University of Windsor
Scholarship at UWindsor

Electronic Theses and Dissertations | Theses, Dissertations, and Major Papers

2004

Process characteristics of client-identified helpful events in emotion-focused therapy for adult survivors of childhood abuse (EFT-AS).

Karen Anne Marie Holowaty
University of Windsor

Follow this and additional works at: https://scholar.uwindsor.ca/etd

Recommended Citation

Holowaty, Karen Anne Marie, "Process characteristics of client-identified helpful events in emotion-focused therapy for adult survivors of childhood abuse (EFT-AS)." (2004). *Electronic Theses and Dissertations*. 3193.
https://scholar.uwindsor.ca/etd/3193

This online database contains the full-text of PhD dissertations and Masters' theses of University of Windsor students from 1954 forward. These documents are made available for personal study and research purposes only, in accordance with the Canadian Copyright Act and the Creative Commons license—CC BY-NC-ND (Attribution, Non-Commercial, No Derivative Works). Under this license, works must always be attributed to the copyright holder (original author), cannot be used for any commercial purposes, and may not be altered. Any other use would require the permission of the copyright holder. Students may inquire about withdrawing their dissertation and/or thesis from this database. For additional inquiries, please contact the repository administrator via email (scholarship@uwindsor.ca) or by telephone at 519-253-3000ext. 3208.

PROCESS CHARACTERISTICS OF CLIENT-IDENTIFIED HELPFUL EVENTS IN EMOTION FOCUSED THERAPY FOR ADULT SURVIVORS OF CHILDHOOD ABUSE (EFT-AS)

by

Karen Anne Marie Holowaty

M. A. University of Windsor, 1995

A Dissertation
Submitted to the Faculty of Graduate Studies and Research
through Psychology
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy at the
University of Windsor

Windsor, Ontario, Canada

2004

© 2004 Karen Holowaty

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

National Library of Canada
Bibliothèque nationale du Canada

Acquisitions and Bibliographic Services
Acquisisitons et services bibliographiques

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 0-612-92546-3
Our file Notre référence
ISBN: 0-612-92546-3

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou aturement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this dissertation.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de ce manuscrit.

While these forms may be included in the document page count, their removal does not represent any loss of content from the dissertation.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Abstract

Few studies have investigated client views of helpful processes within trauma therapies, and it is not known whether clients find controversial reexperiencing interventions useful. The present study used archival data (client self-report questionnaires, interviews, and videotapes of therapy sessions) collected as part of a larger process-outcome investigation (Paivio & Nieuwenhuis, 2001) to examine process characteristics of client-identified helpful events (HE) (N = 29) and researcher-identified control events (CE) (N = 29) in Emotion Focused Therapy for Adult Survivors of Childhood Abuse (EFT-AS). HE were identified by clients on Helpful Aspects of Therapy Questionnaires (HAT; R. Elliott, 1985; Llewelyn, 1988) and post-treatment interviews (PTI; Paivio & Nieuwenhuis, 2001). HE then were located in videotaped sessions and criteria were used to select one event for examination from each client. CE for each client were selected from sessions which did not contain HE, and were from the same stage of therapy as the HE. Selected events were examined from an observer perspective to determine if HE were distinguished from the remainder of therapy (CE) in terms of child abuse content and emotion processes. The Client Experiencing Scale (EXP; Klein, Mathieu-Coughlan, & Kiesler, 1986) and the Emotional Arousal Scale (EAS; Daldrup, Beutler, Engle, & Greenberg, 1988) were used to rate emotion processes. Available client ratings on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) from sessions containing HE and CE also were examined. Results indicated that HE were characterized by a greater focus on child abuse material, greater use of the exposure-based imaginal confrontation (IC) intervention, and higher levels of both modal and peak emotional arousal compared to CE. Statistically significant differences in level

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

of experiencing between HE and CE were not found, possibly due to insufficient power. Finally, the therapeutic alliance was equally strong in HE and CE sessions. Results support key features of EFT-AS and the benefits of the IC reexperiencing intervention in this sample of abuse survivors. As well, results support the reliability and validity of client perspectives about aspects of therapy that are critical to change.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ACKNOWLEDGEMENTS

The road to completing my dissertation was a challenging one, and ultimately a powerful learning experience in many ways. There are a number of key individuals who supported me along the way and who deserve my sincere thanks. I first want to applaud my committee members – Julie Hakim-Larson, Rosanne Menna, and Glynis George, who were a joy to work with and who provided very good suggestions which helped greatly in the refinement of this document. Julie, I will never forget the support and encouragement that you have shown me from the beginning of graduate school until the very end – it was so helpful to know that someone was rooting for me! Rosanne, you were always positive, encouraging, and ready to help if ever I needed it – your friendliness and those times in the lab when you would ask 'How's it going?' I appreciated more than you could know. Glynis, thank you for questions and suggestions which helped me to clarify and broaden my thinking around this project, and for being so accommodating in the midst of your maternal leave! A huge thank you also goes out to Robert Elliott, my external examiner, for his willingness to serve as a member of my committee. Your enthusiasm for my project was much appreciated, and as I am a big fan of your work in experiential therapy, it was an honor to meet and talk with you. I would also like to thank Dennis Jackson, my statistical consultant, for seemingly always having time to answer my stats questions and for having a knack for making concepts readily understandable – no small feat! Finally, the biggest thanks go to my advisor, Sandra Paivio – I could not have achieved this without you! You have helped immensely in refining my thinking and my writing not only on this project but with regard to experiential therapy, and the guiding principles behind all psychotherapies. I have learned so much from working in our psychotherapy lab that I don't think I could put it all into words if I tried! Thank you for sticking it out with me and for believing in me. You are now officially my experiential therapy mentor.

My deepest thanks of all, as always, go to my family and to my friends:

To Mom, Dad, and Will – this document is dedicated to you. Your constant love, acceptance, and support is what enabled me to achieve this – I would not have finished without all of you standing behind me in so many ways. I have always felt that on some level this has truly been a joint effort, and so this is your accomplishment too! Mom and Dad, I simply cannot imagine having more understanding and supportive parents. Thank you for the endless financial backing, the care parcels, and for the long chats on the phone which gave me all of the emotional support I ever needed – you two are the best! Will, you are very simply the best brother anyone could ever ask for – you are always there to help me whenever I need it, and I am so grateful to have you as my pal. Solving my mysterious computer problems, making me laugh with your Simpsons impressions, meticulously packing up my car and driving across the country with me (several times) – your talents are many.

To Baba, Auntie Darlene, and Susie – I am privileged to be able to have so many family members who are also my friends. Thank you for always believing in me and supporting me with the wonderful parcels, the phone calls to see how I am doing and to give

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

encouragement, and for all the fun and laughter we generate when we get together – let's spend more time together starting now!

To Sandy, Trish, and Imogen – It makes me so happy to be able to say that I have made three true friends during my time in graduate school – you are three very talented women, and I am lucky to have known you. Thank you all for your unending emotional support, and our wonderful intellectual discussions! Let's visit each other often.

Others deserving of a thank you – To Jim Evans and Steve Knish, my two mentors from internship in Edmonton, and to Ann Dafoe, my friend, you are three of my very favorite people – thank you for supporting me through this long process and for your kindness.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

TABLE OF CONTENTS

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF TABLES

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

LIST OF FIGURES

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER I

Introduction

The primary objectives of the present study were to locate in videotaped sessions of Emotion Focused Therapy for Adult Survivors of Childhood Abuse (EFT-AS; Paivio & Nieuwenhuis, 2001) events that clients had identified as helpful, and to determine features that distinguished these events from the remainder of treatment. It was expected that helpful events would be characterized by greater focus on child abuse issues and higher quality emotion processes, particularly greater depth of experiencing and higher levels of emotional arousal.

The present study was conducted in the context of programmatic research on EFT-AS. EFT-AS is a short-term individual psychotherapy which emphasizes accessing and emotional processing of trauma memories in the context of a safe therapeutic relationship. The efficacy of EFT-AS has been empirically supported (Paivio & Nieuwenhuis, 2001), and process-outcome studies support the posited mechanisms of change (Paivio, Hall, Holowaty, Jellis, & Tran, 2001; Paivio & Patterson, 1999). In particular, Paivio et al. (2001) found that client emotional engagement with trauma material during the primary imaginal confrontation (IC) procedure used in EFT-AS was associated with multiple dimension change beyond contribution made by common factors. This finding was consistent with both trauma theory and research (Foa, Rothbaum, Riggs, & Murdock, 1991; Jaycox, Foa, & Morral, 1998; Wilson, Becker, & Tinker, 1995) supporting the use of exposure-based procedures for accessing trauma feelings and memories so they are available for exploration and construction of new meaning.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The above research, together with most other studies on helpful aspects of therapy rely on the association of researcher-identified processes with good outcome. Clients rarely have been asked for their opinions about which of the various processes occurring throughout therapy they experienced as most useful. Recently, however, client views about therapy are being sought and considered valuable and equal in importance to the perspectives of therapists and researchers (Bohart, 2000; Duncan & Miller, 2000; Macran, Ross, Hardy, & Shapiro, 1999; Seligman, 1995). The present study examined client opinions of what therapy processes were helpful in EFT-AS. Specifically, the present investigation was a follow-up to a preliminary unpublished study (Holowaty & Paivio, 2000) which summarized helpful aspects of therapy identified by 37 clients who completed EFT-AS. This information was compiled from mid-treatment and posttest questionnaires and interviews asking clients to identify helpful aspects of therapy and estimate their location in therapy. Content analyses of these data indicated that the three most helpful aspects were consistent with postulated mechanisms of change in EFT-AS, that is, exploring child abuse issues during the primary IC procedure, expressing feelings related to childhood abuse, and the therapeutic relationship. These features also are consistent with theory on change processes in other prominent child abuse treatments (e.g. Briere, 2002; Courtois, 1997; Herman, 1992). However, these findings, on their own, had limited usefulness, since clients' perceptions could have been biased by therapists' rationale and other comments about therapy process.

The focus of the present study, therefore, was to locate client-identified helpful events (HE) in videotaped therapy sessions to determine whether HE were distinguished from the remainder of therapy by the above features that clients had identified as

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

important (Holowaty & Paivio, 2000). Twenty-nine HE were located and compared to 29 researcher-identified control events (CE) selected from the same phase of treatment for each client. It was expected that HE would be characterized by a greater focus on abuse-related issues, greater depth of experiencing, and higher levels of emotional arousal compared to CE. Although the therapeutic relationship also was identified as an important aspect of treatment, this is a contextual factor present throughout therapy. It was expected therefore that HE and CE would be characterized by equally strong therapeutic alliances.

Results of this investigation potentially will contribute to theory, research, and practice in the area of child abuse therapy in the following ways. First, this study highlights the value of information from the consumer perspective. Seligman's (1995) Consumer Reports study on psychotherapy effectiveness underscores this point. Seligman argued that client opinions on the helpfulness of various treatments represent a distinct perspective which is to be taken as seriously as the results of controlled outcome studies. More recently, other researchers also have acknowledged the importance of client perspectives (Duncan & Miller, 2000; Macran et al., 1999). Clients' ongoing awareness of their experience is essentially the primary data of therapy, and clients alone have privileged access to their own subjective experience and process of change (Elliott & James, 1989; Greenberg & Pinsof, 1986). Therefore, the importance of their input to the refinement of treatment models cannot be underestimated. Sessions identified by clients as important are viewed as particularly fruitful locations for studying therapy process, because they likely contain aspects of process that were critical to therapeutic change (R. Elliott, 1983, 1985; Elliott & Shapiro, 1992).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Second, results of the present investigation potentially will contribute to knowledge because the convergence of findings across multiple perspectives increases validity and confidence in any treatment model. If client-identified helpful events (HE) contain high quality processes, distinct from the rest of the therapy context (CE), then client perspectives about helpful processes can be considered reliable. As well, if these results corroborate the theoretical perspective, this strengthens confidence in the EFT-AS treatment model and posited mechanisms of change.

Third, the results of the present study potentially will contribute to information on the usefulness of controversial reexperiencing interventions for resolving child abuse trauma. To date, few studies have examined client views of psychotherapy process within trauma therapies, in general, and child abuse therapies, in particular. Because of the risk of retraumatization and low compliance rates for these procedures (Scott & Stradling, 1997), one of the controversies in therapy with this population is whether or not exposure-based techniques are appropriate or necessary for therapeutic change. Knowing whether clients find these procedures useful or helpful would contribute to therapeutic practice with this population.

Fourth, this study potentially will support the utility of the Helpful Aspects of Therapy Questionnaire (HAT; R. Elliott, 1985; Llewelyn, 1988) and the Post-Treatment Interview (PTI; Paivio & Nieuwenhuis, 2001) for assessing client perspectives.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER II

Literature Review

Prevalence of Child Abuse

Childhood abuse involves prolonged and repeated exposure to interpersonal violence in early attachment relationships. It is a traumatic event, just as military combat, imprisonment in concentration camps, domestic violence, and rape are traumatic events (Herman, 1992). Nearly three million children in the United States were reported to have been abused and/or neglected in 1992 (McFarlane & van der Kolk, 1996). In a study of child abuse among Ontario residents (MacMillan et al., 1997), 13% of females and 4% of males reported being sexually abused, and 21% of females and 31% of males reported being physically abused. According to Briere (1992), 20-30% of females and 10-15% of males within the general population have been sexually abused and 10-20% of university students have been physically abused. While there are few estimates of emotional abuse (defined as verbal derogation, threats of violence, and witnessing family violence) Turner and Paivio (2002), in a recent study of Ontario university students, found rates of emotional abuse at 25% for females and 35% for males. Prevalence rates of child abuse in adult clinical samples have ranged from 18-60% (Saxe et al., 1993).

Childhood abuse is a serious problem that can have long lasting consequences for its victims. The various effects which can result from exposure to this trauma will be outlined in the next section.

Effects of Exposure to Traumatic Events

Certain posttraumatic reactions are commonly observed in survivors of all kinds of traumatic events. Posttraumatic Stress Disorder symptomatology [Diagnostic and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Statistical Manual of Mental Disorders (DSM-IV); American Psychiatric Association, 1994], includes three common reactions to trauma: (1) hyperarousal, (2) numbing, and (3) intrusive memories. Another result of traumatic events is (4) disruption to the system of beliefs about self and the world. These four effects will be discussed in turn.

Hyperarousal refers to chronic stimulation of the nervous system, and is reflected in symptoms such as irritability, restlessness, hypervigilance, startle reactions, difficulties concentrating, and sleep disturbance (Briere, 1996; van der Kolk & McFarlane, 1996). After a traumatic event, one's body is constantly on the alert for danger (Herman, 1992). Large increases in heart rate, blood pressure and skin conductance occur in response to sounds, images, and thoughts that resemble the trauma (van der Kolk, 1996). Eventually, hyperarousal occurs in response to intense neutral stimuli as well, and difficulties in regulating arousal develop. Chronic hyperarousal also results in psychosomatic complaints and physical problems such as headaches, hypertension, back pain, and gastrointestinal difficulties (Briere, 1992).

A second posttraumatic reaction is the reliving of the event through intrusive memories such as nightmares and flashbacks (Briere, 1996; Herman, 1992). Traumatic memories can be either forgotten or dissociated to some degree, or they are persistently intrusive. Both of these extremes indicate a failure to integrate the memories (Herman, 1992; van der Kolk, 1996) and intrusion phenomena have been conceptualized as attempts to integrate the traumatic event (M. Horowitz, 1986). Intense emotional arousal at the time of the trauma leaves memories in the form of images, bodily sensations, smells, and sounds that are isolated from other life experiences (van der Kolk, 1996). Since traumatic memories are organized on an implicit, nonverbal level, processing the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

memories on a symbolic verbal level is thus considered crucial for proper categorization and integration of the memories with other experiences (Herman, 1992; van der Kolk, 1996).

A third posttraumatic reaction is numbing. To compensate for chronic hyperarousal and intrusive memories, traumatized individuals often shut down (Herman, 1992; van der Kolk, 1996). One way that survivors shut down is by entering into a detached state of consciousness. While this dissociation may be adaptive during the traumatic event, it is maladaptive afterward because it prevents the trauma memory from being integrated into conscious awareness and healed (Herman, 1992). Maladaptive dissociative symptoms can persist as derealization, depersonalization, out-of-body experiences, and memory gaps (Briere, 1996). In attempts to reduce their distress, survivors also shut down by avoiding any stimuli that are reminders of the trauma (Herman, 1992). Since emotional arousal is akin to re-living the trauma, emotions are experienced as dangerous and to be avoided. This results in constricted emotional experience. Distressing emotional states may also be numbed by ingesting alcohol and drugs (Herman, 1992; van der Kolk & McFarlane, 1996). Emotional numbing has also been implicated in psychosomatic problems (van der Kolk & McFarlane, 1996) and is believed to contribute to immune system breakdown (Pennebaker & Campbell, 2000).

