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Changes in narrative quality pre- and post-emotion focused therapy for childhood abuse trauma

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CHANGES IN NARRATIVE QUALITY PRE- AND POST-
EMOTION FOCUSED THERAPY FOR CHILDHOOD ABUSE TRAUMA

By

Elisabeth Künzle

B.Sc. University of Alberta, 2005

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Abstract

The present study sought to test a theory that the quality of narratives written by adult survivors of childhood abuse would improve after undergoing Emotion Focused Therapy for Trauma (EFTT; Paivio et al., 2008), and that improvement in quality would be associated with trauma resolution. Pre- and post-therapy narratives of 37 subjects participating in EFTT were analyzed for incoherence, positive and negative emotion words, temporal orientation, and depth of experiencing. Results showed a significant increase in positive emotion words, present/future orientation, and depth of experiencing, but the improvement in quality was not associated with trauma-related therapy outcome. Pre-therapy negative emotion words and depth of experiencing were associated with degree of abuse resolution, and pre-therapy incoherence was associated with post-therapy PTSD symptoms. These results support a theory that unresolved trauma disrupts narrative quality, and further suggest that trauma narrative quality provides useful information about client capacity for change in EFTT.

Dedication

This thesis is dedicated to my partner, Ryan Mundorf, who has been an unwavering source of encouragement and support as I developed this thesis over the past two years. Thank-you for helping me to keep balance in my life, and for consistently letting me know how much you love and support me.

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CHAPTER I

Introduction

Objectives

The present study examined changes in the quality of trauma narratives written by adult survivors of childhood abuse (emotional, physical, sexual) before and after Emotion Focused Therapy for Trauma (EFTT; Paivio, Chagigiorgis, Hall, Jarry, & Ralston, 2008). EFTT focuses on exploring emotions, resolving issues with abusive and neglectful others, and creating a more adaptive meaning of the traumatic event. It has been shown to be an effective treatment for child abuse trauma (Paivio et al., 2008). Secondly, this study examined the association between change in narrative quality and therapy outcome. Trauma narratives were examined for changes in the level of client experiencing, proportion of positive and negative emotion words, degree of coherence, and temporal orientation.

Rationale for the Study

The prevalence of child abuse is high both in the general population and among people with psychological problems. Thirty percent of women and forty percent of men report experiencing at least one type of abuse (physical, emotional, sexual) during their childhood (Scher, Forde, McQuaid, & Stein, 2004). Further, the majority of instances of child abuse are perpetrated by a parent (Trocme, McPhee, & Kwok, 1995), a trend that highlights the importance of treatments such as EFTT that focus on resolving issues with childhood attachment figures. Repeated experiences of abuse in childhood are known to result in more severe disturbances in adulthood than single traumatic experiences (Herman, 1992). In particular, because traumatic experiences result in confusing and

emotionally painful information about the world, individuals with unresolved trauma have difficulty making sense of traumatic experiences and their associated emotions. It is suggested that difficulties making sense of the trauma and integrating it into the overall fabric of their life would be evident in the quality of trauma narrative. Narratives written by child abuse victims about their traumatic experiences would be expected to have an impoverished quality, lacking in emotional expression and exploration of meaning for the traumatic event. Thus, the trauma narrative would serve as an indicator of disturbance. Previous research has demonstrated a connection between trauma narrative quality and degree of trauma symptoms (Foa, Molnar, & Cashman, 1995).

Successful exploration of underlying meanings and emotions connected to the trauma is considered to be an important aspect of recovery, as it allows the victim to become aware of their painful emotions and to access information about their previously unmet needs. Exploration of this information contributes to the creation of a new, more adaptive meaning of the traumatic event, and a greater understanding of how the experience fits with one's sense of identity (Greenberg & Paivio, 1997). It is expected that successful resolution of trauma issues would result in a more complete understanding of the self and the traumatic event, and that this change in perspective would be reflected in trauma narratives. The present study seeks to test this theory, by examining the quality of trauma narratives for victims of childhood abuse who have undergone EFTT. Given the focus in EFTT on constructing new meaning and the evidence for its efficacy (Paivio et al., 2008), it is expected that the quality of narratives would improve from pre- to post-therapy, reflecting an association between resolution of child abuse issues and the capacity to form personally meaningful narratives of the traumatic event.

Overview of Literature Review

The following literature review begins with a description of the prevalence and long-term consequences of childhood abuse, followed by sources of disturbance and a description of disturbances that are experienced in adulthood. An overview of theories of narrative construction in healthy individuals will be presented, followed by an explanation of how this process is disrupted for victims of childhood abuse. Treatments for victims of childhood abuse trauma that focus on meaning reconstruction will briefly be reviewed with a particular emphasis devoted to Emotion Focused Therapy for Trauma (Paivio et al., 2008), which is the type of therapy used in the present study. Finally, various aspects of narrative quality that have been studied will be reviewed, with a description of the narrative qualities that were selected for examination in this study.

CHAPTER II

Literature Review

Childhood Abuse

Childhood abuse has been defined in various ways but is generally agreed-upon as being an unwanted experience in childhood perpetrated by an adult, causing physical and/or psychological harm. Childhood sexual abuse can be defined as a child experiencing unwanted sexual activities in which there is a large age or maturational difference between the child and perpetrator, a relationship of authority or caregiving, or the use of force, coercion or trickery to carry out the activities (Banyard, Williams, & Sieger, 2001; Finkelhor, 1994a). Sexual activities may or may not include physical contact between child and perpetrator, and may range from activities involving penetration, to non-penetrative fondling and sexual kissing, to non-contact exhibition or verbal harassment and propositions (Finkelhor, 1994a).

Physical abuse may be defined as a non-accidental injury to a child resulting from an act of physical violence or excessive punishment on the part of an adult and resulting in demonstrable harm or endangerment to the child (Malinosky-Rummell & Hansen, 1993). Emotional abuse is less clearly defined, but includes instances in which a child experiences chronic verbal derogation by a caregiver, is repeatedly threatened with physical injury, or witnesses repeated or prolonged violence between caregivers (Banyard, Williams, & Sieger, 2001; Dube et al., 2005; Paivio, Hall, Holowaty, Jellis, & Tran, 2001).

Prevalence of Childhood Abuse

A substantial proportion of the population has experienced childhood abuse. A recent study examining retrospective reports of childhood maltreatment in an adult community sample found that over one third of respondents (35%) had experienced at least one form of childhood maltreatment, whereas 13% had experienced more than one form of maltreatment (Scher et al., 2004). Estimates for different types of abuse vary considerably across studies. This is suggested to be due to differing definitions of what constitutes abuse, differing definitions of "child," and differences in samples, study designs, and measurement techniques (Goldman & Padayachi, 2000). A recent study of the prevalence of childhood abuse in Ontario reported estimated rates of sexual abuse at 13% for women and 4% for men, and physical abuse at 21% for women and 31% for men (MacMillan et al., 1997). A study of a large community sample in the United States indicated rates of sexual abuse at 32% for women and 14% for men, and physical abuse at 20% for women and 22% for men. Twenty-one percent of respondents in this study reported having experienced more than one form of childhood abuse (Briere & Elliott, 2003). International estimates of the prevalence of sexual abuse range from 7 to 36% for females and 3 to 29% for males (Finkelhor 1994). Fewer studies have examined the prevalence of emotional maltreatment, but recent estimates range from 12% in a community sample of adult men and women (Scher et al, 2004) to 25% of women and 35% of men in a sample of Ontario university students (Turner & Paivio, 2002). Thus, despite some variability in estimates, there is considerable evidence that large numbers of children are exposed to some form of child abuse trauma.

Childhood Abuse and Psychological Outcomes

A history of childhood abuse is also highly prevalent in clinical samples. Studies have shown that 50 to 60% of psychiatric inpatients and 40 to 60% of outpatients report histories of childhood physical or sexual abuse or both (Herman, 1992). Prevalence rates as high as 90% have been reported among specific diagnostic groups (Pilkington & Kremer, 1995). Child abuse has been associated with a wide range of psychiatric problems, including posttraumatic stress disorder, major depression and other mood disorders, drug dependence, alcohol dependence, bulimia nervosa, panic disorder, social anxiety, phobias, conduct disorder, anger problems, attempted suicide, physical symptoms, and ill health (Borger, Cox, & Asmundson, 2005; Putnam, 2003; Springer, Sheridan, Kuo, & Carnes, 2007). Higher levels of symptomatology have been associated with abuse involving multiple perpetrators, the use of force or threat of harm, greater emotional distress at the time of the abuse, and multiple forms (physical, sexual, emotional) of abuse (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Briere & Elliott, 2003; Hunter, 2006; Malinosky-Rummell & Hansen, 1993).

Sources of Disturbance in Childhood Abuse

There are several factors associated with the experience of childhood abuse that result in more severe outcomes than single incident trauma in adulthood. Childhood abuse consists of repeated exposure to trauma, resulting in negative consequences for psychological health. Additionally, because childhood abuse occurs in the context of attachment relationships (abuse perpetrated by parents and caregivers) there are severe consequences for the child's developing sense of self and others, and few opportunities to develop emotion-regulation skills. This deficit often leads to the development of

maladaptive avoidance strategies in order to cope with overwhelming emotion. Finally, abuse from parents teaches the child that close, intimate relationships are associated with pain and fear, leading to difficulties in developing and maintaining healthy interpersonal relationships in adulthood. The following sections describe the primary sources of disturbance associated with child abuse trauma.

Exposure to trauma. Exposure to child abuse trauma is associated with an increased risk of developing posttraumatic stress disorder (PTSD) later in life. One study found that individuals with a history of childhood abuse were 1.75 times more likely to develop PTSD after a traumatic event in adulthood than individuals with no such history (Widom, 1999). Characteristic symptoms of PTSD include persistent re-experiencing of the traumatic event, physiological reactivity to cues that symbolize or resemble the traumatic event, persistent avoidance of stimuli (e.g. thoughts, feelings, people, and places) associated with the trauma, numbing of general responsiveness (e.g. diminished interest in activities, feelings of detachment, restricted range of affect), and persistent symptoms of increased arousal and hypervigilance (American Psychiatric Association, 2000). By definition, traumatic events confront individuals with high levels of stress and unfamiliar situations (Tuval-Mashiach et al., 2004). Trauma disrupts a person's sense of what to expect from the world, casting doubt on previously held assumptions about one's life and identity (Crossley, 2000). The victim may question their own efficacy and worth, and abandon their view of the world as an orderly, predictable, safe place (Harber & Pennebaker, 1992). As such, it may be difficult for the trauma victim to integrate the information from this stressful life event into a coherent part of their life-story.

Duration of the abuse. Complex or Type II trauma is the term used to identify the experiences of prolonged or repeated instances of trauma or victimization, for example, those of prisoners of war, hostages, victims of domestic violence, and victims of childhood abuse. Because they have endured repeated instances of trauma, they can demonstrate a more complex constellation of disturbances than simple PTSD which is typical of victims of a single traumatic experience (Herman, 1992). These disturbances include difficulties in regulating emotional arousal (e.g. difficulty modulating anger, self-destructive and suicidal behaviours), alterations in consciousness (e.g. amnesia and dissociation), somatization, maladaptive perceptions of self (e.g. chronic guilt, shame, self-blame), difficulties in relationships with others (e.g. withdrawal, distrust, revictimization), and an inability to create or accept systems of meaning (e.g. hopelessness, loss of previous beliefs) (van der Kolk, 1996b). The context of childhood abuse is one in which the victim is exposed to a constant threat of danger and lack of safety, and recent research confirms the view that a longer history of abuse is also associated with more severe outcomes. For example, Briere and Elliott (2003) found that a greater number of abuse incidents among victims of childhood physical and sexual abuse is associated with higher levels of trauma symptomatology.

Additionally, the constant unpredictability and lack of safety for the victim in the abusive environment may lead to a sense of hypervigilance and arousal. Because the victim's safety and survival may depend on his ability to predict his abuser's mood states or needs, a child being abused often becomes highly externally vigilant to indicators of impending abuse or danger, often at the expense of attending to his own internal experience (Briere, 1996). This focus on the external environment as a means of survival

draws energy away from the child's developmental task of acquiring self-awareness, resulting in limited understanding and awareness of his own needs and emotions (Briere, 1992).

Overwhelming emotion. The chronic threat of violence during childhood can result in extreme emotional arousal which becomes embedded in memory (van der Kolk, 1996a). This overarousal can be re-triggered later in life by stimuli that call to mind the trauma memory, and the emotions associated with the traumatic event become re-activated as part of the memory's network of associated meaning (Horowitz & Reidbord, 1992). This results in symptoms of intrusion and arousal that are characteristic of PTSD. Furthermore, chronic physiological arousal can affect the victim's capacity to use emotions as signals to promote adaptive action. Because emotional arousal becomes associated with non-threatening stimuli that merely resemble the trauma memory, the adult trauma survivor cannot depend on his emotions to alert him to important environmental information. Emotions thus no longer serve as driving forces toward adaptive action, but are instead experienced as overwhelming reminders of the experience of trauma (van der Kolk, 1996a).

Attachment injuries and the developing sense of self. Furthermore, the experience of childhood abuse occurs in the context of early attachment relationships, with the abuse perpetrated by a parent, stepparent, or another trusted adult in the child's life. One study reported that 48% of cases of reported abuse or neglect were perpetrated by the victim's mother, and 43% by the victim's father or stepfather (Trocme et al., 1995). Several studies have shown that greater long-term harm to the victim is associated with abuse involving a parent. For example, Briere and Runtz (1988) observed greater levels of

anxiety, dissociation, and somatization in women whose childhood victimization had involved parental incest than victims who had experienced extrafamilial childhood sexual abuse. It has been suggested that abuse between a parent and child involves a greater sense of betrayal and loss of trust than if the abuse is perpetrated by someone else (Beitchman et al., 1992).

Attachment theory suggests that a person's sense of self develops in childhood through interactions with his primary caregivers (Bowlby, 1988). When a parent reflects back the child's feelings, responds to his needs, and treats him in a positive, caring manner, the child learns that his feelings are acceptable, his needs legitimate, and that he is a worthwhile and positive person (Briere & Scott, 2006). These early experiences with significant others are embedded in memory and form the basis of a person's sense of self and expectations of others (Bowlby, 1988). By contrast, the context of childhood abuse and neglect is generally indicative of a family environment rife with instability and little available emotional support (Friedrich, Beilke, & Urquiza, 1987; Horwitz, Widom, McLaughlin, & White, 2001). The child's feelings and needs for security, autonomy, and love are often ignored, invalidated, or violated. These negative and invalidating experiences in the context of early attachment relationships can have a profound influence on the developing sense of self. The abused child is thought to develop a sense of self as powerless, worthless, or bad, and others as unreliable, unsupportive, or dangerous, leading to later problems with self-esteem, self-identity, and interpersonal intimacy and trust (Herman, 1992; Liem, O'Toole, & James, 1996). Furthermore, the victim may directly receive negative messages from the abuser, communicating that the victim deserved or is to blame for the abuse. These negative and judgmental messages

may become internalized, resulting in feelings of guilt, shame, self-blame, and low self-esteem (Browne & Finkelhor, 1986).

While attachment theory is primarily concerned with the developing relationship between infants and their caregivers, it still has important implications when children are abused at an older age. Alexander (1992) suggests that sexual abuse often develops out of the context of an insecure parent-child attachment and that a disturbance in attachment is often associated with limited capacity to meet one's needs, monitor oneself, or seek help to stop abuse. Thus, whether abuse occurs in early or later childhood, children who have never developed a secure attachment bond with a caregiver are likely to have limited emotional resources to cope with the trauma of abuse. There have been inconsistent findings regarding whether the age at which a child is first abused is related to the severity of outcomes in adulthood. (Briere & Runtz, 1988). Furthermore, confounding variables such as the child's relationship to the abuser and duration of the abuse may make it more difficult to identify a clear trend (Beitchman et al., 1992). Thus, abuse at any stage of childhood may be associated with a disrupted parent-child attachment relationship and should be regarded as potentially damaging to the child's emotional health.

Attachment and emotion regulation. Secure early attachment relationships between children and their parents are also crucial in the development of healthy emotion regulation skills, self-confidence, and interpersonal trust. Early in life, communication between infant and caregiver occurs solely through emotional expression, and communication of emotions continues to be an integral part of intimate relationships throughout life (Bowlby, 1988). Having parents who empathically mirror their emotions

allows children to learn to recognize, label, and describe their own emotional experience. This consistent support from parents and caregivers allows children to learn to comfort and soothe themselves, and to seek out comfort from others later in life (van der Kolk, 1996b). By contrast, abusive environments provide the child with few opportunities to communicate, receive support for, come to understand and appropriately express emotional experiences. As a result of this invalidation and lack of support, these children often learn few skills for identifying and managing intense emotional reactions and are more likely to "shut down" to avoid experiencing the intense feelings of anger, shame, guilt, and fear associated with the abuse.

