumption of normality has been met for treatment outcomes, Kolmogorov-Smirnov (27) = .13, $p = .20$. A correlation analysis revealed no relationship between resilience and treatment outcomes ($r = .21$), a small negative correlation between the quality of the therapeutic alliance and resilience ($r = -.18$), and a small positive relationship between therapeutic relationships and treatment outcomes ($r = .17$; see Table 3).

Table 2

Descriptive Statistics

	<i>M</i>	<i>SD</i>	Min	Max
Resilience total	73.81	8.35	59.00	96.00
ACE total	2.10	2.08	.00	7.00
ORS average change	3.01	2.70	-4.50	8.00
SRS average	38.61	1.28	35.44	40.00

Table 3

Correlation Between Resilience, Therapist ACE Score, and Client Outcomes

	Resilience total	ACE total	ORS	SRS
Resilience total	--	-.03	.21	-.18
ACE total		--	-.20	.15
ORS			--	.17
SRS				--

Hypothesis 3

It was hypothesized that therapists with higher resilience will have better therapeutic alliance and therapeutic outcomes. Two linear regressions were completed to determine whether therapist resilience would be predictive. Results were nonsignificant for resilience predicting alliance and for resilience predicting therapy outcome.

Hypothesis 4

It was hypothesized that therapists who have had personal therapy will have higher resilience than those who haven't had personal therapy, and will have higher therapy outcomes as a result. An analysis of variance was conducted to compare participants who had experienced personal therapy versus those who had not on resilience and patient outcomes. The analysis of variances was not significant for resilience $F(1, 31) = .10, p = .76$ nor treatment outcomes $F(1, 25) = .40, p = .84$.

Further exploratory cluster analysis revealed two distinct groups within the client average ORS change, but analysis of variance was unable to account for these differences. Various variables were analyzed to assess what defines the two groups identified including: therapist or client gender, ethnicity, therapist total ACE score, therapist ACE item, resilience score, or participation in personal therapy (see Table 4). Comparison of the two ORS clusters found no significant differences between any of the variables.

Table 4

Cluster Analysis

Variable	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	Sig
Gender					
Group 1	1.65	0.49			

Variable	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	Sig
Group 2	1.57	0.53			
Total	1.63	0.49	1, 25	0.13	0.72
Ethnicity					
Group 1	1.05	0.51			
Group 2	1.43	1.13			
Total	1.15	0.72	1, 25	1.47	0.24
SRS Total Average					
Group 1	38.63	1.31			
Group 2	38.56	1.34			
Total	38.61	1.28	1, 22	0.01	0.91
Personal Therapy					
Group 1	1.15	0.36			
Group 2	1.14	0.38			
Total	1.14	0.36	1, 25	0.002	0.97
Resilience Total					
Group 1	74.45	7.60			
Group 2	72.00	8.94			
Total	73.81	7.86	1, 25	0.49	0.49
ACE Total Average					
Group 1	1.70	1.63			
Group 2	1.14	2.19			
Total	1.56	1.76	1, 25	0.51	0.48
ACE 1 Emotional abuse					
Group 1	0.15	0.37			
Group 2	0.29	0.49			

Variable	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	Sig
Total	0.19	0.40	1, 25	0.60	0.45
ACE 2 Physical abuse					
Group 1	0.05	0.22			
Group 2	0.00	0.00			
Total	0.04	0.19	1, 25	0.34	0.56
ACE 3 Sexual abuse					
Group 1	0.05	0.22			
Group 2	0.14	0.38			
Total	0.07	0.27	1, 25	0.62	0.44
ACE 4 Emotional neglect					
Group 1	0.25	0.44			
Group 2	0.00	0.00			
Total	0.19	0.40	1, 25	2.16	0.15
ACE 5 Physical neglect					
Group 1	0.15	0.37			
Group 2	0.00	0.00			
Total	0.11	0.32	1, 25	1.14	0.30
ACE 6 Parental separation or divorce					
Group 1	0.20	0.41			
Group 2	0.14	0.38			
Total	0.19	0.40	1, 25	0.10	0.75
ACE 7 Mother treated violently					
Group 1	0.05	0.22			
Group 2	0.14	0.38			