Traumatic events also challenge, and can produce profound changes in the set of fundamental assumptions and beliefs held about self and the world. Basic assumptions about invulnerability and safety in a just world are shattered following a traumatic event (Janoff-Bulman, 1989). The trauma introduces new data that is incompatible with these fundamental assumptions. For example, before the traumatic event, people typically

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

believe they are invulnerable and safe from harm, and that others can be trusted in a basically good world. After the event, however, these beliefs no longer hold true. Victims of traumatic events thus face a cognitive crisis - they must either rework the new data to fit into their old assumptions, or they must change these assumptions. Self-blame, denial, intrusive thoughts, and reframing the trauma in a positive light are viewed as cognitive strategies used by victims to facilitate the integration process and to avoid the complete shattering of their conceptual system (Janoff-Bulman, 1989).

The posttraumatic effects just described can persist for many years after the traumatic event and can profoundly alter physiological, emotional, cognitive, and memory functioning (Herman, 1992). Childhood abuse also produces effects that are distinct and that do not generally result from other kinds of traumas. These will be discussed in the following section.

Long-Term Effects Specific to Childhood Abuse

Childhood abuse differs from other traumas because in many cases it occurs repeatedly and for a prolonged period of time, and because one's abuser is often simultaneously one's parent or caregiver (Courtois, 1997). According to attachment theorists (Sroufe, 1995) it is through our relationship with our parents that we develop our self-esteem, interpersonal trust, and the ability to regulate our emotions. Chronic abuse by family members damages a child's development (Briere, 1996; Courtois, 1996). Three key aspects of development that are damaged by abuse are: (1) emotion regulation, (2) sense of self, and (3) interpersonal functioning.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Impairments to Affect Regulation

The function of parents is both to protect their child from stressful situations, and help him/her build the biological and psychological capacities needed to deal with further stresses (van der Kolk, 1996). When parents are affectively attuned to their child, they provide the needed balance between soothing and stimulation, and teach him/her the skills needed to regulate his/her own physiological and emotional arousal. When parents empathize with their child's feelings and needs, he/she also learns to recognize, label, and describe emotional experience, and to value it as a useful guide to action and goal attainment (Gottman, 1998; Paivio & Laurent, 2001).

In abusive and neglectful environments, a child's feelings and associated needs are ignored and invalidated. The child is exposed to intense negative emotions and at the same time does not learn to adequately manage this intense negative emotion. This results in problems such as underregulation and overcontrol (Paivio & Laurent, 2001). In underregulation, feelings of fear, anger, sadness, and shame are experienced as overwhelming and unmanageable. Anxiety and depression, for example, are often chronic problems for survivors (Courtois, 1996). Self-destructive behaviors such as self-starving, self-mutilation, and abuse of substances have been explained as attempts to regain control of and regulate one's affective states (van der Kolk, 1996). The abused child learns to suppress feelings of sadness and anger using strategies such as dissociation, disavowal, and overcontrol (Paivio & Laurent, 2001). This cuts them off from core feelings and needs that serve to guide behavior.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Since awareness and regulation of internal states is necessary for self-definition, these emotional impairments also compromise the development of a healthy sense of self (Cole & Putnam, 1992).

Impairments to Sense of Self

According to attachment theories (Ainsworth, 1985; Alexander, 1992; Bowlby, 1988), early experiences with significant others are embedded in memory and form the basis of one's sense of self and expectations of others. When parents are loving, supportive, and provide positive responses, a differentiated sense of self and a positive self-concept can develop. For instance, when one's feelings and needs are empathically mirrored by parents, one learns to recognize and label the full range of one's own emotional experience. The awareness of this internal experience allows an individual to build a solid sense of who they are that is separate from others (Paivio & Laurent, 2001). A secure internal base from which to view self and interact with the world is created, and one expects others will be reliable and trustworthy (Bowlby, 1988).

Abused children, however, live in atmospheres where their needs for security and love go unmet, and where their feelings are not attended to or validated. One's body and personal space may be invaded, and psychological denigration in the form of belittling and blame for the abuse is often present (Briere, 1996; Courtois, 1996). From these conditions, a number of difficulties with self-esteem and identity can develop. Those that have been abused can view themselves as worthless, evil, damaged, helpless, and ineffective (Cole & Putnam, 1992; Herman, 1992; van der Kolk, 1996). Abused children may view themselves as bad so that they can continue to see their parents as good and preserve an attachment with them (Herman, 1992). Long after the abuse, survivors can

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

struggle with negative self-esteem, guilt and shame about the abuse, and feelings of betrayal and powerlessness (Cornell & Olio, 1991; Courtois, 1996; Herman, 1992; Liem, O'Toole, & James, 1996). From an insecure internal base, feelings of emptiness, identity confusion and fragmentation, and problems with personal boundaries may develop (Briere, 1992). Having received neither empathic attunement nor emotional coaching from caregivers leads one to minimize or ignore internal experience (Gottman, 1998). The result of this is a lack of clarity about those aspects of internal experience - beliefs, feelings, wants, and needs - that are essential for defining one's identity and sense of self (Paivio & Laurent, 2001).

Impairments to Interpersonal Relations

Not only beliefs about self but expectations of others are formed through early experiences with caregivers (Ainsworth, 1985; Alexander, 1992; Bowlby, 1988). When parents are loving and supportive children are able to trust others and expect positive responses from them.

Due to past betrayal by family members, abuse survivors can have difficulty trusting and relating to others. They have learned that others can't be trusted or relied upon to be supportive or protective in times of need, and they expect to be used or abandoned (Briere, 1996; Courtois, 1996). Therefore, they are fearful and ambivalent about interpersonal closeness and they have trouble with intimacy and self-assertion in relationships (Briere, 1992; Cole & Putnam, 1992; Courtois, 1996; Herman, 1992; van der Kolk, 1996). This may lead them to avoid interpersonal closeness entirely or to accept some level of neglect and/or aggression in relationships as normal or appropriate (Briere, 1992). Their relationship difficulties, and view of self as marked or different,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

can also produce profound feelings of alienation from others (Courtois, 1996; Herman, 1992; Janoff-Bulman, 1992).

These experiences, along with survivors' maladaptive attempts to cope with the abuse, can produce serious and lasting effects into adulthood. These effects commonly include depression (Courtois, 1996; Malinosky-Rummel & Hansen, 1993), anxiety (Beitchman et al., 1992), and interpersonal problems such as difficulties with marriage partners and with parenting (Cloitre, Scarvalone, & Difede, 1997; Davis, Petretic-Jackson, and Ting, 2001). Child abuse histories also are frequently found in clients dealing with substance use disorders, self-mutilation, suicidal behavior, eating disorders, borderline personality disorder, somatization, and dissociative disturbances such as amnesia and multiple personality disorder (Beitchman et al., 1992; Briere, 1992; Courtois, 1996; van der Kolk, 1996).

Treatment for Adult Survivors of Child Abuse - Theory

Since the objective of the present study is to obtain more data about what therapy processes adult survivors of childhood abuse find helpful, it is necessary to outline what therapy processes are theorized to be helpful in addressing the problems outlined above.

Recommended components in the treatment of child abuse survivors overlap considerably with the components of trauma treatments (Courtois, 1996). There is consensus among trauma experts (Briere, 1992, 2002; Herman, 1992; van der Kolk, McFarlane, & van der Hart, 1996) that treatments for posttraumatic stress disorder and other trauma-induced disturbances should include the following phases: (1) safety within the therapeutic relationship, (2) stabilization of emotion, (3) reexperiencing trauma memories and feelings, (4) restructuring of trauma-related cognitions, and (5) re-

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

establishing social connections. Although the components of treatment for childhood abuse trauma are similar to those outlined above, therapy with child abuse survivors gives much more attention to characterological/developmental and personal functioning issues such as self-identity stabilization, object relations, and cognitive and emotion schema (Courtois, 1997).

The consensus among child abuse experts is that treatment first requires building trust and a safe environment which continues throughout the treatment (Herman, 1992; Olio & Cornell, 1993). This therapeutic relationship must be an equal partnership characterized by collaboration on therapeutic tasks, so that power and control are restored to the survivor (Briere, 1996; Herman, 1992). The therapeutic relationship provides a safe environment for exploring painful abuse material (Briere, 1992, 2002; Courtois, 1996; Herman, 1992). This relationship also serves to counter past negative relational experiences with a new interpersonal experience (Courtois, 1997). For example, a secure attachment to the therapist is crucial in the patient's learning to regulate emotional arousal (van der Kolk et al., 1996). A safe and supportive relationship also helps to change disturbances in self-awareness and self-concept, because it allows relaxed monitoring of the external environment and attention to shift to one's internal experience (Briere, 1992). Reduced anxiety about psychologically intimate relationships is another result of the caring, accepting, responsive, and supportive interpersonal environment provided in the therapy (Briere, 1992).

The second component of treatment with abuse survivors is stabilization of overwhelming emotion. In this phase, there is a focus on educating survivors about symptoms, stabilizing symptoms in order to relieve distress, and on developing adequate

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

ego resources and skills for managing emotions (Courtois, 1997). These resources must be in place before any attempt is made to work with traumatic material. A sense of safety emerges from learning how to manage symptoms that are overwhelming, painful, and frightening. Learning to recognize, tolerate, and manage emotions is an important part of this phase. Helping survivors put words to their emotional states allows them to interpret the meaning of their emotional arousal, instead of somatizing their emotions and having them function solely as unpleasant reminders of the trauma. Once trust, safety, adequate ego resources and emotion management skills are established, exploration of trauma memories and other work can begin.

The third component of treatment therefore involves confronting the abuse memories and feelings, and making sense of these traumatic experiences by putting them into words. Painful trauma memories and feelings are reexperienced at a manageable pace so that integration and symptom reduction can occur. This controlled exposure to the trauma material is considered to be a key aspect of treatment for all kinds of traumatic experiences because it facilitates an emotional reprocessing of the traumatic experience (Briere, 1992, 2002; Herman, 1992; van der Kolk et al., 1996).

Emotional processing has been proposed as a change mechanism to explain fear reduction during exposure therapy (Foa & Kozak, 1986). Fear is represented as a network in memory that includes information about the feared stimulus situation, information about verbal, physiological, and overt behavioral responses, and interpretive information about the meaning of the stimulus and response elements of the structure. It is only by activating this fear memory through imaginal reexperiencing of the trauma memory and feelings that one gets access to pathological elements of the structure such

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

as beliefs that the world is entirely dangerous, the self is entirely incompetent, and that persistent PTSD symptoms are dangerous and never-ending. By reexperiencing these memories and feelings in a safe environment with a trusted therapist the structure and associated meanings can be fully activated and then changed through the introduction of new information; by allowing oneself to fully feel the fear in a safe environment, arousal is decreased and the associated maladaptive beliefs about self and the world are accessed, examined, and re-evaluated. Sufficiently high emotional arousal during imaginal exposure appears to be necessary for the successful processing of traumatic events (Hembree & Foa, 2000), as evidenced by its association with better outcomes for female assault victims in a cognitive-behavioral therapy (Foa, Riggs, Massie, & Yarczower, 1995) and long-term resolution of child abuse issues in an affectively focused therapy (Paivio et al., 2001).

Since reprocessing of emotional information is required for the trauma memories to be changed, painful feelings that have been split off from awareness must be reexperienced, allowed, and owned (Herman, 1992; Paivio & Greenberg, 2000). Overcoming avoidance of emotional and other internal experience is thus an important task in the healing process. With attention paid to acknowledging, labelling, and expressing emotions, survivors are better able to articulate and trust their emotional experience and use it for self-understanding (Courtois, 1996). Reprocessing abuse memories in this phase also involves restructuring beliefs about self and others and constructing new meaning (Courtois, 1997; Janoff-Bulman, 1989). Putting words to one's abuse experience and constructing it into a meaningful narrative allows the traumatic memory to be integrated into one's life story (Herman, 1992).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Treatments for Trauma – Empirical Findings

Many therapy approaches have been proposed for the treatment of posttraumatic stress disorder (PTSD), including behavioral, cognitive, experiential, and psychodynamic. While the effectiveness of these varied approaches has been reported in case reports, most have not been empirically verified (Solomon, Gerrity, & Muff, 1992). Cognitive-behavioral treatments have been the most rigorously tested.

For example, stress inoculation training (SIT) is an anxiety management program in which clients acquire and practice coping skills from training in deep muscle relaxation, breathing control, role playing, thought stopping, social skills training, and cognitive restructuring. The effectiveness of SIT in reducing PTSD symptomatology has been demonstrated in both uncontrolled (Kilpatrick, Veronen, & Resick, 1982) and controlled studies ((Foa et al., 1991; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988). Although SIT techniques may have an impact in terms of changing a victim's self-perceptions, they do not address the organization of trauma memories (Rothbaum & Foa, 1996).

Exposure procedures on the other hand directly aim at modifying trauma memories. The effectiveness of exposure procedures such as flooding and imaginal exposure in reducing PTSD symptoms has been demonstrated in controlled studies of combat veterans (Boudewyns & Hyer, 1990; Cooper & Clum, 1989; Keane, Fairbank, Caddell, & Zimmering, 1989) and female assault victims (Foa, Dancu, & Hembree, 1999; Foa et al., 1991). In the Foa et al. (1991) study, prolonged exposure (PE) produced better outcome for PTSD symptoms at follow-up when compared to SIT and a wait-list control. PE is an exposure procedure in which clients are instructed to repeatedly imaginally

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

relive their traumatic experience in the session; to describe the trauma aloud 'as if it were happening now'. These client narratives are tape-recorded, and clients are instructed to listen to the tape at least once each day as homework. It has been proposed that exposure techniques such as PE are effective in reducing anxiety because they facilitate an emotional processing of the trauma material (Foa, Steketee, & Rothbaum, 1989). Indeed, studies have shown that emotional engagement during exposure is associated with better outcome (Foa et al., 1995; Jaycox et al., 1998).

Another form of exposure in which traumatic memories are reexperienced is eye movement desensitization and reprocessing therapy (EMDR; Shapiro, 1989). In this technique, the client tracks the therapist's rapidly moving finger while imagining a trauma scene and focusing on the accompanying thoughts and physiological arousal. Improvements in PTSD symptoms have been found with this treatment (Silver, Brooks, & Obenchain, 1995; Wilson, et al., 1995; Vaughan, Wiese, Gold, & Tarrier, 1994). One study (Pitman et al., 1996) compared a group of combat veterans receiving EMDR with eye movement to another group receiving EMDR without eye movement. Results indicated that the groups did not differ in amount of symptom improvement. Pitman et al. concluded therefore that the eye movements do not influence outcome in this treatment. The critical aspect appears to be reexperiencing the trauma, similar to PE treatment.

Cognitive processing therapy (CPT; Resick & Schnicke, 1992) was designed for rape victims and combines both exposure and cognitive components. For the exposure component clients describe the rape in writing, and then read it aloud to the therapist. In the cognitive component, the goal is to correct maladaptive thoughts and beliefs related to

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the following issues: safety, trust, power, esteem, and intimacy. Significant improvement in PTSD symptomatology has been found for CPT in comparison to a wait-list control (Resick & Schnicke, 1992). However, it is unclear which of CPT's two components contributed to the improvement (Foa & Meadows, 1997). Treatments such as CPT which are a combination of therapies do not appear to be more beneficial than single therapies alone (Foa, 2000).

The positive results found for exposure procedures contribute to the consensus among trauma experts (Briere, 1992, 2002; Herman, 1992; M. Horowitz, 1986; van der Kolk et al., 1996) that reexperiencing trauma memories and processing feelings through some form of exposure leads to symptom reduction and recovery from traumatic experience. Again it must be said however that the usage of these techniques is controversial due to their psychologically stressful nature (Briere, 1989; Wolfsdorf & Zlotnick, 2001; Zlotnick et al., 1997), and compliance with exposure treatments also can be low (Scott & Stradling, 1997). Discovering clients' views about the helpfulness of these therapeutic processes is thus of crucial importance. The present study will shed light on this neglected aspect of trauma treatment research.

One last important note about research on trauma treatments is that participants in most of these studies have been war veterans and survivors of rape (Foa & Meadows, 1997). Other types of trauma have been subjected to very little empirical study. This is certainly true for the trauma of childhood abuse.