Avoidance as a coping strategy. Child abuse survivors may come to rely on avoidance strategies to cope with these intense and painful feelings and memories. For example, self-destructive behaviours such as substance abuse, suicidal ideation and self-injurious behaviours have been found to be associated with a history of childhood abuse (Browne & Finkelhor, 1986; Hunter, 2006; Paivio & McCulloch, 2003) as have avoidance strategies such as dissociation and somatization (Briere & Runtz, 1988). These behaviours may develop as a means for coping with high levels of internal distress and emotional arousal. Chronic avoidance of emotions causes the individual to become cut off from core feelings and needs that define the self (Bowlby, 1988). This prevents the successful emotional processing of abuse-related memories which is considered essential to resolution of trauma (Foa, Rothbaum, Riggs, & Murdock, 1991). Pennebaker's research suggests that inhibition of thoughts, feelings and behaviours associated with significant events is associated with health risks and physical symptoms (for an overview, see Harber & Pennebaker, 1992). This research suggests that active inhibition of thoughts

and feelings about a significant life event prevents individuals from fully processing the event. This failure to translate one's inner experience into language prevents the individual from fully understanding the event and inhibited emotions may eventually surface in the form of ruminations, dreams and other intrusive cognitive symptoms (Harber & Pennebaker, 1992). Creation of new meaning occurs by reflecting on what has occurred and developing a narrative of how the experience fits with or changes one's identity (Greenberg & Paivio, 1997). Avoidance of emotions associated with traumatic events prevents this process from occurring, resulting in unresolved trauma and continued distress.

Attachment relationships as interpersonal models. Finally, early experiences with caregivers serve as models for the child's future interpersonal relationships. Object relations theories suggest that early experiences with adult caregivers form the basis for mental representations of self and others that are created early in life (for an overview, see Ornduff, Kelsey, & O'Leary, 2001). These early encounters form an internal template for social behaviours through which future interpersonal interactions are interpreted. Early maltreatment by caregivers therefore results in maladaptive object relations that may render these individuals more vulnerable to future relationship dysfunction. In particular, attachment relationships in the context of childhood abuse may lack the establishment of basic trust, appropriate interpersonal boundaries, and flexibility, thus leading to maladaptive relationship patterns that persist into adulthood (Elliott, 1994).

Research has shown that adult survivors of childhood abuse are likely to experience feelings of isolation, stigma, and low self esteem, which may contribute to interpersonal problems, problems in intimate relationships or marriages, difficulty

trusting others, and poor social judgment (Browne & Finkelhor, 1986; Cloitre,

Scarvalone & Difede, 1997; Ornduff et al., 2001; Scoboria, Ford, Lin, & Frisman, 2006).

Relationship violence in adulthood is also associated with a history of childhood abuse.

Survivors of both childhood sexual and physical abuse are at greater risk than their

nonabused peers for revictimization by an intimate partner in adulthood (Browne &

Finkelhor, 1986; Hunter, 2006). Problems with anger control, antisocial behaviours, and

committing acts of violence toward one's children and dating partners or spouses are

associated specifically with a childhood history of physical abuse, particularly among

males (Malinosky-Rummell & Hansen, 1993; Springer et al., 2007).

Levitt and Cloitre (1995) suggest that interpersonal schemas developed in

childhood lead survivors of abuse to have negative expectations about relationships.

Through their childhood experiences, these individuals learn that to be in a relationship is

to be abused, which may lead them to engage in (or be less likely to leave) hurtful

relationships. Russell (1986) suggests that these individuals may have an impaired ability

to judge the trustworthiness of others, which may make them more vulnerable to abuse.

Furthermore, feelings of powerlessness and helplessness that originate in childhood may

persist in adulthood and prevent the survivor from avoiding revictimization (Briere,

1996).

It is important to note that not all victims of childhood abuse experience negative

outcomes in adulthood. Approximately one-third of childhood sexual abuse survivors

demonstrate few or no symptoms following the experience of trauma (Finkelhor, 1990;

Kendall-Tackett, Williams, & Finkelhor, 1993). Research on protective factors and

resiliency after abuse has identified a number of important factors that are associated with

more positive outcomes after abuse. These include having contact with a supportive caregiver or adult, a stable and cohesive family environment, an internal locus of control, an external locus of blame for the abuse, the ability to positively reframe events, and being aware of having positive social support (Hunter, 2006; Liem, James, O'Toole, & Boudewyn, 1997; McClure, Chavez, Agars, Peacock, & Matosian, 2008; Pepin & Banyard, 2006).

As reviewed above, a history of childhood abuse is often associated with significant disturbances in adulthood, in particular, impairments in sense of self, interpersonal relating, and general mental health. Recurrent negative experiences of childhood that are integrated into the child's sense of self and view of the world will have a great impact on the meaning the victim makes of the abuse they have suffered, and it is suggested that this disrupted sense of meaning will be reflected in the victim's personal narrative of trauma. The following section will review the concept of personal narratives, which are the means through which individuals come to understand themselves and their lives, and will discuss the consequences of trauma on narrative quality.

<div align="center">The Creation of Personal Narratives</div>

Definition of Narrative

Narratives can be defined as privately constructed, storied accounts of an experience or of one's life (Hoshmand, 2005). Distinct from other forms of communication, events in a narrative are selected, organized, and connected in such a way to be meaningful for the audience of the narrative (Riessman & Quinney, 2005). In other words, narratives have plots, in which events and actions are drawn together into an organized whole (Polkinghorne, 1995). Ordinarily, plots of narratives require temporal

and causal coherence. Events in the story are connected through some organized theme, and the story contains a clear beginning, middle, and end. This coherence provides a degree of closure and wholeness to the story (Hoshmand, 2005). Furthermore, narratives generally include events, characters, motivations or intentions, and a perspective or stance (Gilbert, 2002). As such, creating a narrative of life events is not merely a matter of remembering the events, but rather it is a task of reconstructing events in order to meaningfully fit them into the narrator's life story (Enosh & Buchbinder, 2005). The process of creating a narrative requires the narrator to combine the many facts, details, emotions, underlying meanings, and implications of the experienced event into a coherent whole.

Functions of Narratives

Creating personal narratives is an essential part of the human experience. It is through the process of creating and expressing a life-story or narrative that a person develops a context in which he can integrate his experiences into a meaningful and coherent sense of identity (Brody & Park, 2004). Narratives also allow people to understand and shape their basic values and beliefs (White & Epston, 1990), as they express their reactions to significant life events. In addition to providing a means for understanding one's identity, the creation of a personal narrative can be an effective way of understanding events in one's life, creating meaning and purpose for these experiences. Creating a narrative imposes structure and organization upon the events a person has experienced (Crossley, 2000) which may make it easier to cope with and contain the emotional impact of these life events (Pennebaker & Seagal, 1999) and facilitate the process of meaning creation.

Language and Narrative

The creation of a narrative requires the person to translate his images and memories of the life-event into language, thus transforming implicit, unconscious emotional and cognitive processes into explicit, conscious processes (Brody and Park, 2004). The use of language to label feelings and experiences allows one to impose structure upon an experience (Pennebaker, 1989). Furthermore, using language to describe, label, and name emotions allows the narrator to observe and reflect upon his experiences from a distance rather than becoming overwhelmed by his emotions (Enosh & Buchbinder, 2005). Current Emotion Focused Therapy theory suggests that verbal symbolization of experience creates separation between the self and the emotion which may be particularly important for those who have experienced emotionally traumatic experiences. Language permits one to articulate and make sense of what was previously an overwhelming and indefinable inner sense, thus making the experience comprehensible and promoting the construction of new meaning (Greenberg & Paivio, 1997).

Trauma Narratives

Survivors of childhood abuse may have difficulty creating coherent, personally meaningful narratives that describe their traumatic experiences (Wigren, 1994). Several reasons have been suggested for this observation, which will be explored in the following sections.

Emotion and memory. The overwhelming fear experienced during a traumatic event can result in memory gaps for the event. This is suggested to be because the extreme physiological arousal that occurs during the event interferes with the individual's

capacity to attend to details of the event. Furthermore the perception of threat to one's physical and psychological integrity is likely to focus one's attention on those details that are most related to the threat, while disregarding threat-irrelevant information (Foa et al., 1995). This attentional bias when faced with overwhelming fear and arousal results in memory gaps for the traumatic event which can interfere with a coherent narrative understanding of the event. According to Foa and colleagues, these mechanisms suggest that the individual's memories of the trauma will be fragmented, disorganized, and highly skewed towards threat-related details and emotions, and accordingly, narratives of the trauma experience are likely to reflect this fragmentation and disorganization.

Avoidance of emotions. Secondly, the ability to describe and discuss one's emotions requires a degree of awareness and distance which may be lacking because the emotions associated with the traumatic event are so overwhelming (Enosh & Buchbinder, 2005). Victims of complex trauma often display a disturbance in the ability to identify and communicate their emotions, called alexithymia. Defining features of alexithymia include: difficulties identifying and labelling emotions, difficulties communicating one's emotional experience, and an externally-oriented thinking style (see Taylor, Bagby, & Parker, 1997). Alexithymia has been associated both with PTSD and past experiences of childhood abuse and neglect (McLean, Toner, Jackson, Desrocher, & Stuckless, 2006; Paivio & McCulloch, 2003; Zlotnick, Mattia, & Zimmerman, 2001) and is hypothesized to develop due to disruptions in early attachment relationships which negatively impact the child's capacity to modulate emotional and physiological arousal (van der Kolk & Fisler, 1994).

Constant avoidance of emotions related to upsetting events takes psychological and physiological energy, and thus ongoing failure to express these feelings has been connected to physical health problems (Pennebaker & Stone, 2004). A landmark study in this field (Pennebaker & Beall, 1986) indicated that those who wrote about upsetting events with a focus on their thoughts and feelings evidenced improvements in health (as measured by fewer visits to doctors). Pennebaker and colleagues suggest that confronting traumatic experiences had a positive effect on physical health and immune function. More broadly, the benefits experienced by those who expressed their reactions to traumatic events may have occurred in part because these experiences were translated into language. Language aids in the understanding and assimilation of the event and thus by failing to express feelings and thoughts associated with upsetting events, individuals will not process the event fully. (Pennebaker & Stone, 2004). The act of accessing emotions and images and converting them to words changes the way the person organizes and thinks about the trauma. By integrating thoughts and feelings the person is able to more easily construct a coherent narrative of their experience.

Conflicting/confusing information about the world. Unlike the adult trauma victim, whose assumptions and beliefs about the world are challenged in the face of trauma, victims of child abuse *develop* their fundamental assumptions and beliefs about the self and the world in the context of these invalidating and incomprehensible experiences. Because the traumatic experiences that disrupt the stability of life events occur in childhood, the sense of continuity and meaning for personal experiences that normally develops is disrupted (Reviere & Bakeman, 2001). Furthermore, their sense of identity and expectations of others develop in the context of unpredictable, abusive,

intimate relationships where the child learns that feelings of intimacy and love are associated with expectations of rejection and harm (Greenberg & Angus, 2004). These conflicting emotions may make it difficult for the child to create a meaningful understanding of the world and of relationships.

Finally, children in abusive environments, in which their experiences, feelings, and needs are often invalidated and minimized, may experience pressure from adult caregivers to disregard their own perceptions of traumatic experiences because of misleading explanations, threats, or pressure to keep the abuse a secret. Some children who disclose the abuse to a non-offending caregiver may be met with disbelief and minimization of the abuse events, reactions that may generate self-doubt and self-blame in the child, thus aggravating the effects of the trauma (Briere & Runtz, 1988; Webster, 2001). These responses from caregivers make it difficult for the child to make sense of the event, causing further confusion and incoherence in the meaning the child makes of the abuse (Pynoos, 1996). Individuals who are unable to develop a personal narrative that integrates their traumatic experiences are more likely to experience a fragmented sense of self (Dimaggio & Semerari, 2001). Conversely, it is expected that child abuse victims who have never developed a coherent or positive sense of self would translate this inconsistency and confusion about their identity into a narrative that is fragmented and barren of personal meaning.

A number of researchers have studied narratives of trauma victims and have observed that on the whole, trauma narratives are more scattered and incoherent than non-trauma narratives. Hembree & Foa (2000) observed that the oral narratives of people who had chronic PTSD contained numerous speech fillers (e.g. "um", "so", "anyways"),

repetitions, and incomplete sentences, and they often reflected confusion and a discontinuity of time and space. Similarly, Wigren (1994) describes how victims of trauma are often unable to talk about traumatic experiences they have been through, "rather, they relate bits and pieces of sensation, image, and affect out of which a narrative must be created" (p. 415). This impoverished quality of trauma narratives reflects the difficulty these individuals have in integrating the information from the trauma into a coherent part of their life-stories. Unresolved trauma impacts a person's ability to impose structure and find meaning within their story of the traumatic event; the following section will review therapy models that address meaning re-construction in the face of traumatic events.

Treatments for Child Abuse Trauma

In order to resolve the emotional aftermath of trauma, trauma victims may engage in psychotherapy, which involves sharing the story of what happened to them. This disclosure re-exposes the individual to their memories of the traumatic event, allowing access to trauma-related feelings and thoughts. Some form of exposure is a component of all trauma therapies, and generally involves describing the traumatic events in detail. In this manner, the individual is encouraged to engage emotionally with the memory of the trauma, and attempts to create a sense of meaning about the situation.

Virtually all treatments for child abuse trauma also emphasize the construction of more adaptive meaning, that is, addressing the disruptions in perceptions of self, others, and the world caused by the abuse. Creating meaning involves seeking the reason for events that occurred, through questions such as "why me?", "why now?", and "what can I learn?" (Tuval-Mashiach et al., 2004). For some, creating new meaning may mean re-

evaluating the event to be less threatening to the sense of self, gaining an awareness of personal growth or change as a result of the trauma, or changing one's world-view or religious beliefs (Park & Blumberg, 2002). Harvey (1990, as cited in Herman, 1992) identifies one crucial element of trauma resolution as the reconstruction of a coherent system of meaning and belief that encompasses the story of the trauma. Supporting this idea, one study found that child abuse survivors who reported having been able to find some meaning in their experience of abuse reported less distress, had better social adjustment, higher self-esteem, and reported greater resolution of the experience (Silver, Boon, & Stones, 1983). While different therapeutic models use different techniques for exploration of trauma material, they share a common element of constructing a new meaning for the traumatic event, which allows the victim to place their history of abuse in a context that makes it understandable and liveable (Enosh & Buchbinder, 2005). In this way, successful therapy for child abuse trauma directly or indirectly changes the quality of a survivor's trauma narrative, as the process of resolution allows the survivor to create new meaning of their experiences.

Psychodynamic Models

Psychodynamic treatments for child abuse trauma specifically address the meaning of traumatic events to help the client achieve insight into the meaning of their symptoms, and integrate the traumatic events into their understanding of self-concept and world image (Solomon & Johnson, 2002). The focus of these therapies is to elicit and explore traumatic events in the context of a safe therapeutic relationship, in order to make the client's unconscious meanings of the traumatic event conscious. This increased awareness allows clients to operate more effectively (Kudler, Blank, & Krupnick, 2000).

Herman (1992) presents a psychodynamically-oriented treatment model for victims of traumatic events, including complex trauma such as childhood abuse, which posits three stages involved in the recovery process. The overall goal of such therapy is to empower the victim and re-establish a sense of control over their life. The first stage requires the establishment of safety within the therapeutic relationship, which begins to rebuild the survivor's damaged capacity to trust. The second stage requires the survivor to explore and reconstruct their memory of trauma, telling the story such that it can eventually be integrated into their life story. Early narratives in this stage often are static, and do not reveal emotions or interpretations of events. However, as the trauma narrative changes and broadens, the survivor can begin to restore a sense of continuity with their past, understanding the context in which the trauma can be understood. The third and final stage of therapy involves reconnection with ordinary life, the creation of a future, a new understanding of self and beliefs, and a renewed focus to actively engage with one's environment, relationships, and the world.

Cognitive-Behavioural Models

Cognitive-behavioural-type treatments are also often used with victims of trauma, particularly those experiencing symptoms of posttraumatic stress disorder. CBT-based exposure therapies generally require trauma victims to come in contact with their memories of the trauma; clients are asked to imagine themselves back in the traumatic situation, imagine and describe critical aspects of the trauma, and hold these in mind until their level of distress drops (Marks, Lovell, Norshirvani, Livanou, & Thrasher, 1998). Exposure to traumatic memories results in desensitization of the hyperarousal response and teaches the survivor that they can tolerate their memories of abuse. Cognitive

restructuring is another common aspect of cognitive behaviour therapy for trauma. This technique teaches clients to identify dysfunctional thoughts and thinking errors, develop more adaptive alternative thoughts and re-evaluate beliefs about themselves, the trauma, and the world (Marks et al., 1998).