Variable	<i>M</i>	<i>SD</i>	<i>df</i>	<i>F</i>	Sig
Total	0.07	0.27	1, 25	0.62	0.44
ACE 8 Household substance abuse					
Group 1	0.25	0.44			
Group 2	0.14	0.38			
Total	0.22	0.42	1, 25	0.32	0.58
ACE 9 Household mental illness					
Group 1	0.50	0.51			
Group 2	0.14	0.38			
Total	0.41	0.50	1, 25	2.82	0.11
ACE 10 Incarcerated household member					
Group 1	0.05	0.22			
Group 2	0.14	0.38			
Total	0.07	0.27	1, 25	0.62	0.44

Discussion

The higher rates of ACEs in therapists found in the first hypothesis are consistent with the findings of other studies examining therapist ACE scores. LaNoue et al. (2020) found emotional abuse was perceived by participants as having the greatest impact in adulthood overall, with participants reporting both positive and negative consequences of these experiences. Of the ACEs, emotional abuse was found to be one of the three most negatively rated events following sexual abuse and neglect (LaNoue et al.,2020). It is not surprising that individuals who have experienced emotional trauma and mental illness in childhood would pursue careers in which these experiences could be transformed or utilized to help others. These findings suggest that

therapist trainees may be more familiar with these traumatic experiences, which could impact their therapeutic work in either positive or negative ways. This study identified significantly lower rates of childhood physical and sexual abuse in trainees as compared to the general population, suggesting that survivors of childhood physical and sexual abuse may be less likely to pursue a career in clinical psychology. Working in the field of clinical psychology relies heavily on the individual's ability to regulate their body, which is a skill that is particularly difficult to hone after experiences of physical and sexual abuse. Research has shown that trauma is experienced, processed, and stored in the body (Van der Kolk, 2015), and significantly impacts the nervous system (Porges, 2017). The embodied nature of experiences of physical and sexual abuse may present a barrier to self-regulation, making it more difficult for individuals with these experiences to enter the field of applied psychology.

Emotional abuse and mental illness often manifest themselves internally through symptoms such as anxiety, depression, low self-esteem, personality disorders, and health problems in adulthood (Yates, 2007). Due to the internal nature of these symptoms, emotional abuse is not as readily identified and treated as experiences of sexual and physical trauma. Trainees who grow up with a family member who manipulates, controls, humiliates, demeans, blames, intimidates, or coerces them may not identify these experiences as traumatic. Trainees may need more psychoeducation and guidance in recognizing the impacts of their personal adverse childhood history and encouragement to explore activities to support healing, such as personal therapy.

LaNoue et al. (2020) reported the ratings of impact predicted adulthood health outcomes are better than the ACE scores alone, which may suggest another psychological factor influencing the functioning of therapists with a history of ACEs. This current study explored two

such factors in therapists: (a) level of resilience and (b) participation in personal therapy. Though these factors did not account for differences in treatment outcomes, they may change the way a therapist sees the impact of these experiences and thus could alter their health outcomes in a way that benefits their clinical work. Since differences in therapists' attitudes, conceptions of therapeutic work, and conceptualization of clients have been shown to impact treatment outcomes (Heinonen & Nissen-Lie, 2020), the way therapists think about their ACEs may have a more significant impact on outcomes than the presence of ACEs alone.

The present study hypothesized that therapists with higher levels of resilience would receive higher scores in client-rated therapeutic alliance and treatment outcomes. Analysis using two stepwise hierarchical linear regressions first revealed a small negative relationship between the quality of the therapeutic alliance and resilience, then a small positive relationship between therapeutic relationships and treatment outcomes. However, the significance for both was very low. This may be due to ceiling effects of the SRS and ORS measures or the use of a non-clinical population that may have been limiting or not representative of a clinical population.