Treatments for Adult Survivors of Child Abuse Trauma – Empirical Findings

To date, most research on treatment with abuse survivors are group treatments for female survivors of childhood sexual abuse. For example, Zlotnick et al. (1997) assigned

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

48 female survivors of childhood sexual abuse with PTSD symptoms to either a 15-week affect-management treatment group or to a wait list control group. During the study participants also received individual psychotherapy and pharmacotherapy. The affect management treatment was developed as a first-stage treatment to provide a foundation for later exploratory and exposure-based approaches, and consisted of cognitive-behavioral strategies for restructuring distorted thinking and managing emotions. More improvement in PTSD and dissociative symptoms was found for the anxiety-management group than for the wait-list control.

Saxe and Johnson (1999) examined the effectiveness of a group treatment for female incest survivors. Thirty-one women in a wait-list control group were compared to 32 women in the treatment group. The treatment was a 20-week program in which participants recounted and explored their own abuse history and its effects on their life. It included experiential exercises to help each group member work through their feelings about the abuse. The treatment group evidenced more reduction of intrapersonal symptomatology than the wait-list control immediately after treatment, and at a six-month follow-up.

In a study by Morgan and Cummings (1999), 40 women recruited through newspaper advertisements who were not participating in either individual or group therapy were compared to 40 women in the treatment group. The treatment was a 20-week program that utilized a feminist approach and encouraged participants to look at their abuse from a societal framework, to place blame for the sexual abuse on their abusers, and to express anger in healthy ways. Participants were also taught about common responses to trauma and ways to manage them. The treatment group

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

demonstrated more reduction in depression, social maladjustment, self-blame, and posttraumatic stress responses than the quasi-experimental control group both immediately after treatment, and at a three-month follow-up.

Research on individual treatment for men and women with different types of abuse are virtually non-existent. As well, exposure procedures appear to have little effect on symptoms related to emotional numbing and avoidance (Solomon et al., 1992), and according to Wilson et al. (1995), have not produced improvements on more general measures of functioning such as self-esteem and interpersonal problems. Changing interpersonal and self-related problems is an important phase in treatment and crucial for long-term recovery from childhood abuse (van der Kolk et al., 1996). EFT-AS, the approach that is the focus of the current investigation, is a comprehensive short-term individual treatment approach which addresses self-related, interpersonal, and affective dysfunction along with specific symptomatology. It is appropriate for both men and women who were exposed to various kinds of childhood abuse, including physical, emotional, or sexual.

Research on EFT

EFT-AS developed in the context of programmatic research (Greenberg & Foerster, 1996; Paivio & Greenberg, 1995) on experiential therapy for resolving interpersonal issues from the past. Greenberg and Foerster (1996) examined the therapeutic steps that were needed to produce resolution of these issues using a Gestalt-derived empty chair intervention in which the client engages in dialogue with an imagined significant other. As compared to those of non-resolvers, the events of successful resolvers contained expression of unmet needs, more intense expression of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

emotion, a positive shift in view of the other, and both validation and assertion of the self such that the other was held accountable for his/her actions.

Paivio and Greenberg (1995) found that a short-term treatment based on the above interpersonal resolution model was effective with a general clinical population. Clients who received therapy, as compared to those who participated in a psychoeducational group, demonstrated significantly greater improvement in symptomatology, interpersonal distress, and perceptions of self and other in the unresolved relationship. The sample in this study included a subgroup of individuals who were dealing with child abuse issues. Process analyses of 72 sessions from this subgroup (Paivio, 1995) revealed distinctive features of therapy for child abuse issues. In particular, imaginally confronting abusive and neglectful others during the empty-chair procedure evoked core trauma material, including fear and avoidance that became a focus for subsequent therapeutic work. These analyses formed the basis of a refined model of resolution specifically for child abuse issues.

Postulated Change Mechanisms in EFT-AS

EFT-AS (Paivio & Nieuwenhuis, 2001) is described as an experiential approach (Greenberg & Paivio, 1997; Greenberg, Rice, and Elliott, 1993) that draws on current emotion theory (e.g. Frijda, 1986) and which emphasizes the central role of emotion in functioning and psychotherapeutic change (e.g. Greenberg & Paivio, 1997). EFT-AS also integrates literature on attachment theory (Bowlby, 1988; Sroufe, 1995) and trauma and child abuse (Briere, 2002; Herman, 1992; van der Kolk et al., 1996). Accordingly, it incorporates change principles which facilitate the "emotional processing" found in exposure therapies for trauma (Foa et al., 1991) and which has been recommended for

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

successful recovery from childhood abuse (Briere, 1992; Herman, 1992; van der Kolk et al., 1996). Mechanisms of change that distinguish EFT-AS from other cognitive restructuring approaches to treatment of trauma-related disturbance (e.g. Resick & Schnicke, 1992) are its emphasis on the role of adaptive emotion and the function of the therapeutic relationship in psychotherapeutic change. The EFT-AS model proposes three interrelated mechanisms of change: (1) accessing and modifying trauma memories that generate maladaptive experiences, such as fear and shame; (2) accessing constricted adaptive emotion, such as anger and sadness, in order to access the adaptive orienting information inherent in these emotions; and (3) providing a corrective interpersonal experience with the therapist. Paivio and Nieuwenhuis (2001) described these features as follows.

Trauma memories are accessed by using evocative empathy and an imaginal confrontation (IC) intervention based on the empirically verified model of resolution described earlier (Greenberg & Foerster, 1996; Paivio & Greenberg, 1995). Evocative empathy is the primary intervention of this experiential treatment. Empathy has been defined as understanding another person's subjective experience from his/her perspective, and includes giving that person your undivided attention along with communicating acceptance and a nonjudgmental attitude toward aspects of their experience, such as thoughts, feelings and needs (Paivio & Laurent, 2001). Therapist empathic responsiveness increases client awareness and understanding of their emotional experience and allows for the correction of emotion regulation difficulties. It also has the capacity to powerfully evoke networks of memory and emotional experience for subsequent reprocessing (Rice, 1974).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Therapists from different theoretical orientations view Gestalt dialogues and interventions such as IC as powerful tools for accessing and exploring affective meaning (e.g. Glickauf-Hughs, Reviere, Clance, & Jones, 1996; Teasdale, 1993; Vaillant, 1994). Imaginal confrontation of abusive and neglectful others fosters reexperiencing and reprocessing of the specific interpersonal sources of disturbance. As well, these types of enactments involve the exploration of thoughts, feelings, needs, nonverbal behavior, interpersonal reactions, and bodily experience in an experientially alive context.

Lasting effects of child abuse not only involve maladaptive emotional responses, but also overcontrolled adaptive emotion, such as anger at violation and sadness at loss. Chronic overcontrol and disavowal of emotional experience leaves one cut off from the orienting information thought to be associated with specific emotions (Frijda, 1986). Thus, accessing adaptive emotional responses in therapy also accesses the associated information which then can be used to promote self development and adaptive action. What modifies maladaptive experiences such as fear and shame in EFT-AS is the information from accessing previously inhibited adaptive emotion, rather than skills training or directly challenging distorted beliefs (Paivio & Shimp, 1998). For example, newly claimed anger at violation is thought to foster a sense of empowerment, interpersonal boundary definition, and promote assertive behavior. Likewise, sadness expression permits grieving, acceptance of loss, and accesses self-soothing resources that help one cope with distress.

Another distinguishing feature of EFT-AS is the posited role of the therapeutic relationship (Paivio & Shimp, 1998). In traditional cognitive-behavioral therapies, the therapeutic relationship facilitates engagement in specific interventions thought to bring

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

about change (Gaston et al., 1995). In EFT-AS however, the therapeutic relationship is both facilitative of therapy tasks, and viewed as directly curative because it counters negative relational experiences. This view of the therapeutic relationship fits with the recommendations of child abuse experts (Briere, 1996; Courtois, 1997; Herman, 1992) that this relationship is an important and necessary vehicle for therapeutic change. Therapist empathic responsiveness creates a secure attachment bond which in turn allows for interpersonal trust, self-definition, and emotion regulation capacities to develop (Paivio & Laurent, 2001).

The constructs that are theorized to be key contributors to therapeutic change in EFT-AS are promoting experiencing, accessing adaptive emotion, and providing a safe, collaborative therapeutic relationship. Research concerning these key processes is reviewed below.

Client Experiencing

The experiencing and reexperiencing of trauma feelings and memories is theorized to be a major contributor to change in the reprocessing and resolution of traumatic experiences including childhood abuse issues (Briere, 1992, 2002; Foa et al., 1991; Herman, 1992; Shapiro, 1989; van der Kolk, McFarlane, & Weisaeth, 1996). Facilitating client contact with their subjective internal experience also is thought to be a critical change mechanism in EFT-AS.

The concept of experiencing always has been central within the client-centred and experiential therapy tradition (Rogers, 1951; Gendlin, 1974, 1997). According to Klein, Mathieu-Coughlan, and Kiesler (1986), experiencing involves attending to and articulating the continuous stream of sensations, impressions, somatic events, feelings,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

reflexive awareness, and cognitive meanings that comprise one's inner world. Experiencing has also been described as a way of knowing that is immediate, bodily, holistic and contextual (Bohart, 1993). When one directs his/her attention to internal experience one feels a bodily sense of 'something', but does not yet know what "it" is in terms of its meaning. It is only when the right words are found for this complex bodily sensation that the process will open and flow forward to reveal additional facets of one's present internal experience (Gendlin, 1996). Experiencing is thus a meaning-making process, in which gut-level knowing is expressed in words and concepts. When this gut-level knowing is acknowledged and accurately articulated, shifts from old to new ways of perceiving oneself and one's difficulties can result (Gendlin, 1974, 1997).

The Experiencing Scale (EXP; Klein et al., 1986) operationalizes this construct, that is, the quality of a client's involvement or participation in the process of exploring their own internal experience during psychotherapy. EXP includes seven stages that define the extent to which inner referents are attended to and utilized as data in therapy. At the lower end of the experiencing spectrum clients speak about things in an externalized, impersonal fashion, with no attention paid to inner experience or the meaning of events for the self. At the mid-level of experiencing, a personal, internal account of events is given with feelings listed or described, but these are not used for self-examination. At the higher end of the experiencing spectrum, clients actively explore feelings and felt meanings, connect them to events in their lives, and use them to resolve current problems.

Experiencing and emotion have not always been well differentiated in the psychotherapy literature (Safran & Greenberg, 1991b). While they do overlap,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

experiencing and emotion are believed to be different constructs (Bohart, 1993). For instance, in the developmental literature, emotion researchers have differentiated the physiological arousal components of emotion from the experience component of emotion. Emotional experience is viewed as the most cognitive component of emotion, the operation of which requires both a language of emotion and a self-concept (Lewis & Saarni, 1985). Emotion is part of experiencing and a bodily felt process is involved in both. However, contact with one's emotions is only one part of experiencing. According to Wiser and Arnow (2001), "A client who sobs deeply and at length in session but does not use the felt experience for self or situational clarification would be described as connecting to a powerful emotion, but not as achieving a deep state of experiencing" (p. 158). Indeed, high emotional arousal is found at the middle of the EXP scale and EXP is more closely related to cognition, but according to Bohart (1993), experiencing is neither a solely affective nor a solely cognitive activity. According to Gendlin (1964) experiencing is a process comprised of two aspects: first, making contact with nonverbally sensed meaning, and second, articulating that meaning using words and concepts. Once inner experience is put into words and made sense of, it can be owned and integrated into existing meaning structures (Greenberg & Van Balen, 1998). Experiencing seems to involve both receiving the impact of sensory events in the moment, and synthesizing both cognitive and affective information to then construct new meaning (McGuire, 1991; Wiser & Arnow, 2001).

Role of experiencing in therapeutic change. Experiential awareness seems to be integral to therapeutic change. Theorists from virtually every therapy tradition have acknowledged that awareness at the purely rational, conceptual level is not capable of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

producing enduring therapeutic change (Bohart, 1993; Mahoney, 1991; Safran & Greenberg, 1991a; Teasdale, 1993). Although the provision of new and corrective experiences at the experiential level is common across therapy traditions (Bohart, 1993; Goldfried, 1980), not all therapy traditions incorporate the experiencing concept, however, and there are different perspectives on the role of experiencing in therapeutic change.

Psychodynamic theorists, for example, emphasize that in order to produce therapeutic change, the process of attaining insight - making the unconscious conscious - cannot be a purely intellectual exercise. Instead, clients must attend to and actively explore and experience painful feelings and cognitive meanings with which one has made visceral contact during a given therapy session (Vaillant, 1994). In traditional cognitive therapies, the promotion of experiencing is not considered an important element in therapeutic change, although recently cognitive theorists have acknowledged the importance of attention to the exploration of affective processes, and are now integrating this into new cognitive models (Guidano, 1991; Safran, 1998). As well, exposure procedures do involve activating and reexperiencing problematic inner experiences, such as anxiety or traumatic memories, in order to change them (Barlow, 1988; Foa et al., 1991).

The concept of experiencing, however, is the cornerstone of all experiential approaches. It is considered integral to authentic and in-depth self-understanding (Gendlin, 1964; Rogers, 1951), and so is regarded as an essential ingredient in therapeutic change (Watson, Greenberg, & Lietaer, 1991; Greenberg & Van Balen, 1998). Clients are guided to attend to, explore, and articulate the implicit meanings associated with their

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

internal experience. It is when one operates from the fluid, unfolding, ever-changing information contained in this internal exploration process that self-understanding and personality change can occur. Greater awareness of self and internal experience also has been associated with more mature ego development (Hy & Loevinger, 1996; Loevinger, 1987). The differentiation of feelings and personal meanings allows one to perceive complexities in interpersonal interaction, accept personal responsibility for problems, and realize that options and choices exist for improving one's life. In contrast, when feelings are not owned and there is reliance on information external to oneself, a sense of personal responsibility and agency within one's own life cannot be cultivated.

Evidence linking experiencing with outcome. High levels of experiencing have been related to good therapeutic outcome mainly in client-centred and experiential therapies (Goldman, 1998; Kiesler, Mathieu, & Klein, 1967; Klein et al., 1986). For example, Goldman (1998) studied 35 depressed clients receiving 16-20 sessions of either client-centred or experiential therapy. Results indicated that higher levels of experiencing on the Experiencing Scale predicted decreased depressive symptomatology and improved self-esteem. Furthermore, experiencing was a significant predictor of outcome even when the therapeutic alliance was controlled for.

Experiencing also has been related to good outcome in psychodynamic therapies (Gomes-Schwartz, 1978; O'Malley, Suh, & Strupp, 1983; Windholz & Silberschatz, 1988). For example, in a study of 38 clients diagnosed with either a neurotic or character disorder who received 16 sessions of dynamic therapy, Windholz and Silberschatz (1988) found that higher levels of client experiencing were correlated with therapist ratings of global overall change.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Client experiencing had not been studied in cognitive therapy until very recently. A recent study found that quality of the therapeutic alliance and higher levels of client experiencing were positively related to outcome in cognitive therapy for depression, while a focus on distorted cognitions was negatively correlated with outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes; 1996).

Although the relationship between the experiencing construct and outcome has not been examined in behavioral therapies, the full experiencing of emotions and accessing associated information or meaning is viewed as crucial to the success of behavioral interventions such as imaginal exposure (Foa et al., 1995; Jaycox et al., 1998). This suggests that to some extent one's internal experiencing must be attended to for exposure interventions to be effective. Thus a process similar to experiencing likely occurs in emotional processing, a concept discussed earlier which has been proposed as the change mechanism operating in exposure procedures. In order for trauma-related emotion such as fear to be reprocessed, a restructuring of the entire network of associated maladaptive meanings and responses must occur. This resembles what occurs in experiencing, which is conceptualized as a wholistic meaning-making process.

Emotional Arousal and Expression

Arousal and expression of emotional experience is thought to be a critical change mechanism in EFT-AS. It also is theorized to be a major contributor to change in the reprocessing and resolution of trauma and childhood abuse issues (Courtois, 1996; Foa & Kozak, 1986; Herman, 1992). Emotions have been defined as innate "action tendencies" which arise as a function of automatic appraisals of the relevance of situations to our basic concerns (Lazarus, 1991). Two perspectives on emotion dominate current thinking.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

These are evolutionary-expressive theories (Izard, 1977; Plutchik, 1980), and cognitive appraisal theories (Arnold, 1960; Lazarus, 1982).