Prolonged Exposure (PE; Foa, Rothbaum, Riggs, & Murdock, 1991) is a treatment approach for traumatic experiences that focuses on exposure to trauma memories through the use of verbal narratives about the trauma experience. Clients are instructed to relive the traumatic experience by imagining it as vividly as possible and describing it aloud in the present tense. Between weekly sessions, clients listen to the tape-recorded narrative of their experience of trauma daily. This treatment is based on information processing theories that suggest that emotional change occurs when trauma victims are able to fully access their trauma memories. This allows them to incorporate new information that is incompatible with the existing fear structure and form a new memory of the trauma (Solomon & Johnson, 2002).

Levitt & Cloitre (1995) describe a treatment designed specifically for child abuse survivors, that combines the principles of exposure therapy with additional skills training to help clients modulate and control their level of emotional arousal (Skills Training in Affective and Interpersonal Regulation/Modified Prolonged Exposure, or STAIR/MPE). Because child abuse victims have difficulty tolerating distress and managing intense feelings of anger and anxiety, the first phase of this treatment (STAIR) begins with a focus on developing emotion regulation skills that will aid in current functioning, and will also help the client confront emotionally distressing memories of trauma encountered in the second, exposure phase of therapy. In the second phase of therapy (MPE), which is

based on the prolonged imaginal exposure technique described by Foa and colleagues (1991), the client is encouraged to close their eyes and speak about the trauma memory as if it were currently happening. The overall goal of these sessions is habituation to the trauma memory, as evidenced by a reduction in the client's reported level of distress within and across sessions. As MPE sessions progress, the focus of the imaginal exposure can vary, with more time spent on portions of the trauma narrative that generate the most emotion. Furthermore, clients and therapist spend part of each session identifying patterns in the client's view of interpersonal interactions that are embedded in the trauma narrative and generating alternative views of self, others, and the traumatic event. This treatment was found to result in significant improvements in affect regulation problems, interpersonal skills deficits and PTSD symptoms for female survivors of childhood abuse, with maintenance of therapeutic gains at 3- and 9-month follow up (Cloitre, Koenen, Cohen, & Han, 2002).

Cognitive processing therapy (CPT; Resick & Schnicke, 1992) was developed as a treatment for rape victims with PTSD, which combines exposure to memories of the traumatic event with cognitive restructuring strategies. Cognitive Processing Therapy for Sexual Abuse (CPT-SA; Chard, Weaver, & Resick, 1997) was developed as an adaptation of CPT with specific focus on issues of childhood sexual abuse survivors. The first few weeks are focused on developing a sense of trust and cohesion within the group therapy sessions. During this time, clients are asked to write about the impact of the abuse on the way they think about themselves, other people, and the world. Particular emphasis is placed on themes of safety, trust, power or control, self-esteem, and intimacy. The next phase of therapy involves exposure treatment, in which clients are asked to

write about their distressing memories of abuse, re-write the same account several times with increasing detail, and to read their narrative at least once a day while focusing on sensory details of the event and allowing themselves to fully experience the accompanying emotions. Following this, clients are encouraged to explore and challenge dysfunctional thought patterns. There is a specific focus on exploring disturbances of beliefs in relation to safety, trust, power, esteem, and intimacy, which are common difficulties for child abuse victims. In the final week of therapy clients relate their re-written account of the trauma and how the abuse impacted them. A pilot study of the efficacy of CPT-SA demonstrated significant improvement on PTSD and related symptom measures, and clients reported changes in their negative cognitions towards themselves, others, and the world, greater ease in managing stressful situations, less avoidance, improvements in relationships, and improved sexual functioning (Chard, Weaver, & Resick, 1997).

Emotion Focused Therapy for Trauma

Emotion Focused Therapy for Trauma (EFTT) is an evidence-based form of therapy for resolving trauma from various types of childhood abuse (Paivio & Nieuwenhuis, 2001; Paivio et al., 2008). EFTT is based in current experiential therapy theory and research (Greenberg & Paivio, 1997; Paivio & Greenberg, 1995) and integrates recent emotion theory and research (e.g. Damasio, 1999; Fridja, 1986). Like other experiential approaches to therapy, a central component of EFTT is a focus on exploring feelings and meanings of life events, a concept that has been labeled as experiencing (Klein, Mathieu-Coughlan, & Kiesler, 1986). Experiencing and its role in EFTT will be discussed in more depth later.

Mechanisms of Change

EFTT focuses on resolving issues with the self and with specific abusive and neglectful others. This may include non-offending caregivers who are neglectful of the child's needs by failing to prevent or bring an end to abuse by another. This therapeutic approach posits two interrelated mechanisms of change through which maladaptive meaning is modified. These are the context of the therapeutic relationship and emotional processing of trauma memories.

Therapeutic relationship. In EFTT the therapeutic relationship provides a safe context for the client to explore trauma material. Over time, clients learn that their frightening, painful, and shameful feelings are more easily tolerated in the presence of an emotionally responsive other, and this sense of safety becomes internalized. Creating an environment in which the client can experience a sense of safety and control within an interpersonal interaction is an essential element of the client's recovery (Paivio & Laurent, 2001). Secondly, the therapeutic relationship is considered to be directly curative in that it provides the client the opportunity for new interpersonal learning with the therapist. Positive interactions with a supportive other counters the client's previous experiences of powerlessness and lack of control, and the therapist-client relationship can become a model for interpersonal support, eventually generalizing to the client's other relationships. Therapist validation and empathy also fulfill an essential validating role for the client who has likely encountered many invalidating and minimizing experiences in the context of early attachment relationships. Years of invalidation from their abusers and/or caregivers means that survivors of child abuse are often confused by and insecure about their feelings and perceptions. Therapist validation communicates to the client that

their feelings and reactions are appropriate and expected, and can also help them to clarify the nature of their emotions (Paivio & Laurent, 2001).

Emotional processing. The second posited mechanism of change in EFTT is emotional processing of trauma memories. This requires the client to become emotionally engaged with his memories of the traumatic experience in order to gain access to the underlying perceptions, beliefs, and expectations that are associated with the traumatic experience. EFTT is unique in emphasizing the importance of both maladaptive and adaptive emotions associated with the trauma experience. Maladaptive emotional responses (such as feelings of guilt or shame) are revealed and explored while at the same time, the client accesses and expresses previously inhibited adaptive emotions, such as anger at violation or sadness at loss. Expressing these emotions allows the client access to the underlying needs and goals associated with adaptive emotions. (Greenberg & Paivio, 1997). For example, feeling anger at the violation that occurred promotes assertiveness, self-empowerment, and interpersonal boundary definition. Expressing sadness at loss allows the client to grieve, accept the loss, and access self-soothing resources (Paivio et al., 2008). Accessing the associated information from these emotional responses is considered crucial to reprocess the trauma and modify the meaning it holds in the client's life. Thus, through emotional processing clients learn both to tolerate previously overwhelming experience and to construct a new meaning for the traumatic events (Paivio et al., 2008).

Interventions

Empathic responding. The primary intervention in EFTT is empathic responding to client feelings and needs. Therapist empathic responses serve three functions:

modulation of intense emotion, increased awareness, and communication of feelings and meanings. As clients internalize therapist expressions of understanding, acceptance, and validation, over time this allows them to increase their capacity for self-soothing and self-acceptance, which is central to the ability to manage intense emotions. Secondly, by identifying the feelings implicit in the clients' descriptions of events, empathic responses teach accurate labelling and description of emotional experience. Many individuals with a history of childhood abuse lack these skills (alexithymia). Finally, empathic responses encourage clients to communicate their emotions and articulate the meaning of their experience, skills which facilitate social relations and increase the likelihood that their needs for social support will be met by others (Paivio & Laurent, 2001). Empathic responses on the part of the therapist promote client exploration and expression of feelings and meanings (i.e. experiencing) and thus facilitate client construction of new meaning and more coherent narratives.

Re-experiencing procedures. EFTT also is unique in emphasizing resolving issues with specific attachment figures. In addition to empathic responding, re-experiencing procedures are incorporated into EFTT to allow the client and therapist to explore and process memories of traumatic experiences with abusive or neglectful others. Imaginal confrontation (IC) is a Gestalt-derived intervention used to access and explore trauma material (Greenberg, Rice, & Elliott, 1993; Paivio & Shimp, 1998). Clients are asked to imagine an abusive or neglectful other in an empty chair facing them, attend to their internal experience, and express current thoughts and feelings about the abuse directly to the imagined other.

According to EFTT theory, resolution of childhood abuse trauma can be understood as an ability to regard oneself as worthwhile and absolved of blame, and having either gained a greater understanding of the abusive other or gained the ability to hold the other accountable for the abuse. This is often accompanied with a sense of empowerment and optimism about the future (Greenberg & Malcolm, 2002). The model of resolution of 'unfinished business' with abusive or neglectful others has been empirically-verified through process analysis, resulting in the identification of the specific steps in therapy processes that discriminated clients who resolved their issues from those who did not (Greenberg & Foerster, 1996). Based on this research, it has been shown that those who successfully resolve unfinished business engage in intense expression of feelings and a sense of entitlement to having needs met, and experience a shift in their view of the self and the abusive/neglectful other, in contrast to those who do not fully resolve their issues. The model suggests that clients begin the process of resolution with an awareness of lingering unresolved feelings, and engage in expression and symbolization of these unresolved emotions and of previously unmet needs. This leads to an eventual re-construction of the client's self-representation as a stronger individual, an increased sense of self-worth, and a more differentiated perspective of the abusive or neglectful other, as someone to be held accountable for their harmful actions, and possibly as more responsive to the client's previously unmet needs (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002). The process of resolution involves exploring feelings and meanings associated with abuse experiences and developing a new view of self, others, and traumatic events. Creating new meaning and coming to better understand one's self and others results in more coherent narratives.

Research supporting EFTT

EFTT with IC has been empirically supported as an effective treatment for adult survivors of child abuse. An initial outcome study demonstrated statistically and clinically significant improvements in several areas of disturbance (symptomatology, abuse-related problems, interpersonal problems, self-affiliation) and maintenance of treatment gains at nine months following therapy termination (Paivio & Nieuwenhuis, 2001). Process-outcome research demonstrates support for both the therapeutic alliance and the IC re-experiencing procedure as mechanisms of change in EFTT (Paivio, Hall, Holowaty, Jellis, & Tran, 2001). In this study, strength of the therapeutic alliance was found to contribute both to increases in self-esteem and to resolution of abuse issues, whereas the IC re-experiencing procedure made a significant independent contribution to the reduction of trauma symptoms. As well, 93 percent of clients who were highly engaged in the IC procedure evidenced clinically meaningful improvements, compared to 70 percent of low engagers, thus providing support for the importance of re-experiencing procedures in emotional processing of trauma memories and feelings.

Empathic exploration (EE) is an alternative re-experiencing procedure designed for clients who are unwilling or unable to engage in imaginal confrontation, often due to the highly arousing and potentially distressing nature of the task. The EE protocol is based on the same model of resolution (Greenberg & Foerster, 1996) and intervention principles as EFTT with IC. However, rather than engaging in dialogue with the imagined abusive or neglectful other, the client is encouraged to spend the session focusing in-depth on their experience of abuse. They are encouraged to vividly imagine abusive/neglectful others and traumatic events in their "minds eye" and express their

thoughts and feelings to the therapist, rather than expressing them to the imagined other. Trauma material and blocks to experiencing are explored exclusively in interaction with the therapist.

Results of a recent randomized clinical trial showed that EFTT with the IC procedure and EFTT with the EE procedure were equally effective. Clients in both IC and EE conditions reported statistically and clinically significant improvements on ten dimensions, including measures of trauma symptoms, target complaints, and abuse resolution. Treatment gains were maintained between 6 and 18 months after termination (Paivio et al., 2008). The similar efficacy of both the EFTT with IC condition and the EFTT with EE condition is likely due to comparable treatment models. Both versions of EFTT maintain a focus on reprocessing trauma material while accessing core emotional processes, rendering them available for further exploration. Both also emphasize client experience and expression of feelings and unmet needs concerning particular attachment figures and offenders, as well a focus on accessing adaptive emotions in order to explore their associated meanings. Furthermore, both versions are based on the same empirically-verified model of resolution (Greenberg & Foerster, 1996) and employ the same intervention principles.

Outcome research to date has shown that both versions of EFTT are efficacious in promoting the construction of new meaning and a changed view of self. Furthermore, trauma exploration during IC and EE procedures has been associated with moderate to high levels of client experiencing, indicating that these procedures promote client exploration of feelings and meanings associated with abuse (Ralston, 2006). This construction of new meaning should be evident in trauma narratives written by clients

before and after EFTT. The present study uses data from the recent outcome study evaluating EFTT with IC and EE (Paivio et al., 2008) to explore the connection between meaning construction as evidenced through trauma narrative quality and resolution of trauma through EFTT.

Research on the Quality of Trauma Narratives

The quality of trauma narratives has been used as an index of emotional processing or resolution of traumatic experiences (Pennebaker, 1993). Harvey (1990, as cited in Herman, 1992) has indicated that a coherent narrative of trauma is an essential element of trauma resolution. Researchers have studied various qualitative dimensions of trauma narratives, many of which can be linked to an inability to resolve trauma or process emotion. The qualities to be examined in depth here are: degree of narrative coherence, temporal orientation of the narrative, words indicating causal or insightful thinking, references to self, references to external (events and dialogue) or internal events (thoughts and feelings), emotion words, and depth of experiencing.

Narrative Coherence

The construct of coherence can be a useful indicator of the degree to which a trauma survivor has processed his experience (Gray & Lombardo, 2001). In order to be able to tell a coherent life story or narrative, one must have a sense of continuity, directionality and meaning (Androutsopoulou, Thanopoulou, Economou, & Bafitid, 2004). Trauma survivors who have not developed a clear understanding of the trauma as part of their life story, or who have not identified and explored the associated emotional experience, are more likely to produce a fragmented, disorganized narrative, reflective of their inner confusion and distress. By contrast, a coherent narrative would indicate that

the traumatic experience has been dealt with and the related emotional issues have been resolved (Fiese & Spagnola, 2005).

Narrative coherence can be defined in terms of how well the individual is able to organize and construct a story (Fiese & Wamboldt, 2003), and this concept has been examined in several ways. One aspect of narrative coherence is the 'completeness' of the narrative, which requires that the narrative follow the sequential order of the experience being recounted (Koenig Kellas & Manusov, 2003), that different parts of the narrative be integrated (Fiese & Wamboldt, 2003), and that there be a demonstrated understanding and resolution of the problem within the narrative (Fiese & Spagnola, 2005). Narrative organization, another aspect of coherence, can be conceptualized in terms of how thoughts are put together to form a whole (Fiese & Wamboldt, 2003). Narrative organization includes an appraisal of the fluidity and orderliness of the narrative, and having a logical order to the story (Fiese & Spagnola, 2005). Sudden breaks in the storyline, unconnected ideas, and the number of times the subject loses track of the topic have been identified as markers of narrative incoherence or disorganization (Main & Goldwyn, 1984; Androutsopoulou et al., 2004). Studies of verbally-recounted narratives have examined the degree to which the subject's emotions are congruent with the thematic content of the narrative (Fiese & Wamboldt, 2003; Fiese & Spagnola, 2005). The succinctness of a narrative, and its relevance to the specific question or instructions posed by an interviewer or narrative task have also been considered to be indicators of narrative coherence (Fiese & Spagnola, 2005; Main, 1991).

Other studies have measured coherence of narratives not as an overall appraisal of the narrative, but rather by examining individual phrases within the narrative. For

example, a number of studies have examined the number of contradictory statements made by subjects within narratives, considering whether these contradictions were acknowledged and explained by the subject or not. (Androutsopoulou et al., 2004; Main, 1991; Main & Goldwyn, 1984). Specific phrases that reflect confusion or disjointed thinking (e.g. "I don't know...") have been considered to be measures of 'fragmentation' or 'disorganization' (Foa et al., 1995; Halligan, Michael, Clark, & Ehlers, 2003; Harvey & Bryant, 1999; van Minnen, Wessel, Dijkstra, & Roelofs, 2002). Other markers of narrative incoherence or fragmentation include: odd changes or connections in speech patterns, sudden or out of place remarks (Main & Goldwyn), speech fillers such as "um," and "but anyway" (Foa, et al., 1995; van Minnen et al.), repetition of words or phrases (Androutsopoulou et al.; Foa et al., 1995; van Minnen et al.) and unfinished thoughts or sentences (Androutsopoulou, et al.; Foa, et al., 1995; Main; van Minnen, et al.).