Additionally, factors unrelated to therapy, such as stress levels and confounding factors like administering outcome measures at the beginning and end of the college semester, could have influenced these findings. The relationship between therapeutic relationship and treatment outcome was expected given the consistent, strong relationship found in Lambert and Barley's (2001) metaanalysis. However, the negative relationship between therapeutic alliance and resilience found in the present study was surprising given Lambert and Barley's (2001) findings and the research of Green et al. (2014) and Pereira et al. (2017) suggesting therapists with higher resilience had better treatment outcomes. It is difficult to assess what contributed to this outcome, but one explanation may be that the present study utilized a subjective measure of

resilience that could have been affected by the timing of administration. Therapist participants were in their first year of training, a developmental period in which they may be more likely to question their competence and experience lower self-efficacy, which could have influenced their ratings.

The present study hypothesized that therapists who have had personal therapy will have higher resilience than those who haven't had personal therapy, and will therefore have better therapy outcomes. Results indicated there was no relationship between either personal therapy attendance and resilience nor in therapy outcomes. Unfortunately, the data was limited by the varied level of specificity in the therapist's response to this question. As a result, the researcher was only able to identify whether the person attended therapy at some point but was unable to learn valuable details of the therapy (e.g., number of sessions attended, therapeutic orientations) that may have led to more clarity.

Limitations of the Study

One limitation of this study is the lack of a normal distribution and a positive skew toward lower scores for resilience and ACEs. Additionally, data was collected in January through April 2021 during the COVID-19 pandemic. The ORS measure was completed by client participants at the beginning and end of an academic school semester, which could have impacted the responses of both participant groups. For example, participants may have experienced higher rates of stress related to final exams, papers, and projects at the end of the semester in addition to the impacts of the COVID-19 pandemic, leading to lower outcome scores than during a time of reduced stress. Another limitation of this study is that it utilized a non-clinical client population who volunteered for class credit; these students may experience comparatively low distress and decreased motivation to engage in therapy as compared to a

clinical population. The therapists in this study were first-year student therapists from one clinical psychology doctoral program who may have varied from students in other degree programs and in previous clinical experience and skills.

Future Areas of Research

Future areas for research include exploring the impact of adulthood trauma on therapists and a study utilizing a clinical population with therapists at a variety of training levels. Despite the absence of a direct relationship between therapist resilience and client outcomes in this study, the study of Resilience Protective Factors in combination with ACE scores may provide a more nuanced relationship between therapist resilience, ACE scores, and client outcomes. Powell et al. (2020) finds the Resilience Protective Factors Checklist measure of family protective factors moderated the impact of ACEs on social relationships, stating, “the impact of ACEs on social relationships changed from negative to positive at higher scores of RPFC [Resilience Protective Factors Checklist] family protective factors” (“Discussion,” para. 2). The relationship may have implications for therapists who have family support in childhood, moderating the impact of ACEs on their development and training in such a way that alters their work as therapists and thus the outcomes of their clients.

Another direction of continued research includes examining client ACE scores and level of resilience. Investigating Client ACEs and resilience would help determine any role these factors might play in the relationship between therapists with ACEs and their clients. Future studies should also include assessment of participants' perception of their abuse experience. The current study was limited to 10 childhood experiences and did not include adulthood trauma and other experiences of childhood trauma. Further study may clarify the influence of other

experiences of trauma in childhood and adulthood. Finally, the use of more objective measures related to outcomes, ACEs experience, and resilience may help to give more robust data.