According to evolutionary-expressive theories, emotion is defined by the following features. First, emotions are an adaptive biological orienting system which enhances survival. A group of at least six emotions (e.g. fear, sadness, anger, disgust, surprise, joy) are regarded as universal and innate (Ekman & Friesen, 1975; Frijda, 1986; Plutchik, 1980). Each emotion is associated with a different expressive-motor configuration (physiological, facial, postural, and vocal) and serves a different survival related function. For example, anger energizes one to defend an attack, fear moves us to escape danger, sadness closes the body down to facilitate recovery from loss, disgust allows us to remove unwanted intrusions, and joy is rewarding and maintains connectedness with others. Second, emotions are innate action tendencies which establish goal priorities and organize us for particular actions that promote survival (Frijda, 1986; Izard, 1991; Greenberg & Paivio, 1997). For example, with the arousal of fear, there is a stoppage of present activity, monitoring of the environment takes precedence, and through the release of adrenaline, the body readies itself to escape potential danger. Third, emotions are motivational. Through their physiological and action tendency components, emotions prepare and motivate people to deal with events. For example, anger is a powerful and energizing experience which serves not only to defend oneself from outside harm and maintain healthy boundaries and psychological separateness from others, but also to be empowered to take effective action and assert one's needs. Fourth, emotions are communicational. They regulate our interactions with others (Ekman & Friesen, 1975; Lazarus, 1982) by providing information to others about

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

our intentions or readiness to act. For example, when sad one reaches out to others for comfort and crying can bring other people to aid in reducing distress.

Cognitive appraisal theorists (Arnold, 1980; Lazarus, 1982), on the other hand, have proposed that what we experience as emotion is actually a complex synthesis of different levels of information, including emotion, cognition, motivation, and memory. For example, Lazarus (1991) referred to emotions as organized motivational-cognitive-adaptational configurations. Arnold (1980) argued that emotional experience is made up of two components - an intuitive or bodily-based appraisal, and a conceptual or cognitive-based appraisal. Leventhal (1984) proposed a model of emotion in which three levels of processing are involved. Accordingly, an expressive-motor level provides the base from which emotional experience is constructed. A schematic level contains emotional memories built over time. A conceptual level is comprised of rules and beliefs about emotional processing which influences the way that a person constructs or synthesizes their emotional experience.

While these theoretical camps emphasize different aspects of emotion, each acknowledges that emotion has both innate and learned components, and that both physiological and cognitive processes are involved in the generation of emotional experience.

In a final comparison of the emotional arousal concept with that of experiencing, each appear to serve distinct purposes in the promotion of therapeutic change and also are to some extent interdependent as vehicles for therapeutic change. For example, it has been suggested that emotional arousal is a critically important precursor to the experiencing task because it activates a network of adaptive information (Clarke, 1989).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Accessed emotion functions as a portal not only to emotion-specific adaptive information vital to healthy self-definition, but also to networks of maladaptive beliefs, meanings, and behaviors described earlier as fear structures (Foa & Kozak, 1986; Rice, 1974). Without access to the emotion-related aspects of internal experience the process of experiencing would be incomplete. Similarly, the utilization of the information associated with aroused emotion toward creating change seemingly would be impossible without the meaning-making process of experiencing. Emotion cannot be accessed without attending to internal experience, and it has been argued that emotional arousal and expression will not produce therapeutic change unless one focuses on and articulates the broader context of beliefs and meanings associated with the emotion (Clarke, 1989; Greenberg & Safran, 1989; McGuire, 1991; Pierce, Nichols, & Dubrin, 1983).

Role of emotional arousal and expression in therapeutic change. Emotion is highly valued and plays a pivotal role in the promotion of therapeutic change in experiential therapies (Greenberg & Safran, 1987; Greenberg & Safran, 1989). Attending to emotional experience activates an associative network of feelings, beliefs, learned responses, motivation and episodic memory which then is available for exploration and change (Greenberg & Paivio, 1997). According to client-centred theorists such as Carl Rogers and Eugene Gendlin, it is only by experiencing and accepting previously denied emotions that important information about the meaning of events is made available. Gestalt theorists such as Fritz Perls argue that dysfunction occurs when emotions are disowned and interrupted before they can enter awareness (Greenberg, Rice, & Elliott, 1993). By arousing and expressing disowned emotions, physical tension is released and emotional memories are activated (Daldrup, Beutler, Engle, & Greenberg, 1988). More

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

recently, experiential therapy theorists view emotion as a biologically hardwired orienting system that provides the organism with adaptive information and guides adaptive action (Greenberg & Paivio, 1997).

Emotional processes also always have played a central role in psychodynamic therapies (Butler & Strupp, 1991; Greenberg & Safran, 1987). In Freud's early theories, emotional arousal was viewed as the process by which emotion is mobilized and expressed with some degree of intensity in order to restore an organism's balance of psychic energy (Greenberg & Safran, 1987; Nichols & Zax, 1977). Although different views on the role of emotion exist within this tradition, psychodynamic theorists generally believe that distorted views of self and other are corrected, and unconscious needs are made conscious, by fully experiencing emotional responses in the context of the transference relationship (Vaillant, 1994).

In traditional cognitive therapy, therapeutic intervention is not directed toward emotional processes. In order to change maladaptive emotional states such as depression and anxiety, focus is placed upon changing the cognitive meaning ascribed to events – by rationally challenging beliefs and providing schema-inconsistent evidence (Beck, 1987). However, recently cognitive theorists have argued that for cognitive theory to progress, it must acknowledge current views which accord emotion a central place in information processing, and recognize that emotional and cognitive processing are interdependent (Guidano, 1991; Safran, 1998; Teasdale, 1993).

Recent developments in behavioral approaches have led theorists to accord emotion a more prominent role in therapeutic change. It has been found that those who benefit most from behavioral interventions such as desensitization are those who more

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

fully experience anxiety while imagining their feared situation (Foa et al., 1995; Jaycox, et al., 1998). Again, emotional processing discussed earlier has been proposed as the change mechanism which explains the effectiveness of exposure procedures (Foa & Kozak, 1986; Foa & Kozak, 1991), and is believed to be central to recovery from trauma and child abuse.

Evidence linking emotional arousal and expression with outcome. Emotional expression has been linked to good outcome in cathartic or feeling expressive therapies (Nichols, 1974; Nichols & Bierenbaum, 1978; Pierce et al., 1983), and in experiential therapies (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Paivio et al., 2001; Pos, Greenberg, Goldman, & Korman, 2003). For example, Pos, Greenberg, Goldman, & Korman (2003) found that early and late emotional processing predicted decreased depressive symptomatology and increased self-esteem, and that late emotional processing predicted outcome. Greenberg and Malcolm (2002) found that intense emotional expression was characteristic of those who resolved lingering bad feelings toward a significant other, as compared to a group of non-resolvers. Paivio et al. (2001) found that repeated high level engagement in the IC reexperiencing intervention used in EFT-AS was associated with good outcome, after contribution by the therapeutic alliance. Intensity of emotional arousal was a critical component in the extent to which clients were engaged in the intervention.

Emotional expression also has been linked to good outcome in brief psychodynamic therapy (McCullough et al., 1991; Taurke et al., 1990). For example, Taurke et al. (1990) found that, whereas in the early phase of treatment clients in both low outcome and high outcome groups showed an average of one affective response per

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

five defensive responses, by the late phase of treatment, the high outcome clients showed a large shift to one affective response per two defensive responses, while the low outcome clients remained the same. They concluded that one of the effective ingredients in psychodynamic therapy involves prompting clients to experience and express feelings that were previously suppressed through various defenses.

Very few studies have examined emotion processes in cognitive therapy. Hayes and Strauss (1998), for example, found that the degree of client destabilization was associated with decreased depressive symptoms and better global adjustment at posttreatment. They defined destabilization as the extent of variability in client's functioning, including signs of in-session distress, external stress such as changes in sleep and appetite, and shifts in old patterns. Notably, destabilization was strongly associated with in-session affective intensity. More recently, Strauss (2001) found that a strong alliance together with higher emotional arousal predicted the most favorable outcomes in a 52-week cognitive therapy for those diagnosed with avoidant or obsessive compulsive personality disorders.

Support for the effectiveness of emotional arousal also has been found in behavioral therapies, particularly trauma therapies. Clients generating higher levels of fear engagement during an exposure procedure sustained greater improvements at the end of treatment (Foa et al., 1995; Jaycox et al., 1998). These behavioral researchers concluded that emotional engagement during exposure is needed for a successful outcome. Engagement with emotions, both during reexperiencing interventions and throughout therapy, is proposed to be one of the main vehicles for change in EFT-AS, and has been associated with good outcome in EFT-AS (Paivio et al., 2001).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The Therapeutic Relationship

The therapeutic relationship is a common change factor across therapy modalities (Horvath & Luborsky, 1993) and a central change mechanism in EFT-AS. It is also theorized to play an important role in recovery from childhood abuse by creating a safe context in which to explore memories and feelings associated with the abuse (Herman, 1992; Olio & Cornell, 1993).

Psychoanalytic theorists (e.g. Sterba, 1934; Zetzel, 1956) offered the earliest conceptualizations of the therapeutic relationship (Horvath, Gaston, & Luborsky, 1993). It was theorized that the realistic, collaborative aspects of the relationship were to be differentiated from distorted aspects of the relationship referred to as transference. Transference is the unconscious projection of the client's unresolved past interpersonal dynamics onto the therapist, and is unreal in the sense that it is a misperception of the therapist. Building upon these ideas, Greenson (1965) proposed that the alliance is a reality-based attachment comprised of both the client's affectionate feelings toward the therapist, and the client's capacity to work in therapy. The strength of this reality-based alliance is used to resolve the neurotic attachment patterns seen in the transference. Pioneering conceptualizations of the therapeutic relationship also came from the client-centred tradition. Rogers (1951) introduced three propositions about the therapeutic relationship. Firstly, he proposed that the relationship conditions of empathy, congruence, and unconditional positive regard were sufficient to produce client change. Secondly, he proposed that these relationship conditions were responsible for change in all types of therapies. Thirdly, Rogers proposed that the therapist alone is responsible for providing the relationship conditions.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Bordin (1979) broadened previous psychoanalytic definitions by providing a conceptualization of the alliance that was transtheoretical. He defined the alliance as the attachment and collaboration between therapist and client. According to Bordin's model the alliance is comprised of three interdependent components: 1) agreement on goals, 2) agreement on therapeutic tasks, and 3) development of a therapeutic bond. Goals are defined as those areas targeted for change, and there must be consensus and clarity about these short and long term outcomes that will result from the agreed upon therapy tasks. Tasks refer to the activities or interventions of therapy, and there must be consensus on which interventions are to be used and how they will help to resolve the client's problem. The bond is defined as the mutual liking, attachment, and trust between client and therapist - it includes all positive personal attachments between client and therapist. According to Bordin the quality of the alliance is a function of the agreement between therapist and client regarding the goals and tasks of therapy. This agreement is mediated by, and in turn mediates, the quality of the bond between therapist and client.

Role of the alliance in therapeutic change. In the traditional psychodynamic view, the alliance is defined as the collaborative and realistic aspects of the relationship, and is differentiated from the transference, which are the distorted reactions from the client to the therapist (Frieswyk et al., 1986; Gaston et al., 1995; Gaston, 1990). The alliance allows the client to receive and work with interpretations provided by the therapist, but it is the working through of transference reactions that directly produces change. While certain psychoanalytic theorists (Brenner, 1979) have contended that all aspects of the therapeutic relationship are transference, and that the reality-based alliance doesn't exist, other psychodynamic theorists view the alliance as curative in and of itself.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

It is thought that a client internalizes both the good-enough aspects of the therapeutic relationship and the working style of the therapist into their capacity to experience and observe, resulting in improved perceptions of self and others. In the behavioral tradition, theorists consistently have emphasized the role of techniques over the therapy relationship, and have viewed the alliance as a supportive context for the interventions (Horvath, 2000). Cognitive-behavioral theorists have also seen the role of the alliance as one of facilitating engagement in interventions by creating an environment of safety and trust (Gaston et al., 1995; Horvath, 2000). It is only recently that some cognitive-behavioral theorists have ventured that the alliance may at times be curative in and of itself. For example, Goldfried and Raue (Gaston et al., 1995) noted that care and validation from a therapist can help some clients to acquire a more positive view of themselves.

Experiential theorists believe that the therapeutic relationship fulfills two roles: 1) functioning as a contextual variable which facilitates key interventions and 2) being directly curative in repairing early negative relational experiences (Gaston et al, 1995). Firstly, utilizing Bordin's (1979) conceptualization of the alliance, experiential theorists (Greenberg & Paivio, 1997) propose that key tasks of therapy, such as experiencing painful emotion, can only be attempted once a therapeutic bond and collaboration on tasks are established. The bond and collaboration provide a safe and stable context which allows one to experience and express the painful emotions that are part of interventions such as exposure and other techniques where trauma is reexperienced. Secondly, the alliance is also considered directly curative in a number of ways. The bond component of the alliance is thought to cure by way of two mechanisms. The therapist's acceptance

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and positive regard is internalized by the client, leading to an increased sense of self-worth. And, the therapist's attunement to and empathic reflection of the client's internal experience directly affirms and validates that experience. The collaboration component of the alliance also contains curative elements. The safety and control inherent within the collaboration component provide new interpersonal experiences. This is especially needed by abused individuals whose problems stem from experiences of profound powerlessness and lack of control (Herman, 1992; Olio & Cornell, 1993).

Evidence linking the alliance with outcome. The alliance has been found to be correlated with outcome in psychodynamic therapies when using client or therapist ratings of the alliance (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000;) and when using observer ratings of the alliance (Eaton, Abeles, & Gutfreund, 1988; Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Gaston, Piper, Debbane, Bienvenu, & Garrant, 1994; Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984; Krupnick et al., 1996; Marziali, 1984). For example, Gaston, Piper, Debbane, Bienvenu, and Garrant (1994) studied the impact of alliance and technique, and their interactions, on outcome within short- and long-term psychoanalytic therapy. They found that quality of the alliance predicted a decrease in symptoms in the short-term therapy, and a decrease in interpersonal problems in the long-term therapy.

The alliance has been found to be correlated with outcome in cognitive therapies when using client or therapist ratings of the alliance (Marmar, Gaston, Gallager, & Thompson, 1989; Muran et al., 1995; Safran & Wallner, 1991), and when using observer ratings of the alliance (Castonguay et al., 1996; Gaston et al., 1998; Rounsaville et al., 1987). For example, Castonguay et al. (1996), in cognitive therapy for depression, found

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

that observer ratings of alliance quality were predictive of decreased depressive symptomatology and improvements in global functioning at both midtreatment and posttreatment. Very few studies have examined the alliance within behavioral therapies. However, the alliance has been found to be correlated with outcome in behavioral therapies when using client or therapist ratings of the alliance (Marmar et al., 1989), and when using observer ratings of the alliance (Gaston et al., 1998).

The alliance has been found to be correlated with outcome in experiential therapies when using client ratings of the alliance (Greenberg & Webster, 1982; Horvath & Greenberg, 1989; Paivio & Bahr, 1998; Paivio & Patterson, 1999). For example, Paivio and Bahr (1998) studied 33 moderately distressed clients receiving a short-term experiential therapy for unresolved interpersonal issues. A Gestalt-derived empty-chair dialogue was the primary intervention for exploring these issues, which included unmet needs in relationships with a parent or adult attachment figure, child abuse and neglect, and complicated grief from loss or abandonment. Using client ratings of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), they found that early and late alliance predicted different dimensions of outcome. A strong early alliance predicted decreased symptomatology at the end of therapy, while a strong alliance at the end of therapy predicted both decreased symptomatology and increased unfinished business resolution.

Overall, there is abundant empirical support demonstrating that the therapeutic alliance is a contextual factor which is integral to client change. Research indicates that this process variable is correlated with, and a good predictor of, outcome across populations and treatment approaches (Horvath & Luborsky, 1993; Horvath & Symonds,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1991; Orlinsky, Grawe, & Parks, 1994). The alliance, when assessed early in therapy, is considered the best predictor of treatment outcome as compared to other process variables (Horvath & Luborsky, 1993). Clients' and observers' ratings of the alliance in particular, are more predictive of outcome than are therapists' ratings (Horvath & Symonds, 1991).