A number of studies have used a variety of these operational definitions of coherence and assessed changes in the quality and content of narratives of trauma survivors. O'Kearney & Perrott (2006), in their review of trauma narrative studies, report that because of the differences in definitions of incoherence and the variety of methodologies employed to assess narrative incoherence, it is difficult to integrate findings about the coherence of trauma narratives. However, some general observations can be made. When comparing subjects' narratives in relation to their level of PTSD symptomology, it was found that subjects that had higher levels of psychological difficulties had more incoherent narratives (Androutsopoulou et al., 2004), and those with higher levels of peritraumatic dissociation had more incomplete narratives (Zoellner, Alvarez-Conrad, & Foa, 2002). Other studies have examined changes in trauma

narratives as a result of therapy. Van Minnen et al. (2002) observed in their study that patients undergoing imaginal exposure therapy showed a decrease in disorganized thoughts in their narratives from pre- to post-therapy, and that this decrease was greater for patients who had a greater improvement in symptoms. Foa and colleagues (1995) observed that narratives of rape victims whose symptoms had not improved as a result of therapy evidenced more repetitions (a measure of incoherence) than narratives of improved patients.

Temporal Orientation

Temporal orientation of narratives refers to the degree to which subjects write about the past, present or future. Klein & Janoff-Bulman (1996) examined this construct by counting the percentage of words about the past, present, and future in written life stories of child abuse survivors. Compared with non-survivors, child abuse survivors devoted more of their writing to discussing the past. They suggested that this reflects a tendency for those who have experienced traumatic childhood abuse to dwell on past negative events, which has the potential to contribute to ongoing psychological distress.

Holman & Silver (1998) examined the degree to which statements in narratives of victims of childhood incest and Vietnam War veterans focused predominantly on the past, present, or future. For example, past temporal orientation could be reflected in statements such as "I can't let go of this experience", present orientation in "I can't change the past, so I live my life today," and future orientation in "I plan to get through this and have a new life" (Holman & Silver, 1998, p.1149). They found that past temporal orientation was associated with higher levels of psychological distress than present- or future-orientation. In another study of individuals who had experienced

terrorist attacks they found that those with a positive future-orientation (i.e. setting goals and planning ahead for their futures) reported lower levels of psychological distress and higher positive affect than individuals with lower levels of future orientation (Holman & Silver, 2005).

On the contrary, Manne (2002) examined narratives of parents with children undergoing cancer treatment, and found that increased use of past tense verbs was associated with fewer symptoms of traumatic stress whereas the use of future tense was significantly associated with all PTSD symptoms. These authors suggested that the use of past-tense words indicated that the parent was able to look back and confront the experience rather than avoid it, whereas future tense verbs were associated with statements of worry about their child's prognosis. The difference in findings among these studies is likely due to the difference in the timeframe of the traumatic event experienced. For those in which the traumatic experience was ongoing, a focus on the future was likely to raise questions of uncertainty and fear thus perpetuating symptoms of distress, whereas for a trauma in the past, adopting a present- or future-orientation would be more adaptive and would indicate a greater degree of resolution.

Causal /Insightful thinking

Causal words (e.g. "because", "reason") are important in narratives because they indicate an attempt to explain the reason a traumatic event occurred and the meaning of that event, whereas insight words (e.g. "realize", "understand", "consider") indicate an attempt to understand or work through an event (Pennebaker & Francis, 1996). Incomplete processing of the traumatic event may be indicated by ongoing attempts to assimilate or understand the traumatic event a long time after the event has passed

(Manne, 2002). One study examining narratives of assault victims being treated for PTSD, observed that a greater use of words suggestive of causal and insightful thinking was related to lower levels of anxiety post-treatment. The authors suggest that cognitive processing of the traumatic event (as indicated by the use of causal/insightful words) is related to better outcome (Alvarez-Conrad, Zoellner, & Foa, 2001).

References to Self

Narratives also vary in the extent to which people explicitly refer to themselves. In their description of a coding system for narrative analysis, one study identified specific linguistic strategies in which subjects avoid the first person pronoun, or use third person pronouns in self-characterizations (Androutsopoulou et al., 2004). The tendency to avoid references to the self in narratives is associated with a history of childhood abuse. In comparing life story narratives of child abuse survivors to control subjects and survivors of parental divorce, Klein & Janoff Bulman (1996) found that child abuse survivors used fewer 'self' pronouns and more 'other' pronouns in their life-story narratives than non-child abuse survivors. Among child abuse survivors, a higher percentage of 'other' pronouns in their life narratives was a predictor of poorer coping skills. The authors suggest that the limited use of the first person pronoun in their narratives may be linked to a continuing sense of victimization on the part of the child abuse survivors. This sense leads to a minimization of the importance of their own experiences, and as a result, they may perceive their life stories as better told through the actions of others rather than through exploration of their own actions, thoughts, and feelings (Klein & Janoff-Bulman, 1996). Acknowledging less ownership of their personal experiences results in an understanding of the traumatic event that is less integrated into the sense of self.

Internal and External Events

A related construct is the proportion of statements in the narrative that refer to external events (e.g. descriptions of events, action, dialogue, and details) as compared to the internal experience of the survivor (e.g. thoughts and feelings). When other people or external events are the focus of the abuse survivor's story, there is a limit to which the person has explored and identified personal meanings and feelings. Androutsopoulou and colleagues (2004) identified narrative coding categories that indicated unnecessary or overly detailed descriptions of events, times and places within narratives. In their analysis of impoverished narratives, Dimaggio & Semerari (2001) contrasted a "good" narrative in the context of therapy, which should make explicit reference to inner states and emotional experiences, with an impoverished narrative, in which there may be lengthy descriptions of facts and behaviour, with minimal references to mental states and emotions. In studies examining changes in trauma narratives from beginning to the end of therapy, it was found that the number of thoughts and feelings (internal events) in narratives tended to increase, while the number of external events (actions and dialogues) described by the subjects decreased (Foa et al., 1995; van Minnen et al., 2002). This shift in focus of the narratives indicates a greater tendency for therapy completers to attend to and explore their inner experience regarding the trauma.

Emotion Words

Several studies have specifically examined the frequency or proportion of negative (e.g. anger, fear, guilt) and positive (e.g. happy, relieved, comfortable) emotion words or expressions within trauma narratives (Alvarez-Conrad, Zoellner, Foa, 2001; Zoellner, Alvarez-Conrad, Foa, 2002; Hellawell & Brewin, 2004; Eid, Johnson, & Saus,

2005). Others have created coding categories for linguistic strategies that reflect 'avoiding emotions' in narratives (Androutsopoulou et al, 2004). Findings of these studies have shown that positive emotion words in narratives of trauma survivors were associated with less psychological distress, and that a higher proportion of negative emotion words in trauma narratives was associated with higher psychological distress and more PTSD symptoms (Eid, Johnson, Saus, 2005). In a similar vein, Foa, Molnar and Cashman (1995) found that patients undergoing therapy for trauma that did not improve had more negative emotions in their narratives than improved patients.

Emotion words are an important construct to examine in trauma narratives because they reflect a trauma survivor who is able to connect to their internal experience, and identify their feelings. Narratives that do not explicitly identify emotions and their relations to events are typical of patients with psychosomatic or interpersonal problems (Dimaggio, Salvatore, Azzara, Catania, Semerari, & Hermans, 2003). Dimaggio & Semerari (2001) refer to these as alexithymical narratives, which may have a coherent structure to the story, but do not refer to emotion states and do not integrate somatic experience with emotions and the meanings of events. Recovery from trauma requires the client to become emotionally engaged with their memories of trauma so that successful emotional processing of trauma material can occur (Briere & Scott, 2006). Over the course of therapy, clients generally become better able to describe their inner states (Dimaggio et al.) resulting in narratives that reflect their emotions in coherent meaning themes (Dimaggio & Semerari).

Experiencing

The construct of Experiencing is also relevant to trauma narrative and embodies many features described above. It is a central construct in EFTT, described earlier, and is the focus of the present study. Experiencing (Klein, Mathieu-Coughlan, & Kiesler, 1986) refers to a person's level of awareness of and engagement with exploring their subjective internal experience. A greater depth of experiencing is achieved through a process in which one first attends to subjective internal experience, including emotional experience, followed by a reflection on the personal beliefs and needs that are associated with the emotions. This allows for new emotional reactions and meanings to emerge (Greenberg & Safran, 1987). Greater depth of experiencing requires an internal focus and reflection upon the meaning of one's personal experiences, ultimately leading to greater self-understanding (Watson & Bedard, 2006). The construct of experiencing is more complex than simple emotional arousal or expression; one may be highly emotionally aroused and expressing emotions (e.g. crying, raised tone of voice), while at a low to moderate level of experiencing (e.g. limited to behavioural descriptions of feelings and reactions, such as "I feel like punching something"). In addition to attention to identifying feelings, a greater depth of experiencing requires self-examination and an investigation of personal meaning within the experience (Wiser & Arnow, 2001). According to the empirically-validated model of resolution (Greenberg & Foerster, 1996) that is the basis for EFTT, higher levels of experiencing occur in later stages of therapy with clients who have more successfully resolved lingering negative feelings towards a significant other (i.e. who are able to express their entitlement to unmet needs, and are exploring or examining perceptions of self and others). In terms of trauma, greater understanding of the trauma

experience and its personal meaning for the victim would be reflected in higher levels of experiencing.

The Client Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986) is an ordinal scale consisting of seven mutually exclusive levels that is used as an index of a client's emotional processing and meaning exploration. Client movement through this seven-point scale reflects greater elaboration and integration of affective experience leading to greater understanding and personally meaningful resolution of problems (Goldman, Greenberg & Pos, 2005).

Low stages of EXP reflect an impersonal manner of expression in which the speaker is objective and intellectual, relating facts and details about events. References to personal involvement remain at the level of description of events and actions, with little or no reference to feelings or internal states. Any references to feelings or private experiences are limited to the events or situations described, without describing the speaker's feelings and personal reactions more generally. Moderate levels of EXP reflect a shift to a description of the speaker's internal experience rather than to events or abstractions. Internal experience is presented or described but is not the focus of purposeful self-examination or elaboration. At high levels of EXP there is a purposeful elaboration or exploration of the speaker's feelings and meanings. The speaker begins to pose and explore questions about the self and internal reactions, which reflects the speaker's expanding awareness of immediately present feelings and internal processes. He links and integrates his inner experiences while continuing the process of exploration and elaboration (Klein et al., 1986; Pos, Greenberg, Goldman, & Korman, 2003).

Studies have consistently shown that higher levels of experiencing in therapy sessions are related to more positive treatment outcome (see Klein et al., 1986 for a review). A recent study comparing Process-Experiential Therapy and Cognitive Behaviour Therapy found that clients with a positive therapy outcome (for both types of therapy) had higher levels of experiencing than clients with poor therapy outcome (Watson & Bedard, 2006). Other studies found that greater client depth of experiencing early in therapy predicted better outcome in EFTT with IC (Robichaud, 2004) and emotion focused therapy (EFT) for depression (Pos et al., 2003).

Pos and colleagues also found that the level of experiencing generally deepened over the course of therapy. Although early levels of experiencing related to outcome when considered in isolation, their predictive power diminished when late experiencing levels were considered. An increased depth of experiencing late in therapy independently was the best predictor of symptom improvement (Pos et al., 2003). These findings support the idea that therapeutic improvement results from engaging in greater depth of experiencing over the course of therapy rather than entering therapy with high levels of experiencing (Pos et al.). Another study found similarly that an increase in levels of EXP across therapy was the strongest predictor of change in EFT for depression as reflected in measures of reduced symptom distress and increased self esteem (Goldman et al., 2005). More generally, these findings suggest that emotional processing and successful resolution of issues occurs in conjunction with a deepening exploration of feelings and meanings over the course of therapy. Examining depth of experiencing as a quality of trauma narratives could thus be a useful index of the degree to which the trauma survivor has examined and constructed a new meaning of the traumatic event.

Additionally, increased experiencing potentially allows the client access to information associated with basic adaptive emotions such as anger or sadness. When the meaning of these emotions is made more available through a deeper process of exploration the client develops a greater capacity to act on these emotions in adaptive ways, for example, asserting oneself in response to feeling anger, or allowing oneself to grieve when feeling sadness (Wiser & Arnow, 2001). Furthermore, the exploration of affective information allows the client access to his or her implicit belief systems that are often intertwined with emotional experience. Awareness of these belief systems allows them to be explored and modified to more adaptive states over the course of therapy (Wiser & Arnow). As the trauma survivor's beliefs and understanding of the trauma changes through the process of resolution, one would expect to observe a corresponding change in the quality of the trauma narrative, reflective of the greater understanding and personal meaning that has been created.

A number of constructs relevant to narrative quality that were reviewed above are captured by the Experiencing Scale. For example, some studies of trauma narratives have examined the proportion of 'internal events' (i.e. thoughts and feelings) as compared to 'external events' (i.e. actions and dialogue) (Foa et al., 1995; van Minnen et al., 2002). The first two stages of the Experiencing Scale indicate statements that are likely to describe external events, (i.e. facts and details about the traumatic event) with little or no personal references or involvement in the events. Statements coded as stage 3 or 4 of the Experiencing Scale show evidence of internal events, such as references to feelings and personal reactions to external events. Stages 5, 6, and 7 of the Experiencing Scale go

beyond a simple description or labeling of feelings and thoughts, and into more meaningful exploration of these feelings and thoughts.

The construct of 'causal or insightful thinking' (Alvarez-Conrad, Zoellner, & Foa, 2001; Pennebaker & Francis, 1996) also is captured by the experiencing construct. Lower levels of EXP are distinguished by their relative lack of exploration of meaning or insight, whereas higher levels reflect greater meaning exploration and insight relating to the self (Klein et al., 1986).

Reference to feelings and use of emotion words also distinguishes high levels of experiencing. Lower levels of the Experiencing Scale (1 & 2) represent statements that are devoid of emotion words. Statements that would be coded as stage 3 or 4 on Experiencing indicate basic labeling and descriptions of affect, while the higher stages of the Experiencing Scale (5, 6 and 7) indicate progressively more exploration of affect.

References to self in trauma narratives (Klein & Janoff-Bulman, 1996) is also captured by the coding criteria for the Experiencing Scale. Stage 1 is devoid of first person pronouns; it reflects a completely impersonal account of an event, whereas stages 2 through 7 include first person pronouns. Coding criteria for the different stages of the Experiencing Scale also capture differences in use of past and present tense. Lower stages (1, 2, 3, 4) are equally likely to be in past or present tense, and in higher stages (5, 6, 7) present tense is most likely used. This aspect of the scale is thought to indicate whether the expressed content of the narrative is experienced in an immediate or remote manner (Klein et al., 1986). A tendency to remain in the past tense would be less likely to indicate full awareness and experiencing of the present moment consistent with findings for trauma narratives. Experiencing is a complex, multidimensional construct that is

thought to be a core change process in EFTT and similar approaches in the experiential/humanistic tradition. More recently, the process has been linked to outcome in psychodynamic and cognitive-behavioural therapies as well (for a review, see Whelton, 2004). The construct of experiencing captures dimensions of quality studied individually in other studies of narrative quality.

The Present Study

Based on the above review of the literature on child abuse trauma and narratives, one would expect that the process of resolving trauma through psychotherapy that focused on meaning construction would be associated with a change in the quality of the trauma narrative written by the victim. For example, one would expect victims to be more emotionally engaged, more able to find meaning, and more able to tell a coherent story of the event as a result of the resolution they have achieved. The present study tested the theory that resolving childhood abuse trauma through Emotion Focused Therapy for Trauma (EFTT; Paivio et al., 2008) is associated with trauma narratives that are more coherent, emotionally-focused, and personally meaningful.

Qualities examined were those found to be predictive in other studies of narrative quality. These include narrative coherence, temporal orientation, and use of positive and negative emotion words, as well as depth of experiencing. Depth of experiencing was examined because the construct captures many of the key qualitative dimensions identified by other researchers, and has not yet been studied as a quality of trauma narratives that is predictive of outcome. It was hypothesized that there would be an observable improvement in the quality of narratives from pre- to post-therapy because EFTT actively promotes client experiencing, that is, attention to and exploration of

affective meaning. This process, in turn, is associated with the construction of coherent, personally meaningful narratives.

It was further hypothesized that the quality of trauma narratives at the end of therapy, controlling for pre-treatment quality, would be associated with therapy outcome. That is, clients with a greater degree of change in depth of experiencing, increased narrative coherence, present- or future-oriented narratives, and more positive emotion words, would be expected to have a greater improvement in trauma-related symptoms and a greater degree of resolution of issues with abusive or neglectful others. Support for these hypotheses would indicate that resolution of trauma issues through EFTT is associated with an increased capacity for the construction of coherent, emotionally expressive, personally meaningful narratives, and that the degree of resolution of child abuse issues can be reflected in the quality of trauma narratives.