Final Takeaways

With the knowledge that therapist trainees are prone to certain ACEs and less prone to other comes, there is an imperative need for trauma-informed teaching and training. Special consideration should be placed on addressing the impact of emotional abuse and exposure to mental illness on trainees, particularly considering LaNoue et al.'s (2020) finding that emotional abuse was perceived to have the biggest impact on participants. It may be beneficial for trauma training to include more extensive training in the areas of sexual and physical trauma when considering the low rates of sexual and physical abuse found in this study. Most notably, the lack of a relationship between therapist ACEs, therapy relationships, and outcomes suggests that trainees who have experienced higher levels of ACEs are no less effective than their peers with lower ACEs. Though the factors impacting the conceptualization and processing of trauma experienced by trainees remain unclear, what is clear is therapists can overcome adverse experiences to become effective clinicians.

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Appendix A

Informed Consent for Participation in Research

This study has been created to understand the influence of therapist childhood adversity, resilience, and personal therapy in psychotherapy. If you feel uncomfortable at any time during this survey, you may discontinue. Your participation and answers will remain entirely anonymous throughout the course of this study and after the completion of this study, and the lead researcher will not know the identity of those who participated. Data use policies will be practiced to ensure the anonymity of all participants. The survey will take an approximate 5-10 minutes to complete. Your participation in this study is beneficial for the training of future psychologists. You are helping researchers better understand factors influencing the therapeutic relationship and treatment outcomes. By beginning this survey, you consent your answers are truthful and are your own experience(s). Further, by completing this survey and subsequently submitting it, you consent your answers may be used for research purposes.

If you have any questions, comments, or concerns regarding this research, please contact the lead investigator, Elizabeth Nunez, MA at enunez15@georgoefox.edu or the faculty supervisor, Marie-Christine Goodworth, PhD at mgoodworth@goergefox.edu at George Fox University Graduate School of Clinical Psychology, 414 N Meridian St. V104, Newberg, OR, 97123. This research study has been reviewed and approved by the Human Subjects Review Board (HSRB) at George Fox University. For research problems or questions regarding subjects, the HSRB may be contacted through Dr. Chris Koch at ckoch@georgefox.edu.

Appendix B

Client Informed Consent

GRADUATE DEPARTMENT OF CLINICAL PSYCHOLOGY

GEORGE FOX UNIVERSITY

CONSENT TO PARTICIPATE IN REMOTE PSYCHOTHERAPY

For our simulated psychotherapy this year we will be using Zoom as our platform. It is important to know that these are not HIPPA compliant and thus we cannot guarantee complete confidentiality. The likelihood of anyone hacking into your session is extremely low. Because this is simulate psychotherapy, sessions can be held using telehealth even if you are outside the state of Oregon. This would not be the case for therapy with a licensed therapist.

Your therapist (a graduate student) is receiving close supervision and oversight in accordance with legal and ethical standards. As such, he or she is expected to follow the direction and guidance of these supervisors. Your therapist will share information about you and the therapy sessions in supervision; however, since this is a professional relationship, extreme caution will be used to protect your privacy by not sharing your name or identifying information beyond those with a need to know. To assist in the supervision process your sessions will be recorded, and reviewed by the supervisors before being destroyed. As well, your outcome rating scores and session rating scores will be used for further research, however, no identifying information will be included.

It is very important that confidentiality is maintained in this experience, yet there are exceptions to the rule of confidentiality. Confidentiality may be broken if:

- You appear to become suicidal or threaten to harm yourself.
- You threaten to harm another person.
- You are unable to care for your basic physical needs.
- You report that a child or elder is or has been abused (physically, emotionally, or sexually).

Please do not leave messages at the HCC or BCH for your therapist. Instead, please use the number provided to you by your therapist to contact them. You may also contact your therapist's primary supervising TA _____ (name of supervising TA) or the Associate Director of Clinical Training for the psychology program (Dr. Aundrea Paxton: 503-554-2386) with questions or concerns.

I, _____, have read and understand the above, and consent to participate in simulated psychotherapy during this semester. I give my consent to participate in telehealth session. I understand that Zoom cannot be guaranteed to be fully confidential.