Empirical Support for the EFT-AS Model

Efficacy of EFT-AS

A recent study demonstrated the effectiveness of EFT-AS for resolving different types of childhood abuse (Paivio & Nieuwenhuis, 2001). Twenty-three individuals immediately began EFT-AS and another 24 served as a control group and were placed on a waitlist. After a wait period of approximately 20 weeks, 21 individuals in the wait group began therapy. In total, thirty-two adult survivors of childhood abuse (emotional, physical, and sexual) received 20 weeks of individual psychotherapy. Clients receiving EFT-AS achieved significantly greater improvements, compared to clients in a wait-list condition, on multiple measures of disturbance. These included general and trauma specific symptomatology, global interpersonal problems, resolution of interpersonal issues with abusive and neglectful others, and self-esteem. Comparable improvements were obtained by the delayed treatment group when they received EFT-AS after the wait interval. These treatment effects were maintained at nine-month follow-up.

Mechanisms of Change in EFT-AS

Emotional processing. Postulated change processes within the EFT-AS context have also been studied. A process-outcome study (Paivio et al., 2001) examined the relative contributions of the therapeutic alliance and the primary reexperiencing

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

intervention to treatment outcome. The reexperiencing intervention is a Gestalt-derived imaginal confrontation (IC) intervention similar to that used in the Paivio and Greenberg (1995) study. As clients are talking about their victimization, they are directed to imagine the abusive or neglectful other in an empty chair, to attend to their internal experience while doing this, and express previously constricted thoughts and feelings about the abuse directly to the imagined other. The quality of client engagement in this intervention was measured using the Levels of Engagement Scale (LES). The observer-rated scale was developed for this study and found to be a reliable and valid measure of client engagement in the imaginal confrontation procedure. Low client engagement was defined as minimal or no interaction with the imagined other. High engagement was characterized by exploring the meaning of abuse experiences and emotional arousal. Repeated high level engagement (dosage) in the IC intervention over the course of therapy contributed to a breadth of change, after contributions made by the therapeutic alliance. This finding supports engagement in IC and the processes of experiencing and emotional arousal and expression as components of change in EFT-AS (Paivio et al., 2001). These findings also are consistent with existing research supporting the effectiveness of exposure and reexperiencing techniques in treatments for trauma (Foa et al., 1991; Jaycox et al., 1998).

Therapeutic relationship. Concerning the therapy relationship, research outlined earlier indicates that the therapeutic relationship reliably predicts outcome across therapy models and client groups (e.g. Horvath & Luborsky, 1993). A clinical assumption with regard to abuse survivors is that it can be difficult for these individuals to establish a strong treatment relationship, because of difficulties with interpersonal trust stemming

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

from negative early attachment experiences (D. Elliott, 1994). Paivio and Patterson (1999) used client self-reports to examine the connection between child maltreatment, alliance development, and outcome in EFT-AS. Contrary to this assumption, clients in EFT-AS reported strong early alliances that were comparable to a group of 33 clients receiving a similar type of experiential therapy for resolving unfinished interpersonal business (Paivio & Bahr, 1998). However, alliance ratings also significantly improved from early to late sessions. In addition, this study found that severity of childhood physical and emotional abuse, and the presence of DSM-IV Axis II symptomatology, were associated with weaker alliances early in therapy. At the end of therapy however, only Axis II symptomatology was associated with weaker alliances and none interfered with outcome. These findings support emphasis on establishing and maintaining a safe and collaborative relationship and support the therapeutic relationship as a change mechanism in EFT-AS.

Importance of Studying Therapeutic Process From Multiple Perspectives

Research that supports proposed mechanisms of change in EFT-AS utilized both client self-report questionnaires and observer ratings. There is a consensus that psychotherapy process should be studied from multiple vantage points (Elliott & James, 1989; Greenberg & Pinsof, 1986). For example, therapists are observers with extensive training and detailed knowledge of the client. They therefore may be able to identify client experiences that clients are unwilling or unable to express (Elliott & James, 1989). The therapist also has privileged access to their own subjective experiences of the therapy interaction. However, this perspective has limitations. Therapists essentially operate from the perspective of an external observer (Rennie & Toukmanian, 1992). They do not

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

have full access to the client's internal experiences of therapeutic change, and thus do not have complete knowledge of the processes operating within the therapy interaction. For example, this was demonstrated in a meta-analysis combining the results of 24 studies which examined the relation between therapeutic alliance quality and outcome (Horvath & Symonds, 1991). Clients' and observers' reports of the alliance were found to be more predictive of outcome than were therapists' reports.

With some exceptions, the client's perspective of helpful therapy processes has generally been neglected in psychotherapy research (Duncan & Miller, 2000; Macran et al., 1999). Researchers have advanced several reasons why obtaining clients' perspectives of therapy is important and advantageous (Bohart, 2000; Duncan & Miller, 2000; Elliott & James, 1989; Macran et al., 1999; Rennie & Toukmanian, 1992; Seligman, 1995; Strupp, 1996). First, from the standpoint of consumer satisfaction, it is important to access clients' opinions about what aspects of our therapy product are helpful and unhelpful, in order that the therapy product we deliver is made more effective. Second, since the whole point of psychotherapy research is to improve the experience and outcome of therapy for clients, their input is central to advancing our understanding of psychotherapy. Clients' opinions about various aspects of therapy process have indeed been found to differ from those of their therapist or external observers. Within experiential approaches, clients are viewed as experts on their own experience, and clients' ongoing awareness of their experiences is considered the primary data of therapy (Greenberg, Elliott, & Lietaer, 1994). Clients alone have privileged access to their own subjective experience and process of change. Thus we cannot fully know about clients' experiences or fully understand how psychotherapy facilitates change

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

without asking them directly for their input. Third, research findings show that about 40% of the variance in psychotherapy outcome is due to the client and factors in the client's life (Bohart, 2000). This suggests that clients have self-healing capacities and are active agents who contribute to their therapeutic success rather than passive recipients of treatments. It strengthens the argument that client observations about what prompted their psychological change are essential to understanding therapeutic change. Fourth, because they are less familiar with theoretical concepts and jargon than therapists and observing researchers, clients also provide a fresh perspective with regard to understanding therapeutic change processes, in the form of new words, thoughts, and descriptions.

There can be limitations, however, to the input clients provide. These include not being aware of or remembering particular processes during therapy, being biased by preexisting beliefs, deliberately or unconsciously limiting information given to the researcher, or being influenced by therapist ideas and rationale of what's helpful (Elliott & James, 1989). Additionally, their lack of conceptual knowledge or vocabulary or awareness could hinder their ability to describe what happened to them. Some of these gaps can be filled by an observer vantage point.

Psychotherapy process research most typically employs the perspective of an outside observer (Lambert & Hill, 1994). An observer is defined as a third-party who does not directly interact with the client and therapist (Rennie & Toukmanian, 1992). They look at psychotherapy process by watching live therapy sessions, watching videotapes of therapy sessions, listening to audiotapes of therapy sessions, or reading transcripts of sessions. There are a number of advantages to having a third party observe

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

therapy interactions. Whereas therapist and client are biased observers, and likely don't have awareness of the full range of processes occurring, a neutral third party can view the interaction more objectively (Rennie & Toukmanian, 1992). The reliability of observer ratings can be established, and observer ratings are convenient because many different therapy processes can be viewed, and viewed repeatedly (Elliott & James, 1989).

Just like the other two perspectives, this one too has limitations. The ratings of observers also are subject to biases and errors, such as past experiences affecting rating judgements (Lambert & Hill, 1994). Another drawback of the observer perspective is its distance from the phenomenon being studied, and the possibility of important aspects being overlooked (Rennie & Toukmanian, 1992). Hence the need for multiple vantage points.

Research on Client Perspectives

The value and credibility of client opinions about psychotherapy was advanced following the Consumer Reports study on the effectiveness of psychotherapy (Seligman, 1995). Seligman (1995) argued that a full understanding of whether or not psychotherapy 'works' or is useful would require both controlled efficacy studies, and those in which client opinions were examined. Recently, psychotherapy researchers have argued not only for consideration of client perspectives (Macran et al., 1999), but also for recognition of clients as active agents who contribute significantly to the change process and who possess their own legitimate theories of change (Bohart, 2000; Duncan & Miller, 2000; Miller & Duncan, 2000; Spinelli, 2001). Researchers have examined client perceptions of factors contributing to therapeutic change in the following therapeutic contexts: short-term behavioral versus analytically-oriented or interpersonal therapy

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988; Llewelyn & Hume, 1979; Sloane, Staples, Whipple, Cristol, 1977), cognitive-behavioral versus interpersonal therapy for depression (Gershefski, Arnkoff, Glass, & Elkin, 1996), cognitive-behavioral therapy (Murphy, Cramer, & Lillie, 1984), psychodynamic therapy (Feifel & Eells, 1963) short-term experiential therapy (Grafanaki & McLeod, 1999), eclectically oriented therapy (Llewelyn, 1988; Martin & Stelmaczonek, 1988), therapy for borderline personality disorder clients (Cooley, 1996), counselling for suicidal behavior (Paulson & Worth, 2002), and group therapy for survivors of childhood sexual abuse (Draucker & Petrovic, 1997; Janocko, 1995; Wheeler, O'Malley,Waldo, Murphey, & Blank, 1992).

In a review by Elliott and James (1989), the main themes in the literature regarding clients' perceptions of helpful aspects of therapy were: facilitative therapist characteristics, a supportive therapy relationship, client unburdening, insight or self-understanding, and therapist encouragement of extratherapy practice. A recent review of this literature by the author revealed the following most frequently reported helpful factors: (a) "aspects of the therapy relationship" which included talking to someone who understands (Grafanaki & McLeod, 1999; Murphy et al., 1984), a helpful therapist (Gershefski et al., 1996), a non-judgemental therapist (Kaschak, 1978), non-specific relationship factors (Llewelyn & Hume, 1979), connection with therapist as a person (Draucker & Petrovic, 1997; Feifel & Eells, 1963; Llewelyn et al., 1988), being seen, heard, and understood by someone who cares (MacCormack et al., 2001), therapist personality (Sloane et al., 1977), a validating relationship (Paulson & Worth, 2002), counsellor facilitative interpersonal style (Paulson, Truscott, & Stuart, 1999), understanding, emotional support, and therapist as real person (Elliott, 1985), therapist

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

interventions such as support, empathy, interpretation, and self-disclosure (Sloane et al., 1977); (b) "expression of emotions" which included emotional expression (Cooley, 1996), catharsis (Feifel & Eells, 1963; Sloane et al., 1977; Wheeler et al. 1992), increased awareness of feelings that previously were avoided (Llewelyn et al., 1988), description and exploration of feelings (Martin & Stelmaczonek, 1988), emotional relief (Paulson et al., 1999), working with emotions (Paulson & Worth, 2002); (c) "insight" which included insight (Cooley, 1996; Llewelyn, 1988; Martin & Stelmaczonek, 1988; Sloane et al., 1977), self-understanding (Wheeler et al., 1992), new perspectives (Paulson et al., 1999), and new information resulting in insight, awareness or cognitive restructuring (Elliott, 1985); (d) "a place or time or structure for talking about problems with someone" (Feifel & Eells, 1963; MacCormack et al., 2001; Paulson et al., 1999) and (e) "problem solutions" (Elliott, 1985; Llewelyn, 1988; Llewelyn et al., 1988) also conceptualized as expressions of new ways of being or behaving (Martin & Stelmaczonek, 1988).

The perspectives of trauma survivors in particular have been examined only within the context of group therapy (Draucker & Petrovic, 1997; Janocko, 1995; Wheeler, O'Malley,Waldo, Murphey, & Blank, 1992). For example, Wheeler et al. (1992) examined the most helpful factors in a 20-session group therapy (with seven female incest survivors) based on Yalom's (1985) process oriented model. First, a q-sort by clients of researcher-generated helpful categories yielded the following top factors: catharsis, self-understanding, existential meaning, and cohesiveness. Second, client-generated responses to the question 'What event (incident, interaction) from this session was most helpful to you?', yielded the following most frequently reported helpful factors: self-understanding, vicarious learning, acceptance, and self-disclosure. Draucker and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Petrovic (1997) conducted a content analysis of 19 male sexual abuse survivors' reported experiences of therapy and helpful therapist characteristics. All had participated in some form of therapy and were recommended for the study by therapists in the community. Participants reported the following as helpful therapist characteristics: being knowledgeable about male sexual abuse issues, informing the client about therapeutic process, being professional but real and connected, respecting client's process and pace, having patience and going the distance with the client, and letting the client go when it is time.

Four studies accessed multiple perspectives of psychotherapy process, wherein client and therapist perspectives of helpful therapy aspects were compared (Feifel & Eells, 1963; Kaschak, 1978; Llewelyn, 1988; Martin & Stelmaczonek, 1988). For example, Martin and Stelmaczonek (1988) found that the types of important events most frequently identified by clients (n = 8) in short-term eclectically-oriented counselling sessions were the same as those identified by therapists. These included expressions of insight and understanding, and personally revealing and significant material pertaining to self or interpersonal relationships. The Martin and Stelmaczonek study also compared the small group of client-identified important events to a group of researcher-identified control events. The dependent measures were observer ratings on five information-processing dimensions: Deep-Shallow, Elaborative-Nonelaborative, Personal-Impersonal, Clear-Vague, and Conclusion Oriented-Descriptive Oriented. Client-identified important events were characterized by dialogue that was significantly deeper, more elaborative, and more conclusion-oriented compared to researcher-identified events.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Trauma survivors' perspectives of individual psychotherapy recently were examined in an unpublished preliminary study. Holowaty and Paivio (2000) examined client reports of the helpful processes within EFT-AS using the archival data of 37 clients collected in the context of a larger process-outcome investigation of EFT-AS (Paivio & Nieuwenhuis, 2001; Paivio et al., 2001). Client views were gathered using the Helpful Aspects of Therapy Questionnaire (HAT; R. Elliott, 1985; Llewelyn, 1988), administered at mid and post treatment (M-HAT, P-HAT), and posttreatment interviews (PTI; Paivio & Nieuwenhuis, 2001). These instruments asked clients to identify helpful aspects of therapy and to estimate their location in therapy. A content analysis of client responses was conducted wherein meaning units based on a single idea, were identified and resulted in the creation of helpful process categories. The frequency with which particular processes were reported across all three data sources (M-HAT, P-HAT, PTI) was calculated in order to provide an indication of which processes clients found the most helpful in EFT-AS. From a total of 286 helpful therapy processes reported by clients, 12 process categories were identified. These categories and their frequencies are presented in Table 1.

Description of the top four processes is as follows. (1) Outward Verbal or Physical Expression of Emotion included disclosure of feelings previously kept hidden, expressing anger physically by using fists or a therapy bat, and emotional expression creating sensations of relief or release (e.g. "being able to vocalize my anger, my hatred; helped me to release the deep seated feelings I had toward my parents"). (2) Aspects of Therapy Relationship included feelings of safety and trust, therapist genuineness and compassion, and collaboration on the goals and tasks of therapy (e.g. "Therapist did not

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 1

Client-Identified Helpful Therapy Processes in EFT-AS

Therapy Process	Frequency
1. Outward Verbal or Physical Expression of Emotion	62
2. Aspects of the Therapeutic Relationship	54
3. Exploring Abuse Issues using the IC Intervention	47
4. Allowing Full Experiencing of Emotions/Memories	45
5. Gestalt-derived Two-Chair Dialogue with Self	17
6. Insight About Self	15
7. Discussion of a Specific Topic	13
8. Specific Therapist Skills	12
9. Specific Therapist Feedback	7
10. Other Unique Processes	7
11. Completing Questionnaires	4
12. Exploration of Present Moment Feeling	3

Note. As reported in Holowaty and Paivio (2000).

N = 37.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

push or force issues, trust was built slowly and carefully"). (3) Exploring Abuse Issues using the IC Intervention involved expressing feelings and needs, and associated meanings such as the impact on self-concept and interpersonal relating, in a dialogue with an imagined abusive or neglectful other (e.g. "[The IC was] a big help in sorting things out – you physically get up and it's a different angle there"). (4) Allowing Full Experiencing of Emotion/Memories included accessing and reliving memories, allowing or accepting painful or threatening feelings that previously had been suppressed, and feeling the reality or experiential impact of one's feelings (e.g. "Able to face and be aware of how much fear I carry").

Results from this preliminary study (Holowaty & Paivio, 2000) indicated that the therapy processes clients found most impactful were consistent with important ingredients of the EFT-AS treatment model. These are, namely, accessing and experiencing previously inhibited emotions, expressing those feelings and exploration of their associated meanings, particularly within the IC procedure, as a means to emotionally process trauma memories, and the therapeutic relationship, which functions as a safe and stable context for exploring trauma feelings and memories. However, it could be argued that clients' perceptions of helpful therapy process could have been biased by therapists' comments about therapy process, or that the experimenters' theoretical bias could have influenced the development of process categories. Therefore, these findings had limited usefulness and required further investigation.