CHAPTER III

Methods

Participants

Participant Recruitment

The present study used data collected as part of a larger process-outcome research

study evaluating two forms of Emotion Focused Therapy for Trauma with survivors of

childhood abuse (EFTT; Paivio et al., 2008). Participants were recruited through

newspaper and radio ads and features, referrals, and posters offering free psychotherapy

for adult survivors of childhood abuse in exchange for participation in a research study.

All participants provided written, informed consent and were treated in accordance with

ethical principles for research with human participants.

Telephone screening and selection interviews to assess suitability for EFTT were

conducted by trained graduate students in clinical psychology. The telephone screening

consisted of a standardized script that assessed criteria for exclusion from the study

(discussed later). Those who met the initial screening criteria participated in a 90-minute

semi-structured selection interview which assessed mental health, interpersonal and abuse

history, current symptoms, level of functioning, and compatibility with the therapy.

Inclusion and Exclusion Criteria

Participants were included based on commonly-accepted criteria for short-term,

insight-oriented, trauma-focused therapy (Wiser & Arnow, 2001). These criteria were the

capacity to form a therapeutic relationship, which was assessed through the interviewer's

clinical judgment and the participant's history of interpersonal relationships, the capacity

to focus on an issue related to the past trauma, and the capacity to modulate affective

experience. Participants were excluded if they were under eighteen years of age, currently

undergoing another type of psychotherapy, had no conscious recollection of the abuse

experience, or if they had concurrent problems that are considered to be incompatible

with the treatment approach or that would take precedence over a focus on trauma issues

(e.g. involved in a current crisis requiring immediate attention, engaging in aggressive or

self-harm behaviour, substance abuse, or involvement in a violent relationship).

Clients selected for participation were assigned to therapists based on scheduling

compatibility. Random assignment to treatment condition (Imaginal Confrontation [IC]

or Empathic Exploration [EE] intervention) took place after session three before the

introduction of the IC or EE intervention in session four. Therapists were assigned to

equal numbers of clients in both treatment conditions. Data were collected from 60

participants.

Selection of Sample for the Present Study

Narratives for analysis in the present study were selected from the data collected

for the larger EFTT outcome study (Paivio et al., 2008). Prior to beginning the rating

procedure, the author of the present study masked the administration time of all the

narratives (i.e. pre-therapy or post-therapy), leaving only the client number as

identification. Pre- and post-therapy narratives for each client were read by the author,

and those pre-post narrative pairs in which the client described the same traumatic

event(s) were selected for analysis. This procedure was undertaken to ensure that any pre-

post differences in narrative quality were not confounded by differences in the content of

the narratives. Thirty-seven pre-post narrative pairs (74 narratives total) were selected for

analysis. Narratives that were not selected for analysis were used for rater training on the measures of narrative quality.

Participants

The sample for the present study consisted of 37 of the 60 clients in the original study (Paivio et al., 2008). Slightly more than half of the participants were female (56.8%). Participants ranged in age from 21 to 71 years old, with a mean age of 44.65 years (SD = 13.25 years). The majority of participants were of European descent (86.5%), were married (40.5%), had one or more children (67.6%), some education beyond high school (71.5%), and were employed either full- or part-time (78.4%) with an annual household income of more than $20,000 (86.5%). Most clients reported multiple types of childhood maltreatment but when asked to identify a primary focus for therapy, most clients identified sexual abuse (45.9%), followed by emotional (27.0%), and physical abuse (10.8%) as the treatment focus. The majority of participants had undergone previous therapy (86.5%) and identified either father (43.2%) or mother (35.1%) as the primary abuser. In this sample, 19 clients were in the IC treatment condition, 18 were in the EE treatment condition.

Data Collection Procedure

Prior to the first therapy session, participants completed the Pennebaker Trauma Narrative writing task (Pennebaker, Kiecolt-Glaser, & Glaser, 1988; described below) and pre-treatment outcome measure questionnaires (described below). A second Pennebaker Trauma Narrative was written prior to the last therapy session, and post-treatment outcome measure questionnaires were completed following the last therapy session.

Measures

Outcome Measures

As the present study focuses on the association between narrative quality and trauma resolution, outcome measures that specifically examine trauma dimensions of outcome were selected for analysis.

The Resolution Scale (RS; Singh, 1994; see Appendix A) is an eleven-item Likert scale that assess the degree of resolution of past issues with abusive or neglectful others. Clients assign a rating to items on a five point scale (1 = *not at all, 5 = very much)* indicating the degree to which they feel distressed by negative feelings and unmet needs, worthwhile, and accepting toward the other person. Test-retest reliabilities of .73 and .81 were reported and validity was established through high correlations between change on the RS and change on other outcome measures (Singh, 1994). Paivio et al. (2001) reported an alpha reliability of .82 with a sample of clients undergoing EFTT. For the present study clients completed one RS questionnaire concerning the primary perpetrator of abuse, and many completed a second RS questionnaire concerning a secondary other who was usually a neglectful mother. For these clients the two scores were averaged to obtain an overall index of resolution.

The Impact of Event Scale (IES; Horowitz, 1986; see Appendix B) is a 15 item questionnaire measuring current levels of subjective distress for life events, with particular focus on levels of trauma-related intrusion and avoidance. Clients rate on a 4 point Likert scale (0 = *not at all,* 3 = *often experienced)* the frequency of each symptom during the past seven days. A literature review of 23 studies using the IES reports the mean internal consistency for the intrusion subscale at $\alpha=0.86$ (range 0.72-0.92) and for

the avoidance subscale at α=0.82 (range 0.65-0.90), and test-retest reliabilities between 0.56 and 0.94. Higher reliability coefficients were obtained when a shorter time interval had elapsed between measurements (Sundin & Horowitz, 2002).

The Target Complaints (Discomfort) Scale (TC; Battle et al., 1966; see Appendix C) examines three problems clients wish to focus on in therapy. Clients rate their degree of discomfort for each problem on a 13 point scale (1 = *none*, 13 = *couldn't be worse*). Battle and colleagues reported test-retest reliability of .68 and high correlations with other outcome measures provided validity evidence. The types of problems identified by clients in the present study included unresolved feelings about childhood abuse, low self-esteem, and interpersonal difficulties (non-assertiveness, anger control).

Trauma Narratives

The Pennebaker Trauma Narrative (PTN; Pennebaker, Kiecolt-Glaser, & Glaser, 1988; see Appendix D) asks participants to write about the most traumatic and upsetting experiences of their lives. This protocol was originally used to study the health effects of disclosing traumatic experiences. In the present study it was requested of therapy clients before their first therapy session, and prior to their last therapy session. The instructions ask participants to explore their deepest thoughts and feelings about the most upsetting experience of their lives and to write continuously for 15 minutes.

Predictor Variables

The following measures were used to assess qualitative dimensions of trauma narratives.

The Client Experiencing Scale (EXP; Klein et al., 1986; see Appendix E) is a seven-point observer rating scale that is used to assess the quality of a client's emotional

engagement and exploration of internal experience. It is generally used to code therapy session tapes or transcripts, but has also been used to reliably code written materials, such as answers to open-ended questions (Barrilleaux & Bauer, 1976; Klein et al., 1986; Le, 2006; Sells & Martin, 2001). In the present study, the EXP scale was used to code level of experiencing as reflected in the written Pennebaker Trauma Narratives, described above. Low levels (1 and 2) of the scale are characterized by impersonal or superficial references to self. Moderate levels (3 and 4) reflect a more personal focus with reference to inner feelings and personal experiences. High levels (5 to 7) of the scale are characterized by exploration of feelings and elaboration of personal meanings. Inter-rater reliabilities of the EXP scale when used to code written materials has been reported as ranging from .81 to .98 (Barrileaux & Bauer, 1976; Le, 2006; Sells & Martin, 2001). Klein et al. (1986) reported high associations with other indicators of successful psychotherapy. In the present study, narratives were divided into statements (each sentence or complete idea), and each statement in the narrative was given a rating on the EXP scale. See Appendix F for examples of statements at each level of the EXP scale.

Emotion words. Positive and negative emotion words were coded in narratives using the *Mind Reading Emotions Library* (Baron-Cohen, 2004; see Appendix G). This is a computer software package that includes a list of 412 emotion words initially developed to help children with autism to recognize emotions. In addition to coding individual emotion words, statements or phrases that were judged by the raters to indicate an emotional state were coded. The positive or negative valence of each word or phrase was assigned based on the context of the sentence. Raters agreed that emotion words or phrases could be coded with neutral valence as well, but no emotion words were

encountered that were judged to be of neutral valence. See Appendix H for examples of emotion phrases and positive/negative valence.

Narrative coherence. Coherence of narratives was defined in terms of the frequency of several markers of "incoherence" or "disorganization" that have been used in other studies. These include instances of: (1) contradictory statements (2) repetitions of phrases, (3) sudden shifts in topic, (4) unfinished thoughts or statements, and (5) statements that indicate confusion (e.g. "I don't know") (Androutsopoulou et al., 2004; Foa et al., 1995; Halligan et al., 2003; Harvey & Bryant, 1999; Main & Goldwyn, 1984; Main, 1991 as cited in Androutsopoulou et al., 2004; van Minnen et al., 2002). Two additional categories of narrative incoherence were created during rater training: (6) incoherent sentence structure, and (7) missing/incorrect word(s). See Appendix J for descriptions and examples of each category.

Temporal orientation. Based on Holman and Silver's (1998) work, temporal orientation was assessed by rating the degree to which each participant demonstrates involvement in the past, present, and future. Examples of statements reflecting each type of temporal orientation include: "I can't let go of this experience" as reflecting past orientation, "I can't change the past, so I live my life today" as reflecting present orientation, and "I plan to get through this and have a new life" as reflecting future orientation (Holman & Silver, 1998). The present study used the example statements as a guide to assign each statement within the narrative a temporal orientation (past, present, or future) See Appendix K for coding rules and example statements in each category.

Qualitative Analysis

Preparation of Narratives

Prior to beginning the rating procedure, administration time (pre- or post-therapy) was masked on all narratives to avoid rater bias during coding. Narratives were typed and divided into statements by the author who was the primary rater. For the majority of narratives, each full sentence was considered to be a separate statement. However, to account for differences in writing style, grammar, and punctuation across narratives, a statement was defined as being one complete idea; as such, some statements consisted of one portion of a long sentence, while others comprised several short sentences.

Training of Raters

Two raters who are graduate students in clinical psychology (including the author) were trained to rate narratives using the EXP scale by an expert EXP rater (Dr. Sandra Paivio). The second graduate student rater has previous experience using the EXP to rate both taped therapy dialogue and trauma narratives (Le, 2006). Training included reading the EXP manual (Klein et al., 1986), reviewing rating guidelines set out by the expert rater, and rating training narratives that were not used for analysis in the study. The two raters coded seven training narratives together, to gain familiarity with the rating rules for the EXP Scale and the additional narrative quality measures. An additional 20 training narratives were coded independently to establish inter-rater reliability. Any discrepancies in ratings were discussed and resolved. Inter-rater reliability on training narratives was determined using percent agreement (75.0% for positive emotion words; 90.6% for negative emotion words; 98.7% for temporal orientation; 75.0% for coherence) and Cohen's kappa (.632 for modal EXP rating; .851 for peak EXP rating). Additional

rating rules that were developed by the two raters during the training procedure were identified and added to the coding manual. Training took approximately 20 hours. These training methods are consistent with the guidelines in the EXP scale manual (Klein et al., 1986) and are based on those successfully used in a similar previous study using the EXP scale to rate trauma narratives (Le, 2006).

Rating Procedure

Each rater coded fifty-two of the experimental narratives on each dimension. Thirty of the narratives were coded independently by both raters and used to calculate inter-rater reliability. For any discrepancies in ratings on these narratives, the two raters discussed differences until agreement was reached and assigned a final rating to each statement in the narrative. Inter-rater reliability was determined using percent agreement (84.6% for positive emotion words; 92.8% for negative emotion words; 96.4% for temporal orientation; 76.2% for coherence) and Cohen's kappa (.803 for modal EXP rating; .798 for peak EXP rating).

Calculation of Narrative Quality Scores

After coding narratives, the author converted ratings into scores for analysis. Two variables based on the EXP scale were created: (1) modal EXP rating (the most frequently occurring level of experiencing), and (2) peak EXP rating (the highest level reached) for the entire narrative. The frequency of positive and negative emotion words/phrases was determined and divided by the total number of statements in the narrative to account for the length of the narrative, creating two additional variables: (3) proportion of positive emotion words, and (4) proportion of negative emotion words. Likewise, the frequency of indicators of narrative incoherence was divided by the number

of statements in the narrative, creating a variable of (5) the proportion of indicators of narrative incoherence. Based on previous findings that a past temporal orientation is associated with higher distress in trauma survivors than a present- or future-orientation (Holman & Silver, 1998), in the present study present- and future-oriented statements were combined into one category, and assigned a code of '1' while statements with a past temporal orientation were coded a '0'. An overall score for the entire narrative was calculated by adding up the scores and dividing by the total number of statements within the narrative. This resulted in a score signifying (6) the proportion of present/future oriented statements in the narrative.

<p align="center">Quantitative Analysis</p>

Descriptive statistics were calculated on demographic variables, outcome measures, and pre- and post-treatment measures of narrative quality. To test the hypothesis that the quality of trauma narratives improves from pre- to post-therapy, one-tailed, paired sample t-tests were carried out on pre- and post-treatment scores of narrative quality variables. Inter-correlations between narrative quality variables were carried out, followed by inter-correlations between narrative quality and outcome variables at pre-treatment and at post-treatment. If significant correlations were found, then a series of partial correlations would be carried out between post-treatment scores on each narrative quality measure and each outcome measure, while controlling for the pre-treatment narrative quality scores, in order to assess how the change in narrative quality is correlated with outcome. For those variables that were significantly associated in the partial correlation analysis, a series of hierarchical multiple regression analyses would be carried out, assessing the independent contribution of post-therapy narrative quality

variables as predictors of therapy outcome, after controlling for pre-treatment symptom

severity and pre-therapy narrative quality.

CHAPTER IV

Results

Data Screening

A MANOVA was run to compare IC and EE treatment groups across the post-treatment scores on the three outcome measures. As no significant differences were found between treatment conditions, $F(3,33) = 1.566$, $p = .216$, on subsequent analyses the two treatment groups were combined into one. Three subjects had bimodal ratings on the modal EXP variable; the mean of the two modes was used for analysis. Prior to analysis, pre- and post-treatment scores on all narrative quality variables and outcome variables were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate analysis. Four missing data points were identified on the Impact of Event Scale (IES) post-treatment measure. T-tests using dummy coding indicated that these data were missing at random, thus mean substitution on the four missing data points was used for subsequent analyses. Examination of z-scores revealed two univariate outliers on the positive emotion words/phrases (pre-treatment) variable and one univariate outlier on the incoherence (post-treatment) variable. To reduce the extreme skewness and kurtosis and lessen the impact of outliers, a square root transformation was performed on positive emotion words/phrases (pre- and post-treatment). A square root transformation on the incoherence variable (pre- and post-treatment) improved skewness and kurtosis statistics, however the distribution remained significantly different from normal. Mahalanobis distance (with the use of a $p < .001$ cutoff) was used to screen for multivariate outliers. No multivariate outliers were identified across the narrative quality and outcome variables, therefore no cases were

rejected from analyses. As a regression analysis was planned, assumptions of

multicollinearity, homoscedasticity, and independence of errors were assessed using VIF

(cutoff < 10) and Tolerance (cutoff > 0.1) statistics, a scatterplot (standardized residual x

standardized predicted value) and partial regression plots of each independent variable on

the dependent variable, and the Durbin Watson statistic, respectively. The data met

assumptions for multivariate regression analysis. Data analyses were carried out both

with variable transformations and without; however as the results of the two analyses

showed no meaningful differences, the data presented here are the original scores without

transformations.

Data Analyses

Descriptive Statistics

The means and standard deviations for the outcome variables at pre- and post-

treatment are presented in Table 1. As shown in Table 1, the means of all three outcome

variables decreased from pre- to post-treatment. A MANOVA analysis was conducted

across all three outcome measures and demonstrated that there was a significant

difference in scores from pre- to post-therapy, $F(3,70) = 36.796$, $p < .001$, indicating that

clients showed an overall improvement in trauma-related symptoms, degree of distress,

and abuse resolution after undergoing EFTT. As indicated in Table 1, there was

significant improvement on all outcome dimensions.