Signature: _____

Date: _____

Graduate Student Therapist Signature: _____

Appendix C

Demographics

1. What is your current age? _____
2. How old were you when you completed a practicum at the Behavioral Health Center at George Fox University? _____
3. Gender:
 - a. Male
 - b. Female
 - c. Gender Queer
 - d. Transgender Male/Transwoman/FTM
 - e. Transgender Female/Transwoman/MTF
 - f. Other (please specify _____)
 - g. Prefer not to say
4. Ethnicity:
 - a. White
 - b. African American
 - c. Latino or Hispanic
 - d. Asian
 - e. American Indian or Alaska Native
 - f. Native Hawaiian or Pacific Islander
 - g. Middle Eastern/Arabic
 - h. Biracial (please specify)_____
 - i. Unknown
 - j. Prefer not to say
 - Other (please specify) _____
5. Did you provide psychotherapy at the BHC as a practicum student or a supplemental practicum student?
 - a. I provided psychotherapy as a practicum student.
 - b. I provided psychotherapy as a supplemental practicum student.
6. In what year of your training were you when you provided psychotherapy at the Behavioral Health Center at George Fox University?
 - a. Second Year/Practicum I
 - b. Third Year/Practicum II
 - c. Fourth Year/Pre-internship
 - d. Fifth Year/Internship
 - e. I provided psychotherapy at the Behavioral Health Center, but it was not a part of practicum experience.
7. Did you hold a Master's Degree prior to conducting therapy at this site?

- a. Yes, I held a Master's degree in the field of counselling, mental health, or psychology.
 - b. Yes, I held a Master's degree in another field unrelated to counselling, mental health, or psychology.
 - c. No, I did not have a Master's degree prior to conducting therapy at this site.
8. What Theoretical orientation did you work from while conducting therapy at the Behavioral Health Center?
 - a. Person Centered
 - b. Psychodynamic
 - c. Cognitive Behavioral Therapy Wave 2
 - d. Cognitive Behavioral Therapy Wave 3
 - e. Other
9. What kind of supervision did you receive while at this cite? Check all that apply.
 - a. Licensed Psychologist
 - b. Licensed Mental Health Professional
 - c. Clinical Psychology Intern
 - d. Clinical Psychology Post doc
 - e. Other (specify)_____
10. How satisfied were you with the supervision you received while at the BHC?
 - a. Very highly satisfied
 - b. Highly satisfied
 - c. Slightly Satisfied
 - d. Neutral
 - e. Slightly dissatisfied
 - f. Dissatisfied
 - g. Very Dissatisfied
11. Did you receive personal therapy prior to or concurrent with your BHC practicum?
 - a. I received personal therapy prior to my BHC practicum
 - b. I received personal therapy concurrent with my BHC practicum
 - c. I received personal therapy both prior to and concurrent with my BHC practicum
 - d. I did not receive personal therapy either prior to or concurrent with my BHC practicum
12. How satisfied were you with the therapy you received prior to or concurrent with your BHC practicum?
 - a. Very highly satisfied
 - b. Highly satisfied
 - c. Slightly Satisfied
 - d. Neutral
 - e. Slightly dissatisfied
 - f. Dissatisfied
 - g. Very Dissatisfied

- h. N/A
13. Did you receive spiritual direction prior to or concurrent with your BHC practicum?
- a. I received spiritual direction prior to my BHC practicum
 - b. I received spiritual direction concurrent with my BHC practicum
 - c. I received spiritual direction both prior to and concurrent my BHC practicum
 - d. I did not receive personal therapy either prior to or concurrent with my BHC practicum
14. Were you required to receive spiritual direction during your BHC practicum?
- a. I completed spiritual direction as a program requirement
 - b. I completed spiritual direction, but it was not required by my program.
 - c. N/A
15. How satisfied were you with the spiritual direction you received prior to or concurrent with your BHC practicum?
- a. Very highly satisfied
 - b. Highly satisfied
 - c. Slightly Satisfied
 - d. Neutral
 - e. Slightly dissatisfied
 - f. Dissatisfied
 - g. Very Dissatisfied