To this end, client responses analyzed in the Holowaty and Paivio (2000) study contained not only descriptions of the therapy processes and events they found most helpful, but also estimates of the session locations of those helpful events. It was thought

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

that additional valuable information about helpful therapy processes in EFT-AS could be gained by studying these client-identified events from an observer perspective.

The Present Study

The present study therefore located 29 client-identified helpful events (HE) and compared process characteristics in these events with those in 29 researcher-identified control events (CE). HE were located in videotaped sessions that had been identified by clients in the Holowaty and Paivio (2000) study. Specific criteria were used to select one helpful event for each client. CE for each client were selected by the researcher from the remainder of sessions that did not contain a client-identified helpful event. These CE were selected from the same phase of therapy as the corresponding HE in order to control for early-late therapy effects. The purpose of the present study was to determine if HE were distinguished from the remainder of therapy (CE) in terms of content and emotion processes. The choice of which processes to examine was guided by results from the Paivio and Holowaty (2000) study of client-identified helpful processes in EFT-AS, as well as child abuse treatment theory (e.g. Briere, 2002; Courtois, 1997; Herman, 1992) and EFT-AS theory (Paivio & Neiuwenhuis, 2001; Paivio & Shimp, 1998). Accordingly, processes which promote change include reexperiencing and exploring child abuse memories and feelings, expressing previously inhibited adaptive emotion and exploring associated meanings, and the therapeutic alliance. Emotion processes could be operationalized by the process dimensions of depth of experiencing and level of emotional arousal. It was expected therefore that HE would be characterized by greater focus on child abuse content, and higher quality emotion processes, particularly greater depth of experiencing and higher levels of emotional arousal compared to CE. The

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Client Experiencing Scale (EXP; Klein et al., 1986) and the Emotional Arousal Scale (EAS; Daldrup et al., 1988) were used to rate emotion processes from an observer perspective. Ratings from HE and CE were statistically compared.

Although the therapeutic alliance also had been identified by clients as a core helpful aspect of EFT-AS (Holowaty & Paivio, 2000), process examination of alliance quality was a secondary focus in the present study for a number of reasons. Only one client was able to identify a specific session in which a helpful aspect of the therapy relationship occurred. Furthermore, aspects of the therapeutic relationship that clients found helpful (e.g. feelings of safety and trust in the therapist, therapist genuineness and compassion, and client control over the process of therapy) appear to be contextual factors rather than discrete events. This is consistent with EFT-AS theory that the alliance is a crucial contextual factor which needs to be maintained throughout the entire course of therapy, and with research on client perspectives (e.g. Draucker & Petrovic, 1997; Gershefski et al., 1996; Llewelyn et al., 1988; Paulson & Worth, 2002) where general and presumably consistent therapist aspects, such as being validating or non-judgmental, were reported as helpful. Unlike some psychodynamic models that rely on explicit working through of transference reactions emerging from the therapy relationship in order to produce change (Gaston et al., 1995), the alliance in EFT-AS typically is not an explicit focus of treatment process, except when ruptures interfere with treatment, and ruptures are explicitly averted. Alliance factors therefore would not be expected to differ noticeably between sessions. Research supports this position and indicates that alliance quality generally is stable across therapy with small fluctuations in the form of ruptures and repairs (Horvath, 1994; Nieuwenhuis, 2002). Therefore, I did not expect to find a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

difference between HE and CE in terms of alliance quality, and there was no justification for conducting labour-intensive process analyses of this dimension. However, available client scores on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) from sessions containing HE and CE were examined.

Hypotheses and Expectations

1) It was predicted that client-identified helpful events (HE) would be characterized by a greater focus on child abuse issues, compared to researcher-identified control events (CE).

2) It was predicted that HE would be characterized by greater depth of client experiencing, compared to CE.

3) It was predicted that HE would be characterized by higher levels of emotional arousal, compared to CE.

4) It was expected that sessions containing HE and CE would be characterized by equally strong therapeutic alliances.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER III

Method

Participants

In this study, I have used archival data collected between 1995 and 1997 in psychotherapy research conducted at the University of Saskatchewan (Paivio et al., 2001; Paivio & Nieuwenhuis, 2001). This research was approved by the ethics board at the University of Saskatchewan and the University of Windsor. Participants in the present study are a subset (N = 29) of the total Paivio et al. (2001) sample (N = 37) for which complete process and outcome data was gathered. Paivio et al. (2001) reported client recruitment, inclusion and exclusion criteria, therapy, and therapist characteristics as follows.

Recruitment

Participants were recruited through referrals and newspaper features about free psychotherapy in exchange for completion of assessment questionnaires. Therapy was described as focusing on child abuse experiences and emotional expressiveness. Respondents were screened by telephone (n = 110) and in semi-structured selection interviews (n = 63). Questions assessed compatibility with the therapy, mental health and interpersonal history, abuse characteristics, and current symptom status.

Inclusion and Exclusion Criteria

Individuals were excluded if they were under 18 years, currently undergoing another therapy, taking psychoactive medication, in a crisis that required immediate attention, and had no conscious recollections of childhood abuse. They also were excluded if the primary presenting problem involved extreme emotion dysregulation with

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

a risk of aggressive or self-harm behavior, if they were currently in a violent relationship, or had currently active drug or alcohol problems. Those who were excluded were referred to other organizations. Participants were included on the basis of commonly accepted criteria for short-term insight-oriented therapy (Beutler, Clarkin, & Bongar, 2000) including motivation, capacity to form a therapeutic relationship, and capacity to focus on the circumscribed issue of child abuse. Twenty-three individuals immediately began EFT-AS and another 21 began therapy following a wait period. Thirty-seven individuals completed therapy and 24 of these also completed follow-up assessments.

A subset (n = 29) of participants from this original investigation (Paivio et al., 2001) were included in the present study. Clients were included if at least one helpful event could be readily identified in videotaped therapy sessions. Eight clients were excluded due to failure to complete self-report instruments or to vaguely defined helpful events and locations on those instruments.

Therapy and Therapists

Therapy

Paivio et al. (2001) described the therapy as follows. Therapies consisted of an average of 19 weekly, one-hour sessions (SD = 4.01, range, 7-27). Length was decided collaboratively according to individual client needs. The treatment manual (Paivio, 1996) applied the general principles of emotion focused therapy (Greenberg & Paivio, 1997) to this client group and incorporated similar techniques to those used in process-experiential therapy (Greenberg, Rice, & Elliott, 1993). There were three interrelated therapeutic tasks. The first was establishing a safe and collaborative therapeutic relationship. The primary intervention was empathic responding to client presently-felt

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

subjective experience. This is intended to help clients feel accepted, understood, and less isolated, direct clients' attention to their internal experience, and help clients articulate the meaning of these experiences. The second task was overcoming defensive processes, including avoidance or overcontrol of emotional experience, and guilt and shame about the abuse. A variety of Gestalt-derived and imagery techniques were used for exploring and reducing defensive processes as they emerged in the course of exploring trauma material. For example, 2-Chair dialogues are used to help explore self-critical and self-interruptive conflicts, whereby the client enacts the critical or interruptive part that suppresses adaptive experience. The third task was resolving issues with past abusive and neglectful others. This entailed accessing maladaptive aspects of the memory or meaning system, such as fear/insecurity and shame, and accessing previously inhibited adaptive emotional responses, such as anger and sadness, so that the associated adaptive information could be used to modify meaning. A Gestalt-derived imaginal confrontation (IC) technique was used to evoke trauma material and help clients express previously constricted feelings to the imagined other(s). This is intended to promote entitlement to unmet need, self-empowerment and interpersonal boundary definition, and holding abusive and neglectful others accountable for harm (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). In cases that included extreme distress from intrusive symptoms, anxiety management strategies, such as provision of structure, breathing regulation, and present-centredness, were used to help regulate emotional intensity. The IC intervention generally was introduced in session four. The IC procedure is as follows: As the client is talking about the abuse, he or she is asked to imagine the abusive/neglectful other in an empty chair, to attend to their internal

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

experience while doing this, and express their current thoughts and feelings about the abuse directly to the imagined other. This quickly accesses core emotional processes, including fear and avoidance, that then become the focus of therapeutic exploration. This intervention is used throughout therapy according to individual client processes and treatment needs. In the Paivio et al. (2001) study the frequency with which clients participated in the intervention throughout therapy varied considerably. It ranged from 0 to 10 sessions (M = 3.27, SD = 3.01). For clients who were unwilling or unable to engage in IC, that difficulty became the focus of therapeutic exploration and alternate interventions, usually empathic exploration, were used to help these clients explore abuse material. The final phase of therapy focused on integrating information from therapy experiences into a new view of self, others, and abusive events. The last session was devoted to feedback and termination.

Therapists

Paivio et al. (2001) described therapists as follows. Therapists (7 female, 3 male) were 6 doctoral and 3 masters-level students in Clinical and Educational Psychology, and one registered Psychologist (S. Paivio, Principal Investigator). Mean age was 34 years (range, 24 to 49). All therapists had previous clinical experience with this population and a minimum of one graduate-level clinical practicum. Clinical experience ranged from 1 to 14 years (M = 6.3 years). Student therapists received 54 hours of training in EFT-AS prior to seeing clients in the study. This consisted of reviewing the treatment manual and videotapes of therapy sessions with expert therapists, as well as supervised peer skills practice and therapy with "practice" clients. The supervisor and principal investigator (S. Paivio), a Ph.D. registered Psychologist with 14 years of experience, conducted seven of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

the therapies and all of the training and supervision. Clients were assigned to therapists on the basis of client gender preference and a compatible schedule. Preference for a female therapist was indicated by nine female clients and one male client. All therapies were conducted at a clinic in the Psychology Department at the University of Saskatchewan.

Measures

Client Clinical Characteristics at Pretreatment

Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998). The CTQ is a 28-item retrospective measure of the frequency and severity of different types of abuse and neglect. Clients rate the frequency (0 = never true, 5 = very often true) with which various events took place when they "were growing up". The CTQ yields a total score for extent of maltreatment (severity x frequency) and empirically derived factor scales (5 items each) which measure emotional and physical abuse, sexual abuse, emotional neglect, and physical neglect. Three validity items measure minimization/denial. Bernstein and Fink reported internal consistencies ranging from .79 to .95; test-retest reliabilities, before and after 3.6 months of treatment for substance dependence, ranged between .80 and .88; and good convergent validity with other measures of disturbance.

PTSD Symptom Severity Interview (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993). The PSSI is a semi-structured interview with each of 17 items corresponding to one of the DSM-IV criteria for PTSD. Severity, over the last two weeks, is rated by the interviewer using a 4-point scale (0 = not at all, 3 = very much). The PSSI yields a total severity score and cluster scores for avoidance, re-experiencing, and arousal. Foa et al. 1993) reported alpha coefficients ranging from .69 to .85; test-retest reliabilities over one

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

month ranging from .66 to .77; intraclass correlations ranging from .73 to .91; and significant associations between the PSSI and other measures of psychological distress.

Symptom Checklist-90-Revised (SCL; Derogatis, 1983). The SCL is a 90-item questionnaire that measures global symptom distress. Clients rate on a five-point scale (0 = not at all, 4 = extremely) the degree of distress experienced during the past seven days. Derogatis (1983) reported internal consistencies ranging from .77 to .90, and test-retest reliabilities over one week between .80 and .90, and convergence with other measures of symptom distress.

Impact of Event Scale (IES; M. Horowitz, 1986). The IES is a widely-used 15-item questionnaire measuring trauma-related intrusion and avoidance. Clients rate the frequency of each symptom within the past seven days on a 4-point scale (0 = not at all, 3 = often experienced). Horowitz (1986) reported split-half reliability for the total scale of .86, test-retest reliability over one week of .87, and alphas for the subscales of .78 and .80.

Inventory of Interpersonal Problems (IIP; L. Horowitz, Rosenberg, Baer, Ureno & Villasneno, 1988). The IIP consists of 127 items and yields an average score for distress from interpersonal sources. Clients rate on a five-point scale (0 = not at all, 4 = extremely) the degree of distress experienced during the past seven days. Horowitz et al. 91988) reported test-retest reliabilities between .89 and .98, internal consistencies between .89 and .94, and high agreement between the IIP and other measures of improvement.

Structural Analysis of Social Behavior, Intrex (Introject) questionnaire (SASB; Benjamin, 1988, 1996). This measure is based on an interpersonal diagnosis of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

personality that is used to understand psychological disorders, such that internalized representations of interactions with early caregivers come to guide our actions with others and toward self. It serves as a measure of self-esteem and self-control. The SASB introject questionnaire (introjection – treating yourself as caregivers have treated you) is a 32 item self-report measure that asks clients to rate on an 11-point scale (0 = never true, 100 = always true) how they most often treat themselves. Scores on the dimension of Affiliation (SASB-A) range from +1600 (how affiliative, supportive, or how loving one feels toward oneself) to –1600 (how hostile one is toward self). Scores on the dimension of Control (SASB-C) range from +1600 (how spontaneous one allows oneself to be) to –1600 (how overcontrolled one is with self). Benjamin (1988) reported test-retest reliabilities ranging from .67 to .90, and substantial evidence for the construct validity of the SASB and internal consistency of the items.

Helpful Events

Helpful Aspects of Therapy Questionnaire (HAT; R. Elliott, 1985; Llewelyn, 1988). The HAT is a paper and pencil self-report instrument which polls clients' views about what aspects of therapy they found particularly helpful. The HAT (see Appendix A) asks clients to provide open-ended responses to four questions: (1) which therapy event they found most helpful, (2) what made it helpful, (3) to rate how helpful it was on a scale ranging from 1-9, and (4) to identify its location in a particular session. Clients are asked to describe up to three events in this manner. The helpfulness or importance of each event is then rated on a 9 point Likert-type scale. The HAT is a qualitative measure that is frequently used in psychotherapy process research (Elliott, Slatick, & Urman, 2001). Support for the validity of events reported on the HAT has been demonstrated by

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

quantitative indicators of clinical significance, such as therapist ratings on established process measures, and client scores on standardized outcome measures and process measures, as well as information from posttherapy interviews (e.g., Elliott et al., 1994; Grafanaki & McLeod, 1999). Predictive validity has been shown (r = .60) for the scale ratings with session outcome (Elliott, 1986). The HAT was administered at midtreatment (M-HAT) and at posttreatment (P-HAT).

Post-Treatment Interviews (PTI). The PTI is a semi-structured interview which requires one to two hours to complete. Clients are asked whether and how their views of self and others that were the focus of therapy have changed, what in-therapy events contributed to these changes, and how these events were helpful in creating change (see Appendix B). The PTI was developed for and administered during the larger investigation of EFT-AS (Paivio & Niewenhuis, 2001). The PTIs were audiotaped and have been transcribed, but have never been analyzed. Transcriptions ranged in length from 10-25 pages. For the purposes of the present study, only responses to questions identifying helpful events and their locations were examined. A preliminary study (Holowaty & Paivio, 2000) used PTI data to identify client-reported helpful processes. The validity of the PTI was supported by the convergence of results from Holowaty and Paivio (2000) with EFT-AS and child abuse treatment theory (Briere, 2002; Courtois, 1997; Herman, 1992; Paivio & Shimp, 1998). The present study further assesses the utility of the PTI in locating episodes for analysis and its validity.

Process Measures

The Experiencing Scale (EXP; Klein et al., 1986). The EXP is a 7-point ordinal scale which evaluates the depth and quality with which clients explore inner referents.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The following outlines the levels of experiencing: (1) material is impersonal and superficial, (2) material is personal but involvement is detached, (3) material is narrative and descriptive, (4) clients shift to an internally elaborated focus, (5) clients self-reflexively pose a problem for themselves and elaborate on it from an internal perspective, (6) clients synthesize newly realized feelings and experiences to produce meaningful structures and resolve issues, and (7) there is a constant shifting and exploration of inner referents which leads to insights and change. Both modal and peak ratings are made for the depth of experiencing present in client statements found on either transcripts, audiotapes, or videotapes. At every client speech turn, ratings of current experiencing level are made, with the rater listening for changes up or down in level. One modal and one peak rating is then assigned to the entire segment. The modal rating refers to the experiencing level occurring most frequently in the segment. The peak rating refers to the highest level achieved within the segment.