Table 1

Means and Standard Deviations for Outcome Variables

	Pre-treatment	Post-treatment	
Outcome variable	*M (SD)*	*M (SD)*	*F value*
IES	25.49 (8.26)	10.99 (8.25)	56.95***
RS	37.86 (7.71)	25.57 (10.02)	35.52***
TCD	9.98 (1.94)	5.29 (2.33)	94.97***

Note: n=37; IES = Impact of Event Scale, RS = Resolution Scale, TCD = Target Complaints/Discomfort Scale; *** p < .001

Six narrative quality variables were calculated from analysis of the trauma narratives. Depth of experiencing is captured by a modal and a peak score on the EXP scale for each narrative. Proportion scores were calculated to represent the variables of positive and negative emotion words/phrases, present/future orientation, and incoherence, each score accounting for the length of the narrative (i.e. number of statements). The means and standard deviations for the narrative quality variables at pre- and post-treatment are presented in Table 2. The means of all narrative quality variables increased from pre- to post-treatment with the exception of negative emotion words, which decreased, and incoherence, which remained equal from pre- to post-treatment. To test the hypothesis that the quality of the narrative improves from pre- to post-therapy, one-tailed, paired t-tests were carried out (overall alpha set at .05). As shown in Table 2, positive emotion words/phrases, present/future orientation, modal and peak experiencing showed a significant improvement from pre- to post-test.

Table 2

Means, Standard Deviations and Pre-Post Differences for Narrative Quality Variables

	Pre-treatment	Post-treatment	
Narrative Quality	*M (SD)*	*M (SD)*	*t(36)*
Positive Emotion Words	0.25 (0.28)	0.42 (0.31)	3.217**
Negative Emotion Words	1.16 (0.51)	1.12 (0.55)	-0.467
Incoherence	0.04 (0.06)	0.04 (0.08)	0.054
Present/Future Orientation	0.26 (0.27)	0.47 (0.30)	4.041***
Experiencing-Mode	3.16 (0.76)	3.55 (0.88)	2.011*
Experiencing-Peak	4.16 (0.65)	4.95 (0.62)	5.806***

Note. n=37; one tailed significance level *p < .05, **p < .01, *** p < .001

MANOVA analyses with all six narrative quality variables were conducted to determine whether there were any gender differences in trauma narrative quality, at pre-treatment and post-treatment. The MANOVA analyses were non-significant (pre-treatment $F_{(6,30)}$ = 1.200, p = .333; post-treatment $F_{(6,30)}$ = 1.507, p = .210), suggesting that there are no significant gender differences in trauma narrative quality.

Additionally, independent samples t-tests were conducted at pre-treatment and post-treatment to determine whether individuals of different education levels differed significantly on the degree of narrative incoherence. Individuals with high-school education were compared to individuals with graduate degrees, and no significant differences in degree of narrative incoherence were found at either pre-treatment [$t(13)$ = -.395, p = .699] or post-treatment [$t(13)$ = -.517, p = .614].

Inter-correlations among Narrative Quality Variables

To determine whether any narrative quality variables were significantly correlated with each other, two-tailed bivariate Pearson's correlations were carried out among the six narrative quality variables. Since narrative quality changed from pre- to post-therapy, separate analyses were carried out on pre-treatment narratives (Table 3), and post-treatment narratives (Table 4). As shown in Table 3, for pre-treatment narratives, modal experiencing was significantly correlated with all variables except incoherence. Peak experiencing was significantly correlated with modal experiencing and present/future orientation; as well, its correlation with positive emotion words was moderately large and thus noteworthy (Cohen, 1988). Positive emotion words and present/future association were significantly correlated with each other. Incoherence was not significantly correlated with any of the other measures of narrative quality.

Table 3

Bivariate Pearson's Correlations among Pre-treatment Narrative Quality Variables

Narrative Quality	1	2	3	4	5	6
1. Positive Emotion Words	1.000	.129	.002	.523**	.470**	.304
2. Negative Emotion Words		1.000	-.201	.171	.451**	.023
3. Incoherence			1.000	.042	.072	.252
4. Present/Future Orientation				1.000	.517**	.502**
5. Experiencing (mode)					1.000	.339*
6. Experiencing (peak)						1.000

Note. n=37; * p < .05, ** p < .01

Results for post-treatment narratives were very similar to those reported above for pre-treatment narratives. As shown in Table 4, modal and peak experiencing were significantly correlated with each other, as well as with present/future orientation and positive emotion words. Present/future orientation and positive emotion words were significantly correlated with each other. Negative emotion words and incoherence were independent of the other measures of narrative quality.

Table 4

Bivariate Pearson's Correlations among Post-treatment Narrative Quality Variables

Narrative Quality	1	2	3	4	5	6
1. Positive Emotion Words	1.000	-.158	-.240	.641**	.472**	.376*
2. Negative Emotion Words		1.000	-.268	.053	.078	.047
3. Incoherence			1.000	-.016	.126	.198
4. Present/Future Orientation				1.000	.600**	.680**
5. Experiencing (mode)					1.000	.666**
6. Experiencing (peak)						1.000

Note. n=37; * p < .05, ** p < .01

Inter-correlations between Narrative Quality and Outcome Variables

The second hypothesis suggests that improvement in quality of trauma narrative predicts therapy outcome. To determine whether any narrative quality variables were significantly correlated with any outcome variables, two-tailed bivariate Pearson's correlations were carried out between the six narrative quality variables and the three outcome variables. Again, separate analyses were conducted for pre-treatment narratives (Table 5), and post-treatment narratives (Table 6). As shown in Table 5, use of fewer negative emotion words and lower depth of experiencing (mode) were associated with

less resolution of abuse issues (RS) at pre-treatment. As well, the positive association between present/future orientation and discomfort on target complaints (TCD) is moderately large (Cohen, 1988).

Table 5

Bivariate Pearson's Correlations between Pre-treatment Narrative Quality and Pre-treatment Outcome Variables

	Outcome Variables		
Narrative Quality	*IES*	*RS*	*TCD*
Positive Emotion Words	-.060	.034	.106
Negative Emotion Words	-.046	-.359*	.161
Incoherence	.068	-.064	-.169
Present/Future Orientation	.149	-.179	.289
Experiencing (mode)	-.061	-.336*	.139
Experiencing (peak)	.199	.037	.157

Note. n=37; IES = Impact of Event Scale, RS = Resolution Scale, TCD = Target Complaints/Discomfort Scale; * $p < .05$

Table 6 shows that there are no significant correlations between any of the post-treatment narrative quality variables and the post-treatment outcome measures.

Table 6

Bivariate Pearson's Correlations between Post-treatment Narrative Quality and Post-treatment Outcome Variables

	Outcome Variables		
Narrative Quality	*IES*	*RS*	*TCD*
Positive Emotion Words	.059	.005	-.156
Negative Emotion Words	.178	-.159	.187
Incoherence	-.130	.108	-.091
Present/Future Orientation	.146	.111	-.011
Experiencing (mode)	-.187	.032	-.171
Experiencing (peak)	-.066	-.025	.006

Note. n=37; IES = Impact of Event Scale, RS = Resolution Scale, TCD = Target Complaints/Discomfort Scale

Because none of the narrative quality variables were consistently correlated with any of the outcome measures across the two assessment times there was no evidence to suggest that change in narrative quality predicted outcome. Therefore, planned partial correlation analyses and hierarchical multiple regression analyses were not conducted.

Supplementary Data Analysis

Correlations between Pre-treatment Narrative Quality and Post-treatment Outcome Variables

Because client pre-treatment variables have often been found to be predictive of therapy outcome, an additional analysis was conducted to determine whether there was an association between pre-treatment narrative quality and therapy outcome. Two-tailed bivariate Pearson's correlations were carried out between the pre-treatment scores on the six narrative quality variables and the post-treatment scores on the three outcome

variables. As shown in Table 7, the narrative incoherence at pre-treatment was significantly associated with more trauma symptom distress (IES) at post-treatment, and use of more negative emotion words at pre-treatment was associated with greater resolution of abuse issues (RS) at post-treatment. Additionally, the associations between deeper modal and peak experiencing at pre-treatment and greater post-treatment abuse resolution (RS) were moderately large and noteworthy (Cohen, 1988).

Table 7

Bivariate Pearson's Correlations between Pre-treatment Narrative Quality and Post-treatment Outcome Variables

	Outcome Variables		
Narrative Quality	*IES*	*RS*	*TCD*
Positive Emotion Words	.227	-.106	-.038
Negative Emotion Words	-.045	-.396*	-.055
Incoherence	.399*	.146	.094
Present/Future Orientation	-.034	-.244	.011
Experiencing (mode)	-.062	-.295	-.003
Experiencing (peak)	-.125	-.302	-.080

Note. n=37; IES = Impact of Event Scale, RS = Resolution Scale, TCD = Target Complaints/Discomfort Scale; * p < .05

CHAPTER V

Discussion

Purpose of the Present Study

The purpose of the present study was to examine changes in the quality of trauma

narratives written by adult survivors of childhood abuse before and after Emotion

Focused Therapy for Trauma (EFTT, Paivio et al., 2008). It was hypothesized that

narrative quality at post-treatment would be characterized by greater depth of

experiencing, more positive emotion words, more focus on the present and future (as

opposed to the past), and greater coherence, when compared to pre-treatment narratives.

It was also hypothesized that improvements in trauma narrative quality would be

predictive of better therapy outcome, in terms of trauma symptom distress (IES),

resolution of abuse issues (RS), and discomfort on target complaints (TCD).

Summary and Implications of Study Results

Scores on all three outcome measures decreased significantly across assessment

times, indicating that clients improved after undergoing EFTT. These results are

consistent with the findings for the larger sample of clients in the outcome study (Paivio

et al., 2008) from which the present sample was drawn.

Hypothesis One: Change in Narrative Quality

There was a significant improvement in several dimensions of trauma narrative

quality from pre- to post-treatment, providing partial support for the first hypothesis of

the study. Specifically, as expected, post-therapy narratives had a greater depth of

experiencing, more positive emotion words, and a greater focus on the present and future,

as compared to pre-therapy narratives. These findings suggest that these dimensions of

narrative quality were affected by resolution of trauma issues through the process of EFTT, thus changing the way clients described traumatic experiences. However, the degree of incoherence and the proportion of negative emotion words used in narratives did not change from pre- to post-treatment. The following sections discuss findings for each of the narrative quality dimensions.

Experiencing. The finding that depth of experiencing in narratives increased from pre- to post-therapy is consistent with previous studies showing that over the course of therapy the number of references to internal events (i.e. thoughts and feelings) in narratives tends to increase, while the number of references to external events (i.e. actions and dialogue) tends to decrease (Foa et al., 1995; van Minnen et al., 2002). This finding is particularly relevant to the therapeutic approach used in the present study because promoting experiencing is a primary task in EFTT. Clients are encouraged to attend to and explore their subjective experience (feelings and meanings) associated with abuse (Paivio et al., 2008; Ralston, 2006). Thus the greater depth of experiencing in written narratives from pre- to post-treatment likely reflects client engagement in the process of experiencing during therapy.

Positive emotion words. The significant increase in the proportion of positive emotion words in narratives from pre- to post-therapy is consistent with expectations regarding the resolution of trauma issues through EFTT. According to the treatment model, as clients learn to express their previously unmet interpersonal needs and hold the perpetrator (rather than themselves) accountable for harm, they experience a shift in their view of self, as a more competent and worthwhile individual (Greenberg & Malcolm, 2002). Results of outcome analyses indicated that, following EFTT, clients reported

significantly increased self-confidence and self-esteem (Paivio et al., 2008). This more

positive self-image may be reflected in the post-therapy trauma narratives, which contain

more positive emotional expressions, such as hope, self-confidence, and a sense of

personal strength. Additionally, a key component of EFTT is therapist empathy and

validation of the victim's emotions, and assisting the abuse survivor to modulate their

own emotional responses. Over time, therapist empathic responses are thought to be

internalized as the survivor learns skills for self-soothing and self-acceptance (Paivio &

Laurent, 2001). It is possible that an increase in positive emotion words in the post-

therapy narrative reflects the survivor's greater ability at the end of therapy to focus on

positive emotions as a means of self-soothing and modulating emotional arousal or

negative emotional responses.

Present/future orientation. Results also showed that, following therapy, trauma

narratives contained more statements that focused on the present and future than pre-

therapy narratives. Thus, it seems that clients were more likely than before to describe

traumatic experiences in terms that connected the past abuse to their present and future

lives. This is also consistent with expectations for clients who have resolved traumatic

issues in therapy. The model of EFTT aims to help clients let go of unmet needs and

expectations concerning abusive and neglectful others (Paivio et al., 2008). Resolution of

past trauma means that survivors are no longer stuck in the past but are better able to

focus on their present lives and goals for the future, and this may be reflected in a greater

present/future orientation in the post-therapy narrative.

The shift in narrative temporal orientation from past to present/future is also likely

connected to the process of therapy termination, which coincides with the time when

post-therapy narratives were written. The last sessions of EFTT typically include discussions of how clients have changed and their plans for the future, more so than early sessions which focus on past trauma. Thus client narratives at the end of therapy may reflect this changed treatment focus.

Negative emotion words. It is particularly noteworthy that in the present study there was no significant change in the proportion of negative emotion words used in trauma narratives from pre- to post-therapy. These results are understandable both in terms of the trauma narrative task (Pennebaker, Kiecolt-Glaser, & Glaser, 1988) and the EFTT therapy model (Paivio et al., 2008). First, since clients were directed to describe "the most upsetting or traumatic experience of their lives", it seems likely that these experiences would continue to be described in negative terms. As well, EFTT focuses on reducing maladaptive emotions such as fear, shame, and self-blame, but also helps clients to access and explore previously constricted feelings of sadness at loss and anger at maltreatment. These feelings are negative but adaptive in promoting appropriate action, such as self-soothing, seeking comfort, and self-assertion. It is possible that certain negative emotional states (shame, fear) were more evident in pre-therapy trauma narratives, while other negative emotional states (anger, sadness) were more prevalent in post-therapy narratives. Thus, the proportion of negative emotion expressions in narratives may not decrease, but the content of the negative emotional expressions may have changed. Future research can examine this possibility by separately coding adaptive and maladaptive negative emotional states.

Incoherence. Results of the present study also indicated no change in degree of coherence of trauma narratives from pre- to post-therapy. Previous research has revealed

mixed findings concerning the narrative coherence variable. For example, some studies found that narrative fragmentation (i.e. the 'flow' of the narrative) did not change (Foa et al., 1995; van Minnen et al., 2002) but that ratings of disorganized thoughts decreased over the course of therapy (van Minnen et al., 2002). Different findings are likely due to different definitions of, and methods for coding incoherence, fragmentation, and disorganization. The criteria for incoherence in the present study included indicators of fragmentation (repetitions, unfinished thoughts), disorganized thoughts (those implying confusion or disjointed thinking), as well as additional indicators of incoherence drawn from other studies (e.g. sudden shifts in topic, incoherent sentence structure or missing/inappropriate words). Present findings using these criteria suggest that the degree of coherence in trauma narratives is unaffected by the process of trauma resolution through EFTT. This partly could be attributable to the Pennebaker narrative task (Pennebaker et al., 1988) which directed clients to write about traumatic events without regard to spelling, grammar, or sentence structure. It is also possible that incoherence is partly a function of client verbal or writing skill capacity that is unrelated to trauma resolution. A limitation of the present study is that it did not include a measure of client verbal or written communication skill which could have been used to assess the discriminant validity of incoherence ratings.

Inter-correlations of Narrative Quality Measures

A number of narrative quality variables were found to correlate with each other both at pre- and post-treatment. First, the association between modal and peak ratings of experiencing at both assessment times supports the validity of the ratings on this dimension. Second, a pattern of inter-correlations among narrative quality dimensions

supports the validity of the narrative quality construct. Just as dimensions of psychological distress associated with trauma and assessed in outcome measures typically are inter-correlated, one would also expect that dimensions of narrative quality affected by trauma would be inter-related.

Specifically, at pre-treatment modal depth of experiencing was associated with a larger proportion of both positive and negative emotion words, and a larger proportion of statements with a present/future orientation. These findings make sense in terms of the different stages of the Experiencing Scale measure (EXP; Klein et al., 1986). Low levels on the EXP are devoid of emotion words, reflecting an impersonal and external view of events. At moderate to high levels of experiencing, emotion words and phrases are more prevalent and serve to more fully describe and explore the narrator's internal state (Klein et al., 1986). Similarly, low levels on the EXP scale are likely to be focused on the past (e.g. when giving descriptions of traumatic childhood events) whereas high levels of EXP involve personal meanings and implications of the abuse, which are more likely to focus on the individual's present and future life (Klein et al., 1986). Since this was the first study to use the Experiencing Scale to assess the quality of written trauma narratives, the above findings support the EXP as a valid index of narrative quality.