In various studies, interrater reliability of modal EXP ratings from either audiotapes or transcripts has ranged from .65 to .93, while that of peak ratings has ranged from .61 to .93 (Klein et al., 1986). A study of different segment lengths that were rated on the Experiencing Scale revealed that interrater and rate-rerate reliabilities were not affected by segment length (Kiesler et al., 1964), with rate-rerate correlations showing a median value of .80. The EXP is a well-established process measure that has been found to positively correlate with outcome (Castonguay, Goldfried, et al., 1996; Goldman, 1998; Kiesler et al., 1967). It can be reliably used with data in the form of transcripts and audiotapes, and is used less frequently with videotapes (Klein et al., 1986).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

The Emotional Arousal Scale (EAS; Daldrup et al., 1988). The EAS is a 7-point ordinal scale which assesses the level of emotional intensity presented by clients within videotaped therapy sessions. For the present study, the two lowest points were combined and the two highest points were combined, forming a 5-point ordinal EAS scale. It was thought that there would be very few examples of the extreme points of the scale, and that by combining them interrater reliability would be more readily achieved. Differentiation between the five scale categories involves language, vocal, and nonverbal cues of emotional intensity. The following outlines these levels of emotional intensity: (1) there is no visible emotional arousal in voice, body, gestures, or words. Clients either do not admit to any feelings and there is no visible evidence of arousal or clients may admit to feelings in words, but there is no evidence of arousal, (2) feelings are expressed in words but there is very little emotional arousal present in voice, body or gestures, (3) feelings are expressed in words and some emotional arousal is allowed to show in voice, body, or gestures, (4) feelings are expressed in words and moderately intense arousal is shown in voice, body, or gestures, (5) feelings are expressed with either fairly full or full and intense arousal in which clients are freely releasing with voice, words, or physical movement. The EAS requires a rater to make two ratings. One rating is made for the modal and the other is made for the peak intensity of emotional arousal present in client statements found in videotaped therapy segments. At every client speech turn, ratings of emotional arousal level are made, with the rater listening for changes up or down in level. One modal and one peak rating is then assigned to the entire segment. Modal intensity represents average expressed intensity during a treatment segment, and peak intensity refers to the maximum level of emotional arousal achieved during the segment.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Machado, Beutler, and Greenberg (1999) indicated that the EAS has adequate reliability and validity as a measure of the quality and intensity of emotional expression. Interrater agreements in the form of correlation coefficients were $r = .66$ for modal ratings, and $r = .71$ for peak ratings (Machado et al., 1999). A kappa of .71 for modal ratings has been demonstrated in other studies (Rosner, 1996). Although originally designed to assess the presence and intensity of anger, Machado et al. (1999) expanded its focus to assess six primary emotions. In the proposed study it was used to assess the intensity of whichever emotion the client presented.

The Working Alliance Inventory – Client Version (WAI; Horvath & Greenberg, 1989). The WAI is a 36-item self-report questionnaire that asks clients to rate on a 7-point Likert scale (1 = "never"; 7 = "always") how accurately each item describes their current experience of the therapy relationship. It is based on Bordin's (1979) transtheoretical conceptualization of the therapeutic alliance. The WAI consists of three subscales (12 items each) measuring therapeutic bond (the mutual liking, attachment, and trust between client and therapist), agreement on the tasks (therapeutic strategies and techniques), and agreement on the goals (areas targeted for change). The WAI yields scores on each of these three subscales and a total score which is the average of all 36 items. Estimated alphas ranged between .87 and .93 (Horvath & Greenberg, 1989).

The Levels of Engagement Scale (LES; Paivio et al., 2001). The LES is an observer-rated measure of the quality of client engagement in the IC intervention. It is an ordinal scale consisting of five mutually exclusive categories: refusal, resistant, reluctant, willing, and full engagement in IC. Each category is defined by the presence of behaviourally-defined criteria for three process dimensions: (a) psychological contact with the imagined

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

other, (b) involvement in the intervention process, and (c) emotional expressiveness. Thus, it is an indicator of the level of emotional contact with trauma material. A single category rating is assigned to a circumscribed segment of therapy dialogue that follows the introduction of the IC intervention. This rating is based on both the proportion of time spent interacting with the imagined other and the quality of the interaction. Interrater reliability of 52 IC episodes sampled from early, middle, and late sessions was $k = .81$; the LES also demonstrated good convergent and divergent validity (Paivio et al., 2001).

Procedure

Administration of Measures

The following describes administration of measures in the original Paivio and Nieuwenhuis (2001) study from which data for the current study are drawn. The PSSI was administered during the pre-therapy screening interview and the CTQ was administered at pretreatment. Instruments measuring symptoms and clinical characteristics (SCL, IES, IIP, SASB) were administered at pre, mid, and posttreatment. The HAT was administered at mid (usually after session 10) and at posttreatment, and the PTI was conducted by trained research assistants following completion of treatment. The WAI was administered following the 3rd, 4th, 5th, 10th, 13th, and 20th sessions of treatment. The LES was used to rate the quality of client engagement in the IC intervention in a previous study (Paivio et al., 2001) of clients used in the present investigation. Paivio et al. also calculated dosage of IC (Quality of engagement on the LES x Frequency of participation) over the course of therapy, and the mean alliance quality (early and late session WAI scores).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

For the present study, the EXP and EAS were used to rate client behavior during Client-Identified Helpful Events and Researcher-Identified Control Events in videotaped therapy sessions. As well, the mean WAI, LES and dosage of IC were used to examine client process characteristics in the present study.

Selection of Therapy Events

Selecting client-identified helpful events. A total of 110 events accompanied by a location estimate were reported on M-HATs, P-HATs and PTIs by 37 clients. Locating these events in videotaped sessions was the first step in identifying a sample of rateable events for the present study. Clients' reports of the exact session location or best estimate, clients' description of event content, and therapist process notes for each therapy session, were used in order to locate each event on videotape. Thirty-eight events were readily located. The location and content information was unclear for 36 events. In these cases, the events were identified by watching videotaped sessions which, based on client and therapist reports, could possibly contain the event. The remaining 36 events were impossible to locate on tape either because the content description was too vague to identify the event in a single location or the event did not have a clear beginning or end (Luborsky, 1998). An event was included in the sample if, in this researcher's judgement it was distinct enough to be identified in one and only one session and had a clear beginning and end. Following these considerations, 54 circumscribed events (49% of the original 110 events) for 29 clients were located for rating.

More than one helpful event was locatable for most clients. However, only one helpful event from each of 29 clients was selected for rating (53.7% of the 54 locatable events) in the present study. This sample was thought to be sufficiently large to permit

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

analyses. The second step was to establish selection criteria for deciding which event to include in the sample. It was reasoned that an event identified in two or three of the data sources was likely more salient and significant for the client than an event appearing only once in any of the sources. Thus, the same event identified on both the mid and post HAT was considered to be more salient than one listed only on either the M-HAT, P-HAT, or the PTI. Additionally it was decided that events listed on the P-HAT should be chosen over events listed on the M-HAT, because in the P-HAT clients were selecting events that stood out over all twenty therapy sessions. The following hierarchical criteria were utilized to select one helpful event for each client: (1) The event was identified on both the M-HAT and P-HAT, (2) the event was listed as most important on the P-HAT, (3) the event was listed as second most important on the P-HAT, (4) the event was listed as most important on the M-HAT, (5) the event was listed as second most important on the M-HAT, (6) the event was listed on the PTI, but not M-HAT or P-HAT.

Information on data source, therapy stage, and length for the final sample of 29 HE is as follows. With regard to data sources, six HE (20.7%) were found on all three sources (M-HAT, P-HAT, & PTI) and four (14.0%) were present on both the M-HAT and P-HAT. Twelve (41.3%) were reported only on post-measures (P-HAT and/or PTI), while seven (24.1) were reported only on the mid-treatment measure (M-HAT). Regarding stage of therapy, 14 HE (48.3%) were from the early stage (sessions 1-7), nine (31%) were from the middle (sessions 8-14), and six (20.7%) were from the late stage (sessions 15-20). Twenty-one HE (72.4%) were from the first half of therapy prior to the mid-treatment point (sessions 1-10), while eight (27.6%) were from the second half of therapy (sessions 11-20). Thus, most events were from the early stage of therapy, ruling

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

out recency effects in terms of client reports. Regarding length, the mean length was 30.28 minutes (SD = 13.60). Thus, most HE were between approximately 20 and 40 minutes in length.

Selecting researcher-identified control events. The third step was to identify therapy events that would serve as a control group. A control event was selected for each of the 29 clients in the HE sample. These events were selected by the researcher according to the following criteria: (1) they occurred in sessions that did not contain a HE, (2) they occurred in the same phase of therapy (early, middle, late) as the HE selected for rating, (3) they did not occur in either the first or last session, since these sessions often contain more procedural elements and less intense work on core therapy issues. From the pool of remaining sessions one session was randomly selected for each individual client, and one clearly identifiable thematic event was isolated. (4) Only topics or themes from the middle 40 minutes of the session were considered, since themes discussed at the beginning and end of the therapy hour frequently contain less intense work on core therapy issues, (5) Themes centering on abuse or its impact on self-concept were chosen over non-abuse related themes in order to reflect and maximize the possible presence of high quality content and process such that CE could be legitimately comparable to HE, (6) Trauma work involving the IC intervention or other gestalt techniques was selected if present for the same reason as that formerly stated, (7) Finally, as in the length of HE, the length of these control group events was determined solely by the parameters of the event's theme.

After locating an event in a particular therapy session, the fourth and final step involved specifying the beginning and end of that event. Following the method of theme

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

identification used by Luborsky (1998), an event began when specific reference was made by the client or therapist to the theme of that event. An event segment was judged to have ended when that theme was no longer being discussed and the topic clearly changed, or the session ended.

Information on stage of therapy and length for the final sample of 29 CE is as follows. Since CE were deliberately selected from the same stage of therapy as HE, there was no difference between CE and HE for therapy stage. Regarding length, the mean length was 30.17 minutes (SD = 9.56). Thus, most CE also were between approximately 20 and 40 minutes in length and were not different in length from HE.

Since the lengths of each client's HE and CE were not matched, an analysis was conducted to rule out the possible effect of event length on therapy process quality. A paired samples t-test compared the mean length in minutes for the HE group (M = 30.28, SD = 13.60) to the mean length for the CE group (M = 30.17, SD = 9.56) and yielded no significant difference, t (1, 28) = .037, p = ns. This indicated that lengths of HE and CE did not differ, and that any differences in process quality between HE and CE would not be attributable to length.

Training of Raters

Two student raters were recruited who were unfamiliar with the data, and blind to the hypotheses and research design. These raters were acquired as volunteers through a graduate student research work exchange agreement in which the present author was a participant. For each measure there were two raters: a primary rater and a reliability rater. The present author served as reliability rater for both measures. The present author, who had experience developing and using process measures (Paivio & Nieuwenhuis,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

2001; Paivio et al., 2001; Paivio, Hall, & Holowaty, in press), trained both raters in consultation with Dr. Paivio. The primary rater for the EXP was a female doctoral level student in clinical psychology. Training required approximately 60 hours to attain adequate interrater reliability in the EXP. The primary rater for the EAS was a female fourth year honours student in psychology. Training required approximately 50 hours to attain adequate interrater reliability in the EAS.

The training procedure was the same for both measures. This entailed reviewing videotaped examples of Emotion Focused Therapy sessions that were not included in the present study, and a detailed discussion of the criteria for levels of the EXP and EAS following each example until agreement on a level was reached. Training manuals for both EXP and EAS rating were developed as training progressed. These were comprised of detailed descriptions of each level in the scale. These manuals were used to facilitate agreement on scale levels during training and during the rating of events. The research supervisor (S. Paivio) who had extensive experience utilizing both measures served as a consultant to help resolve difficult rating discrepancies.

For both measures, raters were trained to agree on a single rating for the entire event. Raters first assigned modal level ratings to 5 minute segments. When more than half of these segments contained the same level rating, that became the overall modal (most frequently occurring) rating for the entire event. The highest level reached in any segment became the peak rating for that event. In cases where segments were evenly split between two levels, the lower level became the modal rating, and the highest level reached in any segment, became the peak rating for the event. This is consistent with EXP rating rules (Klein et al., 1986). Raters were trained in this manner until adequate

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

interrater agreement (r = .80) was obtained by the two raters, on both modal and peak level ratings.

Rating of Events

Videotapes containing the sample of events were prepared by the author prior to rating. All identifying information on videotapes, such as session number, dates of sessions, and client and therapist initials, was concealed. The only information provided on the videotapes was the assigned event number and the exact start and end times for the particular event contained on the videotape. Events were rated in random order. Raters viewed only the assigned portion of the videotape that defined the parameters of the event.

Twenty sessions (approximately one third of the sample) were rated by both raters in order to establish interrater reliability. This has been sufficient in studies using measures with established psychometric properties (Goldman, 1998; Greenberg & Malcolm, 2002; Martin & Stelmaczonek, 1988). The procedure for rating EXP was as follows. After viewing each event, both raters independently assigned overall modal and peak ratings to the event. Rating discrepancies were discussed and resolved immediately after the independent rating of each event in order to control for rater drift. The rating made by the primary rater served as the final category rating utilized in the analyses. The primary rater also coded the remaining 38 sessions (two thirds of the event sample). The procedure for rating the EAS was identical to that for EXP except that, in addition, raters identified the predominant emotion present throughout the event. Interrater reliability of modal and peak ratings on the EXP and EAS was assessed for the pair of raters by calculating the proportion of rater agreement and Cohen's (1960) kappa (k), which

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

corrects for chance agreements. For Modal EXP, proportion of agreement was .85 and k = .70. For Peak EXP, proportion of agreement was .85 and k = .77. For Modal EAS, proportion of agreement was .80 and k = .71. For Peak EAS, proportion of agreement was .75 and k = .62. These kappas indicate acceptable to very good agreement beyond chance (Fleiss, 1981).

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER IV

Results

Client PreTreatment Characteristics

Table 2 presents the demographic, abuse, and clinical characteristics of the 29 clients included in the present study.

Demographic characteristics. As indicated in Table 2, the mean age of clients in the present study was 38 years (SD = 12.15; range, 18-72). Clients were predominantly female (79%). In terms of ethnicity, twenty-seven clients (93.1%) were of European origin and two clients (6.9%) were Aboriginal. In terms of marital status, 14 clients (48%) were married, 10 (35%) were single, three (10%) were separated or divorced, and two (7%) were widowed. Sixty-two percent of clients had one or more children (M = 1.62; SD =1.66). In terms of employment, 16 clients (55%) worked full- or part-time, 12 (41%) were unemployed, and one (3%) was a student. In terms of household income 10 clients (35%) earned less than $20,000, 11 clients (38%) earned between $20,000 and $39,000, five clients (17%) earned within the $40,000 to $59,000 range, and three clients (10%) earned more than $60,000. On average, clients completed at least one year of education beyond high school (M = 13.86; SD = 3.02).

Abuse characteristics. In terms of abuse type, most clients (68%) reported multiple types of childhood maltreatment. However, clients were asked to identify one type of abuse as a primary focus for therapy. Twelve clients (41%) focused on emotional abuse which ranged from chronic verbal derogation by a caregiver, to repeated threats of harm, and/or witnessing extreme family violence. Eleven clients (38%) focused on

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 2

Client Demographic Characteristics

Variable	M	SD
Age	38.03	12.15
Years of Education	13.86	3.02
	N	%
Sex (female)	23	79.3
Ethnicity		
European Origin	27	93.1
Aboriginal	2	6.9
Children (>1)	18	62.0
Marital Status		
Single	10	34.5
Married	14	48.2
Separated/divorced	3	10.3
Widowed	2	7.0

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 2 continued

Client Demographic Characteristics

Variable	N	%
Family Income		
<$20,000	10	34.5
$20,000-$39,000	11	38.0
$40,000-$59,000	5	17.2
>$60,000	3	10.3
Employment Status		
Full-time	11	38.0
Part-time	5	17.2
Unemployed	12	41.4
Student	1	3.4
Abuse Type		
Physical	6	20.7
Emotional	12	41.4
Sexual	11	37.9

Note. N = 29.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

sexual abuse which ranged from a single episode of anal penetration, to paternal incest over many years, and/or repeated victimization by several perpetrators. Six clients (21%) focused on physical abuse which ranged from harsh physical discipline to severe beatings that resulted in injury.

Clinical characteristics. Table 3 shows that the total severity score on the CTQ was M = 164.69 (SD = 29.25). This is more than one standard deviation higher than that reported by Bernstein et al. (1994) for a sample of substance dependent patients (Total M = 104.8; SD = 36.2). All clients' CTQ scores for the type of abuse they focused on in therapy were above recommended thresholds for abuse (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997). This indicates that histories of relatively severe maltreatment were reported by these clients. Fifteen clients (51.7%) met criteria for a diagnosis of PTSD on the PSS-I. The mean severity on the PSS-I was 22.65 (SD = 10.96). This is comparable to results reported by Foa et al. (1991) for rape victims, three to 12 months following the rape (M = 24.77, SD = 5.7).