It noteworthy that the proportion of negative emotion words used in trauma narratives was associated with depth of experiencing (mode) only at pre-treatment. Deeper exploration of feelings and meanings associated with trauma requires the identification of emotion words, and this seems to be particularly the case at pre-treatment when trauma issues are still unresolved. According to the EXP construct and the model of EFTT (Paivio & Pascual-Leone, 2008) emotional experience and expression

allows the individual to access new information associated with traumatic experiences and thus acts as a catalyst for exploring the meaning of emotions and constructing new meaning over the course of therapy. After therapy however, when the individual has already explored and come to terms with traumatic events, this role of negative emotion words may not be as relevant. Rather, at the end of therapy, a focus on the present and future and on positive feelings may be more relevant to meaning exploration (experiencing). This accounts for the associations among these narrative quality variables at post-treatment in the present study.

Finally, results of the present study indicated no significant associations between incoherence and any other narrative quality variables at either pre- or post-treatment. There is no reason to assume that fragmented, disjointed, or inconsistent statements concerning traumatic events would be related to a particular temporal orientation or use of positive emotion words. In terms of depth of experiencing, high levels on the EXP involve an exploratory stance and can be characterized by verbal dysfluency (Klein et al., 1986). Thus, narrative incoherence might reflect lack of trauma resolution for some clients, but a productive exploration of subjective experience (i.e. high level of experiencing) for others. This may account for the incoherence dimension operating independently from the other narrative quality dimensions.

Hypothesis Two: Narrative Quality and Therapy Outcome

The second hypothesis of the study, that improved narrative quality across therapy would be predictive of better therapy outcome, was not supported. None of the post-treatment narrative quality variables were significantly associated with post-treatment outcome measures using zero-order correlations. Therefore, planned analyses examining

the association between pre-post change in narrative quality and pre-post outcome were not carried out. Limited power due to the small sample and reducing the degrees of freedom would preclude finding meaningful results.

With regard to experiencing, this finding is inconsistent with those reported in other studies. For example, two studies of Emotion Focused Therapy for depression found that improved depth of experiencing across therapy sessions was a significant predictor of outcome (Goldman et al., 2005; Pos et al., 2003). The difference between these and present findings could be partly due to the different treatment focus (depression versus trauma) and the use of different outcome measures. As well, the Goldman and Pos studies examined in-session experiencing using videotaped therapy sessions rather than written trauma narratives. It is possible that greater client depth of experiencing within therapy sessions is more directly related to treatment outcome than depth of experiencing in written trauma narratives.

The finding that use of positive emotion words in narratives was unrelated to the degree of trauma resolution is also inconsistent with previous research. One study for example, found that positive emotion expressions in trauma narratives were associated with lower psychological distress (Eid, Johnson, & Saus, 2005). However, differences in findings may be due to the nature of the trauma or the length of time passed. Eid and colleagues examined trauma narratives written several weeks after military training accidents, whereas the present study examined narratives written years after experiencing interpersonal trauma in childhood. It is also possible that proportion of positive emotion words in the present study is predictive of other therapy outcomes that were not

measured, for example, reduced global distress, reduced depressive symptoms, or improved self esteem. Further research can examine this question.

In terms of temporal orientation, previous findings are mixed. Present findings are consistent with those reported by Klein and Janoff-Bulman (1996) who also found no association between use of past or present words in the trauma narratives of child abuse survivors and psychological distress. However, other studies reported that a past temporal orientation was associated with higher levels of psychological distress than present- or future-orientation (Holman & Silver, 1998) and that a positive future-orientation was associated with lower psychological distress and higher positive affect than a past-orientation (Holman & Silver, 2005). In the present study, it may be that the change in temporal orientation was related to other measures of therapy outcome (e.g. symptoms of depression, anxiety, or self-esteem) besides trauma resolution.

Overall, results of the present study indicate that, although the quality of written trauma narratives improved from pre to post-treatment, this improved post-treatment narrative quality was unrelated to post-treatment trauma resolution. Since none of the correlation coefficients approached significance, this is unlikely a function of limited power. Rather, failure to find a link between post-test narrative quality and outcome could indicate that the quality of trauma narratives is not a direct index of the degree of resolution of trauma issues.

Pre-treatment Narrative Quality and Therapy Outcome

There were, however, significant associations between pre-treatment narrative quality and post-treatment outcome. Greater use of negative emotion words and deeper modal and peak experiencing at pre-treatment were significantly associated with greater

resolution of abuse issues on the RS at post-treatment. It appears that clients who enter therapy with the ability to articulate or write about their negative feelings related to trauma are able to begin exploring the meanings and implications of these feelings. They are therefore better able to benefit from a therapy such as EFTT that requires these client capacities, and better able to engage in therapy processes and resolve issues related to abusive and neglectful others. Present findings are consistent with those reported in a previous study of EFTT. Robichaud (2004) similarly found that modal depth of experiencing (observer ratings of therapy dialogue) during exploration of trauma issues in early EFTT sessions was predictive of outcome. These findings suggest that client capacity for experiencing early in therapy is prognostic of client improvement in EFTT. Present findings using written trauma narratives provide additional support for this conclusion.

Finally, in the present study, greater narrative incoherence (i.e. repetitions, contradictions, confusion about events, sudden shifts in topic, and unclear statements) at pre-treatment was significantly associated with more PTSD symptom distress at post-treatment on the IES. This is consistent with previous research that found an association between narrative incoherence and higher levels of psychological difficulties and trauma-related dissociation symptoms (Androutsopoulou et al., 2004; Zoellner, Alvarez-Conrad, & Foa, 2002).

In terms of clinical implications, it may be useful to clinicians to recognize that narrative incoherence and confusion about events early in therapy may be a marker for less improvement in trauma symptoms at the end of therapy. Information about client pre-treatment characteristics is clinically useful in terms of treatment assignment or

tailoring treatment plans to meet clients' needs. In this case, treatment plans would consider their ability to explore feelings and meanings associated with trauma and to coherently talk about traumatic events. For example, more emphasis could be devoted to developing skills for emotional awareness and expression with those clients who demonstrate a limited access to emotion words and capacity for experiencing. Future research could explore the association between experiencing in pre-treatment written narratives and observed depth of experiencing in therapy dialogue during early sessions. As well, future research could explore whether the relationship between pre-therapy narrative quality and therapy outcome is mediated by therapy process variables, such as observed depth of experiencing during sessions, or the client's level of engagement or willingness to explore emotionally painful material with the therapist.

Strengths and Limitations of the Present Study

This study examined change in trauma narrative quality of child abuse survivors following a manualized treatment which was a controlled experimental context (Paivio et al., 2008). In contrast to many previous studies that have used a cross-sectional design, this study allows us to link changes in narrative quality to therapy processes.

The present study was also the first to use the Experiencing Scale as a multidimensional measure of narrative quality in written trauma narratives. The significant findings indicate that experiencing is a useful index of trauma narrative quality, thus contributing to future research in this area. Furthermore, the present study used similar measures of temporal orientation, incoherence, and emotion words as previous studies of narrative quality, allowing for comparisons across study results.

Results of the present study also provide information about the importance of narrative quality – clients' capacity to coherently articulate and describe traumatic experiences and their meanings – to treatment outcome. These pre-treatment client capacities likely influenced their ability to productively emotionally engage with trauma material during EFTT and thus maximally benefit from therapy. Information about these client capacities at pre-treatment could help shape treatment plans in EFTT. These results also raise questions for future research regarding the association between written narrative quality and in-session therapy processes.

Another strength of the present study was the sample, that included both men and women, different types of child abuse (sexual, physical, emotional), a range of abuse severity, and moderate levels of psychological distress. Thus the sample is likely representative of abuse survivors in the general population (Scher et al., 2004). Furthermore, the majority of participants (78%) identified either mother or father as the primary perpetrator of abuse, and are thus representative of the majority of child abuse victims, who experience abuse perpetrated by a parent or caregiver (Trocme, McPhee, Kwok, 1995). The findings of the present study can therefore be applied to a broad range of victims of child abuse.

However, the study's sample also poses some limitations in terms of generalizability of results. Participants were included and excluded from the sample based on suitability for this type of therapy. Inclusion/exclusion criteria included capacity to form a therapeutic relationship, to focus on an issue related to past trauma, and to modulate affect, as well as absence of concurrent problems considered incompatible with the treatment approach (current crisis, involvement in a violent relationship, aggressive or

self-harm behaviour, or substance abuse). Many survivors of child abuse report these types of concurrent problems (Browne & Finkelhor, 1986; Malinosky-Rummell & Hanson, 1993). Additionally, the sample was homogeneous in terms of cultural background, income level, and education level.

Another limitation was the low inter-rater reliability of some of the narrative coding measures that was reported in the Methods section. In particular, the incoherence measure had a percent agreement below 80% which is considered less than optimal (Lombard, Snyder-Duch, & Bracken, 2002). Although there was an interpretable pattern of findings, this could have influenced confidence in validity of the findings. It should be noted however, that other narrative quality variables (most notably negative emotion words and temporal orientation) had high percent agreement (above 90%) thus providing confidence in findings concerning these variables. Additionally, the small size of the sample in the study and multiple measures of narrative quality increased the risk of Type I error, such that some of the significant findings may have been due to chance. It is also possible that some existing associations among variables were not found to be statistically significant in this study, due to increased Type II error. Replication of this study with a larger sample would provide more power for analyses, and thus more confidence in the findings.

Finally, previous research has suggested that controlling for writing skill or cognitive ability is recommended when assessing narrative incoherence. In particular, Gray and Lombardo (2001) found that the differences in narrative coherence (as measured by an index of reading level) between a PTSD and non-PTSD group disappeared when they controlled for writing skill and cognitive ability. While a more

explicit measure of writing ability could be used in future studies, in the present study, no

differences were found in degree of narrative incoherence between groups of individuals

with high-school education and those with graduate degrees, providing some indication

that the incoherence measure is distinct from writing or cognitive ability, and adding

validity to the results concerning narrative incoherence.

Directions for Future Research

The findings of the present study raise several questions that could be explored

through further research. Future research could explore whether depth of experiencing

and use of emotion words in written trauma narratives is related to client depth of

experiencing during therapy sessions, and whether the change in the quality of the

narrative over time is mirrored by a change in depth of experiencing across sessions.

Secondly, the finding that pre-therapy negative emotion words and depth of

experiencing in narratives are associated with therapy outcome raises questions about

whether greater depth of experiencing prior to therapy is associated with therapy process

factors, such as greater in-session experiencing, client levels of engagement, or

willingness to participate in therapy tasks. Future research could examine whether

therapy process variables mediate the relationship between pre-therapy depth of

experiencing and outcome. It may also be useful to explore whether there are factors that

influence pre-therapy depth of experiencing. For example, this may be related to clients

having previous experience in therapy or other client variables (e.g. severity of PTSD,

dissociation) that would influence the ability to explore emotions and meanings.

Thirdly, this study found that positive emotion words and present/future

orientation in narratives were not correlated with trauma-related indices of outcome.

Future research could examine whether these aspects of narrative quality are related to other measures of therapy outcome such as depressive or anxiety-related symptomatology, or self-esteem. Additionally, based on the finding that the proportion of negative emotion words does not change from pre- to post-treatment, it may be useful to examine whether the content of negative emotion words (adaptive versus maladaptive emotions) in narratives changes, even though the overall proportion does not.

Conclusions

The present study indicated that several of the measured dimensions of narrative quality were related to each other. Thus findings support the multifaceted construct of narrative quality, as well as the validity of the Experiencing Scale as an index of narrative quality.

Present findings also indicated that for individuals undergoing EFTT, there is a significant improvement in the quality of their written trauma narratives from pre- to post-therapy. After therapy, clients were able to articulate their story of trauma with more emphasis on positive emotions, the present and future, and a focus on personal feelings and meanings, and to understand the implications of the abuse. This improvement in narrative quality likely is a function of reprocessing traumatic experiences during therapy. Over the course of EFTT clients are encouraged to express and explore previously inhibited feelings and needs concerning perpetrators of abuse and neglect and construct a new understanding of self, others, and traumatic events (Paivio et al., 2008). It is likely that this process and new understanding is reflected in their manner of describing traumatic experiences.

Contrary to expectations however, improved post-treatment narrative quality was not associated with post-therapy outcome; narrative quality and the degree of trauma resolution at post-treatment were independent of each other. Because pre-therapy narrative quality (i.e., more use of negative emotion words, greater depth of experiencing, and less incoherence) was predictive of better therapy outcome, this suggests that more impoverished narrative quality reflects client capacities that negatively influence their ability to benefit from therapy.

In general, the present study demonstrated that trauma narrative quality changes in predictable ways as a function of therapy, and that less severe narrative disruptions are associated with a positive treatment outcome. These findings support a general theory of trauma narrative quality that suggests that an individual's capacity to create and express a coherent life-story and understanding of self is disrupted by trauma. There is increasing interest in the area of trauma narratives and, to date, findings concerning narrative quality are mixed. Results of the present study contribute to this new area and suggest areas for future investigation.

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Appendix A

Resolution Scale (RS)

Instructions: The following questions ask you how you feel now in terms of your unfinished business with the significant other person whom you specified at the beginning of therapy. Please circle the number on the scale that best represents how you currently feel.

1. I feel troubled by my persisting unresolved feelings (such as anger, grief, sadness, hurt, resentment) in relation to this person.

1	2	3	4	5
Not at all				Very much

2. I feel frustrated about not having my needs met by this person.

1	2	3	4	5
Not at all				Very much

3. I feel worthwhile in relation to this person.

1	2	3	4	5
Not at all				Very much

4. I see this person negatively.

1	2	3	4	5
Not at all				Very much

5. I feel comfortable about my feelings in relation to this person.

1	2	3	4	5
Not at all				Very much

6. This person's negative view or treatment of me has made me feel badly about myself.

1	2	3	4	5
Not at all				Very much

7. I feel okay about not having received what I needed from this person.

1	2	3	4	5
Not at all				Very much

8. I feel unable to let go of my unresolved feelings in relation to this person.

1	2	3	4	5
Not at all				Very much

9. I have a real appreciation of this person's own personal difficulties.

1	2	3	4	5
Not at all				Very much

10. I have come to terms with not getting what I want or need from this person.

1	2	3	4	5
Not at all				Very much

11. I view myself as being unable to stand up for myself in relation to this person.

1	2	3	4	5
Not at all				Very much

12. I feel accepting toward this person.

1	2	3	4	5
Not at all				Very much

Appendix B

Impact of Events Scale (IES)

The "event" refers to the early experiences of childhood trauma/abuse for which you sought therapy.

Below is a list of comments made by people after stressful life events. Please read the list below, and for each item, circle the number indicating how frequently these comments were true for you *during the past seven days*. If they did not occur during that time, please mark the 'not at all' column.

0 = Not at all
1 = Rarely experienced
2 = Sometimes experienced
3 = Often experienced

1. I thought about it when I didn't mean to..0 1 2 3

2. I avoided letting myself get upset when I thought about it or was
   reminded of it...0 1 2 3

3. I tried to remove it from memory 0 1 2 3

4. I had trouble falling asleep or staying asleep....................................0 1 2 3

5. I had waves of strong feelings about it 0 1 2 3

6. I had dreams about it...0 1 2 3

7. I stayed away from reminders of it...0 1 2 3

8. I felt as if it hadn't happened or wasn't real 0 1 2 3

9. I tried not to talk about it...0 1 2 3

10. Pictures about it popped into my mind...0 1 2 3

11. Other things kept making me think about it......................................0 1 2 3

13. I was aware that I still had a lot of feelings about it, but I didn't
    deal with them..0 1 2 3

14. Any reminder brought back feelings about it 0 1 2 3

15. My feelings about it were kind of numb...0 1 2 3

Appendix C

Target Complaints (Discomfort) Scale (TC)

This form is to be filled out by the research assistant based on the client's report.

WHAT PROBLEMS OR DIFFICULTIES DO YOU WANT HELP WITH IN YOUR THERAPY?

1. Problem 1:_____

_____

_____

2. In what situations does this problem occur or become most severe?

_____

_____

_____

3. In what ways would therapy help this problem? (Be as specific as possible.)

_____

_____

_____

4. The boxes below are numbered from 01 to 13 to indicate how much this problem is bothering you now. Please enter, in the blank to the far right, the number that best describes how much this problem is bothering you now.

13	Couldn't be worse
12	
11	
10	Very much
09	
08	
07	Moderately
06	
05	
04	A little
03	
02	
01	Not at all

5. Problem 2:_____

_____

_____

6. In what situations does this problem occur or become most severe?

_____

_____

_____

7. In what ways would therapy help this problem? (Be as specific as possible.)

_____

_____

_____

8. The boxes below are numbered from 01 to 13 to indicate how much this problem is bothering you now. Please enter, in the blank to the far right, the number that best describes how much this problem is bothering you now.

13	Couldn't be worse
12	
11	
10	Very much
09	
08	
07	Moderately
06	
05	
04	A little
03	
02	
01	Not at all

9. Problem 3:_____

_____

_____

10. In what situations does this problem occur or become most severe?

_____

_____

_____

11. In what ways would therapy help this problem? (Be as specific as possible.)

_____

_____

_____

12. The boxes below are numbered from 01 to 13 to indicate how much this problem is bothering you now. Please enter, in the blank to the far right, the number that best describes how much this problem is bothering you now.

13	Couldn't be worse
12	
11	
10	Very much
09	
08	
07	Moderately
06	
05	
04	A little
03	
02	
01	Not at all

Appendix D

Pennebaker Trauma Narrative

During the next 15 minutes, please write down your thoughts and feelings about the most upsetting or traumatic experience of your life. In your writing, we'd like you to really let go and explore your **very deepest thoughts and feelings**. You might tie your topic to your relationships with others, including parent, lovers, friends, or relatives, to your past, present, or your future, or to who you have been, who you would like to be, or who you are now. Once you begin writing, continue to do so without stopping of the entire 15 minutes without regard to spelling, grammar, or sentence structure. All of your writings will be completely confidential.

Appendix E

The Client Experiencing Scale

Stage 1 The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's involvement is impersonal, so that he or she reveals nothing important about the self and the remarks could as well be about a stranger or an object. As a result feelings are avoided and personal involvement is absent from communication.

Stage 2 The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his or her interest is clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings. Thus the personal perspective emerges somewhat to indicate an intellectual interest or general, but superficial, involvement.

Stage 3 The content is a narrative or a description of the speaker in external or behavioural terms with added comments on feelings or private thoughts. These remarks are limited to the events or situations described, giving the narrative a personal touch without describing the speaker more generally. Self-descriptions restricted to specific situations or roles are also a part of Stage 3. Thus feelings and personal reactions come into clear but limited perspective. They are "owned" but bypassed or rooted in external circumstances.

Stage 4 At Stage 4 the quality of involvement or "set' shifts to the speaker's attention to the subjective felt flow of experience as referent, rather than to events or abstractions. The content is a clear presentation of the speaker's feelings, giving a personal, internal perspective or account of feelings about the self. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse, requiring the speaker to attempt to hold on to inner referents. By attending to and presenting this experiencing, the speaker communicates what it is like to be him or her. These interior views are presented, listed, or described, but are not the focus for purposeful self-examination or elaboration.

Stage 5 The content is a purposeful elaboration or exploration of the speaker's feelings and experiencing. There are two necessary components: First, the speaker must pose or define a problem, proposition, or question about the self explicitly in terms of feelings. The problem or proposition may involve the origin, sequence, or implications of feelings or relate feelings to other private processes. Second, the speaker must explore or work with the problem n a personal way. The exploration or elaboration must be clearly related to the initial proposition and must contain inner

references that have the potential to expand the speaker's awareness of experiencing. These may also be evidence of and/or references to the process of groping or exploration itself.

Stage 6   At Stage 6 the way the person senses the inner referent is different. There is a *felt sense* of the there-and-yet-to-be-fully-discovered, that is, of an unclear inner referent that has a life of its own. It is a sense of potneitally more than can be immediately thought or named. This felt sense is more than recognizable feelings such as anger, joy, fear, sadness, or "that feeling of helplessness". If familiar or known feelings are present, there is also a sense of "more" that comes along with the identified feelings.

Stage 7   The content reveals the speaker's steady and expanding awareness of immediately present feelings and internal processes. He or she clearly demonstrates the ability to move from one inner referent to another, linking and integrating each immediately felt nuance as it occurs in the present experiential moment, so that each new sensing functions as a springboard for further exploration and elaboration.

Appendix F

Examples of EXP Ratings from the Present Study

Level 1.
"If anything occurred differently, i.e. someone came to door she would think something evil was happening. She would swear and yell aloud about the devil creating problems in her and our lives."
"At its worst my dad, when not working, would lash back at her and start yelling"
"On that occasion my grandmother and aunt came. No one ever talked about what happened or why my relatives were there"

Level 2.
"He was there and thought I was stealing from him. He proceeded to punch, kick, and then strapped me in the back and behind."
"My dad had major back surgery and was in the hospital for seven months. He told me later (I was less than 10) that he hurt his back from the cold taking me to hockey."
"I was about 8 years old, an alter boy at a church where I lived, on this day I was asked to go along with a priest to help do some decorations in the church"

Level 3.
"Everywhere we went, on the outside my dad tried to make us look like a normal family, but at home it was anything but. It was the not knowing when my mom was going 'to go off' that made things tense around home."
"Other kids at school would often make fun of me because I was unsure of how to defend myself. I remember coming home from school on a number of occasions and wondering if my mom was going to call me names or scream at me, or hit me because she felt I deserved it."
"I recall being about 7 or 8 years old and I was afraid to go home by myself because my uncle was babysitting again."

Level 4.
"After a little while I would be begging my mother & pleading as if for my life for her to believe that I didn't do it on purpose & I am not a bad kid. But she would never believe me."
"I was shocked, traumatized, scare, I cannot describe, humiliated publicly as I screamed back, Dad 'I was a good boy' (over and over) but never able to get out more than that."
"She totally humiliated me and made me feel like I was all those things that she said I was"

Level 5.
"Feeling accepted is very difficult for me, I understand it stems from my childhood, still searching 'how to' inside to be accepted. Don't understand the how-to's of forming close relationships, have 'a fear' of not being able to bond, trust, being hurt again, hard to imagine anything different than the past, extremely sensitive & serious to how others see me so I close up"

"I think the model he set sort of spoiled my views about marriage. I felt bad for my mother in her victim role, I did not want to marry a victim or dependent type and tended to despise them"

"Even now in my adult life I struggle with that same fear; of being punished for no reason, being hit because I felt responsible somehow for the problem"

"If this is all a result of how my dad treated me, why can't I change things now. He has been dead for 10 years and I seldom spoke to him before that time. Why can't I see how stupid these residual feelings are and let them go? Frustration (but not enough to act!)"

Level 6.

"What to do...? Do I continue to look at/explore the past? How do I move forward??"

"This has been a rollercoaster ride and I never thought that any of this would make any sense in the end"

"This is the next big hurtle I have...to undo everything that was done to me in the past and embrace who I am"

"I now am closer to a woman in my life, a relationship of trust is building, I can let her into my thoughts and feelings, some of them I'm not sure of, but that is ok. I have let her in as best as I can."

Level 7.

Ratings were not detected in the present study.

Appendix G

The Emotions Library – Emotion Word List

Group	Word List				
Afraid	afraid	desperate	cowardly	daunted	worried
	nervous	dreading	disturbed	cowed	threatened
	frantic	intimidated	discomforted	jumpy	panicked
	uneasy	terrified	vulnerable	watchful	
Angry	angry	grumpy	moaning	moody	annoyed
	complaining	furious	wild	displeased	explosive
	frustrated	bitter	discontented	exasperated	heated
	indignant	infuriated	provoked	miffed	needled
Bored	bored	unimpressed	distant	blank	distracted
	inattentive	complacent	unfocused	vague	unenthusiastic
	indifferent	jaded	listless	passive	vacant
Bothered	bothered	impatient	flustered	pestered	restless
	tense	ruffled			
Disbelieving	disbelieving	doubtful	questioning	suspicious	cautious
	cynical	guarded	incredulous		
Disgusted	disgusted	distaste	revulsion		
Excited	excited	adventurous	lively	enthusiastic	keen
	alert	aroused	hysterical	inspired	refreshed
	spirited	exhilarated	invigorated	vibrant	ardour
	titillated				
Fond	liking	fond	loving	trusting	affectionate
	close	respectful	adoring	devoted	cherishing
	affinity				
Happy	comfortable	glad	happy	joking	lucky
	merry	safe	teasing	calm	cheeky
	cheered	delighted	enjoying	fine	grateful
	overjoyed	playful	pleasure	proud	relaxed
	amused	content	easy-going	mischievous	positive
	relieved	carefree	casual	sociable	triumphant
	unconcerned	jubilant	exonerated		

Hurt	bullied	attacked	hated	hurt	blamed
	cheated	ignored	betrayed	broken	criticized
	disbelieved	disliked	disrespected	abused	battered
	compelled	corrected	demoralized	downtrodden	exploited
	neglected	offended	terrorized	tortured	confronted
	contradicted	deflated	deserted	patronized	scorned
	aggrieved	belittled	discredited		
Interested	asking	believing	interested	listening	concentrating
	absorbed	curious	fascinated	impressed	tempted
	admiring	vigilant	awed	lured	spellbound
Kind	friendly	helpful	kind	polite	caring
	giving	calming	cheering	comforting	concerned
	encouraging	forgiving	patient	warm	understanding
	welcoming	willing	pitying	empathic	congratulatory
Liked	liked	forgiven	welcomed	adored	appreciated
	comforted	included	needed	praised	rewarded
	supported	wanted	accepted	flattered	reassured
Romantic	attracted	bewitched	romantic	attractive	enticed
	flattered	flirtatious	intimate	passionate	entrancing
	seduced	seductive			
Sad	lonely	lost	sad	tired	upset
	disappointed	tearful	discouraged	gloomy	heartache
	heartbroken	homesick	hysterical	troubled	weak
	withdrawn	despairing	devastated	disillusioned	dismayed
	distraught	empty	grieving	resigned	agonizing
	anguished	condemned	grave	overwrought	pining
	subdued	tormented	turmoil	maudlin	
Sneaky	sneaky	lying	humouring	calculating	insincere
	fawning	mysterious	concealing	luring	tempting
	deceitful				
Sorry	sorry	ashamed	embarrassed	guilty	responsible
	humiliated	mortified			
Sure	honest	strong	sure	bossy	decided
	serious	competitive	persuaded	prepared	pushy
	stubborn	arrogant	assertive	cocky	committed
	convinced	determined	knowing	smug	composed
	sang-froid				

Surprised	surprised horrified	shocked startled	dazed wonder	appalled	scandalized
Thinking	thinking calculating	dreamy expectant	thoughtful fantasizing	judging choosing	brooding contemplating
Touched	soppy	touched	overcome	sentimental	nostalgic
Unfriendly	bullying unkind ignoring aggressive disapproving contemptuous gleeful brazen resentful animosity unapproachable	difficult blaming scolding detesting disrespectful contradictory hostile contrary sadistic belittling	hateful cold selfish rude condemning despising rejecting disinclined stern haughty	mean cruel threatening uncaring defiant discouraging remote pitiless unreceptive supercilious	unfriendly disliking violent argumentative humiliating judgmental sarcastic oppressive vindictive condescending
Unsure	shy clueless bewildered insecure mystified deferential	silly undecided disoriented modest subservient	unsure baffled hesitant reluctant ambivalent	confused bemused humble so-so self-deprecating	puzzled uncomfortable inadequate self-conscious
Wanting	greedy	wanting	begging	hopeful	jealous

Appendix H

Guidelines & Examples of Emotion Phrases

a) Behavioural descriptions of feelings
   "I can feel myself cringe"
   "I just remember screaming and shaking really bad"
   "I saw his car in the driveway, I nearly peed my pants"

b) Other people's emotions
   "They are so disappointed that I am divorcing..."
   "I don't know why she was mad at me"
   "He told me he loved me"

c) Other people's behaviours that evoke emotion in the narrator
   "She would threaten me with 'wait until your dad gets home!' "
   "The time my father mocked me and belittled me..."
   "...but the ridicule in class was unavoidable"

d) 'I feel _____ ' statements
   "He has made me feel lower than dirt"
   "I have never felt settled or secure"
   "Now I feel strong and not afraid of speaking my mind"

e) Dialogue indicating emotion
   "What a bastard! What a cheap, insensitive s.o.b."
   "...her comments like 'you're so fucked up'"
   "Goddamn the day you were born!"

f) Colloquial expressions that indicate emotion
   "...really just kind of shattered my world"
   "I walked on egg shells all the time"
   "immersed in this bottomless pit of an existence"
   "walking with a death cloud over her"

g) The context of the sentence is considered when assigning emotional valence to an emotion word/phrase. A normally "negative" word is given positive valence if the context of the sentence suggests a positive emotional state.
   Examples of positive valence:
   "There was nothing wrong with me"
   "I don't want to exist with fear, loathing, or deep rage anymore"
   "I'm not feeling as frantic"
   Examples of negative valence:
   "I realize I can't be happy all of the time"
   "I never had nurturing where it was safe"
   "The lack of support"

Appendix J

Guidelines and Examples for Coding Narrative Incoherence

    a) Contradictory statements
"This certainly has affected my adult life. The only real decent relationship is with my husband – dysfunctional"
"I picked up his coffee cup and through *[sic]* it across the room striking me in the head and nearly cutting my ear off"
"I push men away but I find myself being able to connect with men and not pushing them away"

    b) Repetitions of phrases
"My grandmother tried to intervene and she was assaulted I mean assaulted."
"I'm just glad I made the right choices to a degree so that as I grew older I was making the right choices"

    c) Sudden shifts in topic
"A few neighbourhood boys came into the tent, asking me to show them my private parts. I recall one of them putting ice on my genitals. I remember sensing that we were doing something wrong but I don't remember any then feelings. I remember my father coming home drunk one night and crying that my mother wasn't home, complaining that she didn't love him. Another frightening situation occurred when my grandmother was dying with cancer"

    d) Unfinished thoughts or statements
"Because of what happened to me at grandma's I've always hated my breasts my dad even"
"I am affected by people not seeming to care about me. And somehow"
"I wanted it all to go away. I wanted them to"

    e) Statements that indicate confusion or memory lapse about the course of events
        (*not* emotion words that indicate confusion during the event)
"I always wonder whether its true or not I question if I made it up. I think I saw her, heard her call my name and left her there."
"Age unknown. Perhaps 10"
"I don't know how much longer we had to stay there living"

    f) Incoherent sentence structure
"Sometimes or most times she wouldn't respond and I would have to hurry to school because I had to go to the bathroom there but no food."
"My introverted inaction to close out all external stimuli, conversation, communication etc. of any kind to avoid further emotional physical & mental abuse"
"I was hurting myself thought, lonely, depressed, sad, and hurt inside with me where to share or get better from it"

g)   Missing or incorrect word(s) such that the sentence is nonsensical or confusing
"I have at times felt suicidle *[sic]* when I feel people don't like make and I get very depressed"
 "But now after 18 years of matter, I divorce for almost 6 years"

Appendix K

Coding Rules and Examples of Temporal Orientation

- Each statement is coded as reflecting a past, present or future orientation

- Consider the context/meaning of the statement first in determining temporal orientation. Verb tense can be an indicator of temporal orientation, but there may also be statements with a present-tense verb that have a past or future orientation.

- When a statement is a mix of two temporal orientations use the core or most important part of the sentence to assign the rating. E.g. If the sentence is a present tense statement that serves to introduce an event in the past, code it as past.

a) Example statements (past)
"It is hard to remember much of my youth. There are only 'highlights' most of which are negative"
"The most vivid memory feels like it would always be the day..."
"I used to run from sadness and pain so that I wouldn't be hurt anymore"
"I feel sad that as a child I could go to no one and I felt alone and different"

b) Example statements (present)
"Now, as an adult, I realize intellectually how devastating their stupidity and ignorance was and how it impacted my life"
"I think I grew up too quick as a child & didn't really have a chance to act like a kid. Maybe that's why I am so much like one at times."
"I find myself opening up to people more and expressing myself. It's a new me. My self confidence is growing everyday."
"Today I am hitting something and I don't want to deal with emotional crap"

c) Example statements (future)
"I am so in touch with who I am and where I want to go in the future. It's fantastic!"
"I worry about my future, I worry about the anger I bury, and how I keep allowing people to get away with things, in order to show I am the better person"
"I've come to the realization that forgiveness is for me, not for them! It's something I need in my life to move forward."
"My years left here on earth will be improved and more joyful. The past is gone."
"I pray that I can continue to do so"

VITA AUCTORIS

Elisabeth Sylvia Heidi Künzle was born May 26, 1982 in Edmonton, Alberta. She graduated from Harry Ainlay Composite High School in 2000. From there she went on to the University of Alberta where she completed a Bachelor of Science degree in Psychology in 2005. She completed her Master of Arts degree in Clinical Psychology in 2008 at the University of Windsor. She is currently enrolled in the doctoral program in Clinical Psychology at the University of Windsor.