Clients reported moderate levels of symptom distress (T-score = 51, using out-patient norms) as measured by the SCL. The distress score on the IIP was M = 1.84 (SD = .60). This is almost a standard deviation higher than norms for an out-patient psychiatric sample (M = 1.48, SD = .56) reported by Horowitz et al. (1988). Overall, clients were comparable to other moderately distressed clinical groups of adult survivors described in the literature, with relatively severe abuse histories and marked interpersonal and self-esteem difficulties.

Analyses comparing included and excluded clients. Since clients were excluded from the present sample because they were unable to identify locatable HE, analyses

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 3

Client Clinical Characteristics at Pretreatment

Variable	M	SD
CTQ	164.69	29.26
PSSI	22.65	10.96
SCL	1.29	.75
IES	23.17	9.63
IIP	1.84	.60
SASB-A	-338.79	489.46
SASB-C	-199.48	360.90

Note. CTQ = Childhood Trauma Questionnaire; PSSI = PTSD Symptom Severity Interview; SCL = Symptom Checklist-90-Revised; IES = Impact of Events Scale; IIP = Inventory of Interpersonal Problems; SASB-A = Structural Analysis of Social Behavior - Introject Questionnaire (Affiliation); SASB-C = Structural Analysis of Social Behavior - Introject Questionnaire (Control).

N = 29.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

were conducted comparing the group of 29 clients included in the present study to the eight clients that were excluded. Chi-square analyses were conducted on categorical variables of ethnicity, sex, marital status, employment status, income level, and abuse type. No statistically significant difference between observed and expected frequencies for HE versus CE was found for ethnicity $\underline{X}$ (2, $\underline{N}$ = 37) = 4.09, $\underline{p}$ = ns, sex $\underline{X}$ (1, $\underline{N}$ = 37) = .069, $\underline{p}$ = ns, marital status $\underline{X}$ (3, $\underline{N}$ = 37) = 3.73, $\underline{p}$ = ns, employment status $\underline{X}$ (3, $\underline{N}$ = 37) = .499, $\underline{p}$ = ns, income level $\underline{X}$ (3, $\underline{N}$ = 37) = 2.45, $\underline{p}$ = ns, or abuse type $\underline{X}$ (2, $\underline{N}$ = 37) = 1.54, $\underline{p}$ = ns. A MANOVA comparing the two groups on age, years of education, number of children and clinical characteristics revealed no significant overall effect for group, $\underline{F}$ (8, 28) = .716, $\underline{p}$ = ns. Thus, clients included in the sample did not differ from those excluded and were representative of therapy completers, in terms of pretreatment characteristics.

It was thought that excluded clients who were unable to identify specific HE may have differed from included clients on other core processes for which data was available. Therefore, clients included were compared to those excluded in terms of the quality of engagement in IC, as measured by the LES (Paivio et al., 2001), dosage of IC (quality x frequency of participation) over the course of therapy, and average client-rated alliance quality. The mean quality of engagement for included clients was 2.52 (SD = 1.06), while for excluded clients it was 1.56 (SD = .56). The mean dosage for included clients was 10.65 (SD = 9.48), while for excluded clients is was 3.19 (SD = 4.80). The mean alliance quality averaged over treatment for included clients was 6.03 (SD = .57), and for excluded clients was 6.18 (SD = .39). A MANOVA revealed a significant overall effect for group, $\underline{F}$ (3, 33) = 3.79, $\underline{p}$ = < .05. Subsequent univariate $\underline{F}$ tests indicated a

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

significant difference between groups for quality of engagement in the IC intervention averaged over treatment, F (1, 36) = 5.89, p = < .05, and for dosage of IC, F (1, 36) = 4.572, p = < .05. There was no significant difference between groups for client-rated alliance quality averaged over treatment, F (1, 36) = .50, p = ns. These results indicated that, compared to those included, the eight excluded clients made less emotional contact with, and allowed less exposure to, trauma material in the context of the IC intervention across treatment.

Results Concerning Content of HE and CE

Events first were categorized in terms of content. These content categories are presented in Appendixes C and D, along with information on the client's view of event helpfulness, phase of therapy, length, and process ratings. Content categories reflect the researcher's view of the dominant processes and themes observed in an event. Appendix E contains descriptions of content categories.

Table 4 presents content categories for client-identified helpful events (HE) and researcher-identified control events (CE). For the purposes of statistical analyses, these specific categories can be grouped into three global categories, that is, direct focus on abuse (categories 1-3), indirect focus on abuse (categories 4-6), and non-abuse focus (categories 7-9). Summarizing across the first three categories indicates that a larger proportion of HE (86.2%) versus CE (27.6%) were characterized by direct and explicit reexperiencing of child abuse material. As well, a larger proportion of HE versus CE contained the IC intervention. Conversely, summarizing across the middle three categories, a larger proportion of CE (51.8%) versus HE (13.8%) were characterized by an indirect focus on abuse issues, such as exploring self-conflicts. Additionally,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 4

Event Content

Variable	Helpful N	Helpful %	Control N	Control %
Content of Event				
1. Explored Child Abuse Memories During IC	18	62.1	4	13.8
2. Explored Child Abuse Memories	3	10.3	4	13.8
3. Allowed Painful Emotion & Grieved for Self	4	13.8	0	0.0
4. Explored Abuse Impact on Current Functioning	0	0.0	7	24.2
5. Explored Self-Conflict During 2-Chair	4	13.8	1	3.4
6. Explored Self-Conflict	0	0.0	7	24.2
7. Explored Current Relationship	0	0.0	4	13.8
8. Explored Problem at Work	0	0.0	1	3.4
9. Explored Non-Abuse Trauma Memory	0	0.0	1	3.4
Abusive/Neglectful Other Focused On				
Parent/parental figure	18	62.1	14	48.3
Other family members	4	13.8	3	10.3
Non family member	1	3.4	2	6.9
Non-interpersonal	6	20.7	10	34.5

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 4 continued

Event Content

Variable	Helpful N	Helpful %	Control N	Control %
Predominant Emotion Expressed				
Anger	14	48.3	15	51.7
Sadness	5	17.2	8	27.6
Fear	5	17.2	5	17.2
Shame	1	3.4	0	0.0
Disgust	1	3.4	0	0.0
Hurt	2	6.9	0	0.0
Contentment	0	0.0	1	3.4
Guilt	1	3.4	0	0.0

Note. N = 29 for both Helpful and Control Events.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

summarizing across the last three categories, a larger proportion of CE (27.6%) versus HE (0.0%) focused on non-abuse-related issues such as problems with work or a current relationship. In order to test for differences in content focus between HE and CE, Chi-square analyses were conducted on each of the three global content categories (direct focus on abuse, indirect focus on abuse, and non-abuse focus). These analyses indicated a significant difference between observed and expected frequencies for HE as compared to CE in terms of direct focus on abuse issues, $\underline{X}(1, \underline{N} = 58) = 20.31$, $\underline{p} < .001$, and indirect focus on abuse issues, $\underline{X}(1, \underline{N} = 58) = 9.47$, $\underline{p} < .01$. Results of the analysis of non-abuse focus were inconclusive due to violation of test assumptions. Odds ratio calculations indicated that a direct focus on abuse issues was 16.45 times more likely to be present in HE, while an indirect focus on abuse issues was 6.69 times more likely to be present in CE. These results support the hypothesis that HE would be characterized by a greater focus on abuse issues.

Table 4 shows the abusive or neglectful others that were the focus of HE and CE. As indicated, parents and parent figures (mothers, fathers, stepparents) were the focus of most events for both HE (62.1%) and CE (48.3%), followed by other family members, such as brothers, sisters or grandfathers. There is a similarly small focus for both HE and CE on non-family others, such as a spouse or a stranger. In more CE (34.5%) than HE (20.7%) interpersonal issues were not present. Chi-square analyses were conducted on each of the four abusive other categories reported in Table 4. These analyses revealed no statistically significant difference between observed and expected frequencies for HE as compared to CE in terms of focus on parental figures, $\underline{X}(1, \underline{N} = 58) = 1.11$, $\underline{p} = \underline{ns}$, and non-interpersonal focus, $\underline{X}(1, \underline{N} = 58) = 1.38$, $\underline{p} = \underline{ns}$. Results of analyses for focus on

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

family members and focus on non-family members were inconclusive due to violation of test assumptions. These results show that HE were not distinct in terms of focus on abusive other.

Table 4 also indicates that anger was the predominant emotion expressed in about half of both HE and CE, with sadness and fear following as the next most predominant emotions in both HE and CE. Summarizing across types of emotion in Table 4, HE appeared to contain a greater variety of emotions compared to CE (7 versus 4). However, separate Chi-square analyses conducted on each of the emotion categories revealed no statistically significant difference between observed and expected frequencies for HE versus CE in terms of anger, $\underline{X}(1, \underline{N} = 58) = .07$, $\underline{p} = \underline{ns}$, sadness, $\underline{X}(1, \underline{N} = 58) = .89$, $\underline{p} = \underline{ns}$, or fear, $\underline{X}(1, \underline{N} = 58) = .00$, $\underline{p} = \underline{ns}$. Results from analyses of remaining emotion categories were inconclusive due to violation of test assumptions. These results indicate that HE were not distinct in emotion content.

Table 4 also shows the frequency with which the IC procedure was present in events. A larger proportion of HE (62.1%) versus CE (13.8%) contained the IC. A Chi-square analysis indicated a significant difference between observed and expected frequencies for HE versus CE with regard to presence of the IC, $\underline{X}(1, \underline{N} = 58) = 14.35$, $\underline{p} < .001$. Odds ratio calculations indicated that the IC was 10.00 times more likely to be present in HE. This finding suggests that clients found the IC procedure a helpful aspect of the therapy.

Results Concerning Emotional Processes in HE and CE

Table 5 presents the means and standard deviations for EXP and EAS (modal and peak) ratings for HE and CE as well as results of analyses comparing event groups. As

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Table 5

Means and Standard Deviations on Emotion Processes

Variable	Helpful Events		Control Events		
	M	SD	M	SD	F (1, 28)
EXP - Mode	4.00	.53	4.21	.82	2.35
EXP - Peak	5.07	.99	4.72	.84	2.96
EAS - Mode	3.14	1.09	2.45	.51	13.69***
EAS - Peak	4.07	.92	3.45	.51	15.02***

Note. EXP = Experiencing Scale; EAS = Emotional Arousal Scale.

N = 29 for both Helpful and Control Events.

***$p \leq .001$.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

indicated in Table 5, both helpful and control events are characterized by moderate levels of client experiencing, in terms of modal ratings and somewhat higher peak EXP ratings. In terms of emotional arousal, Table 5 also shows higher peak versus modal ratings on EAS for both HE and CE. However, both modal and peak EAS ratings are greater for HE compared to CE. A repeated measures MANOVA was conducted, with HE and CE as independent variables, and four processes (EXP modal, EXP peak, EAS modal, and EAS peak ratings) as the dependent variables. This analysis yielded a significant overall effect for event type, $\underline{F}$ (4, 25) = 5.63, $\underline{p}$ = < .05. Subsequent univariate $\underline{F}$ tests, presented in Table 5, indicated significant differences in emotional arousal between event groups for both modal, $\underline{F}$ (1, 28) = 13.69, $\underline{p}$ = < .001, d = .69, and peak, $\underline{F}$ (1, 28) = 15.02, $\underline{p}$ = < .001, d = .72. These findings support the hypothesis that HE would be characterized by higher levels of emotional arousal compared to CE. However, results failed to support expected differences between groups in terms of experiencing, for both modal, $\underline{F}$ (1, 28) = 2.35, $\underline{p}$ = ns, d = .28, and peak, $\underline{F}$ (1, 28) = 2.96, $\underline{p}$ = ns, d = .32. The Cohen's d calculations indicate medium effect sizes (Cohen, 1969).

Finally, client-rated WAI scores were available for sessions containing HE and CE for 14 of the 29 (48.3%) clients in this study. These are presented in Figure 1. Alliance quality was high for both HE (M = 6.13; SD = .57) and CE (M = 5.96; SD = .69). Figure 1 also indicates that for two clients (case 3 = client #28; case 14 = client #16) the alliance was rated noticeably lower for the session containing CE compared to HE. Nonetheless, a paired samples t-test yielded no significant difference between HE and CE sessions in terms of alliance quality, $\underline{t}$ (1,13) = 1.12, $\underline{p}$ = ns, d = .30. This finding

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

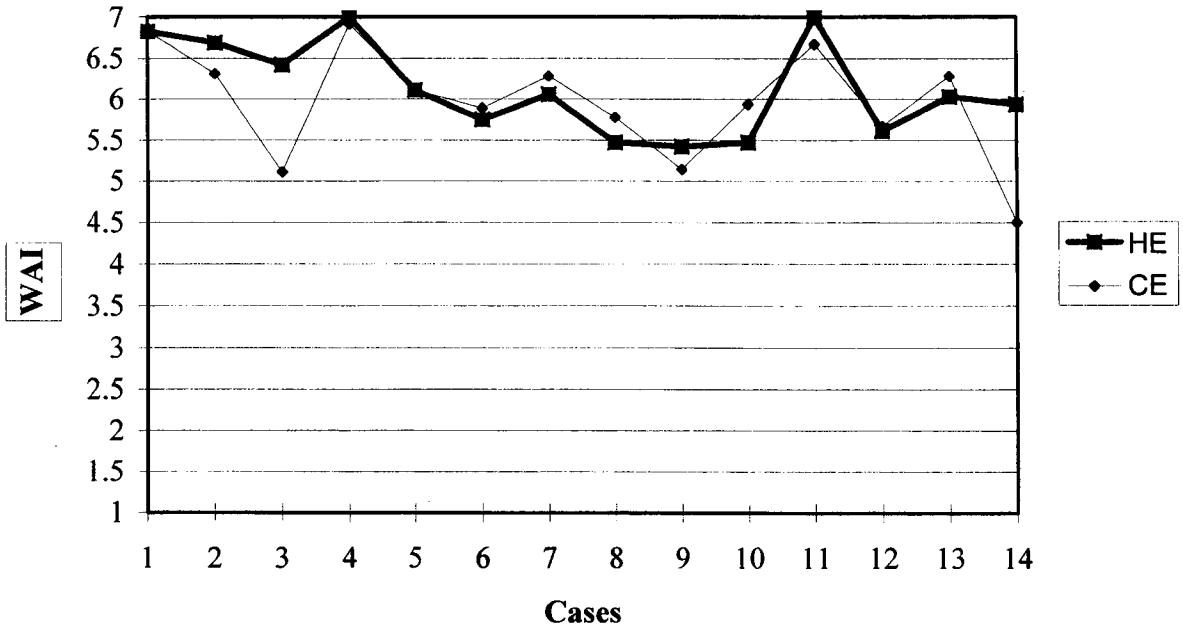

Figure 1. Client-rated therapeutic alliance quality in HE Vs. CE sessions for each of 14 clients.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

supports the expectation that sessions containing both HE and CE would be characterized by equally strong therapeutic alliances.

Post Hoc Analyses

The nonsignificant difference between HE and CE groups in terms of depth of experiencing was further explored. It was reasoned that this result was due to the possibility that clients with lower capacity for experiencing, who were included in mean values, would have difficulty both recognizing high level experiencing and differentiating among its various depths. 'High experiencers', on the other hand, would have a greater capacity to recognize deeper levels of experiencing and possibly distinguish this process from more superficial exploration. Therefore, the 13 clients who received peak EXP ratings of 6 or greater on their HE were examined. A within-subjects repeated measures MANOVA was conducted, with event type (HE, CE) as the independent variable, and EXP modal and EXP peak ratings as the dependent variables, to determine whether HE and CE differed in level of experiencing for clients whose events received the highest EXP ratings. This analysis yielded a significant overall effect for event, $\underline{F}$ (2, 11) = 25.14, $\underline{p}$ = < .001. Subsequent univariate $\underline{F}$ tests indicated a significant effect for EXP peak, $\underline{F}$ (1, 12) = 20.27, $\underline{p}$ = < .001, but no effect for EXP modal, $\underline{F}$ (1, 12) = .65, $\underline{p}$ = ns. This result is portrayed in Figure 2. Thus, higher levels of peak experiencing were present in HE compared to CE for those clients who had the capacity for high levels of experiencing.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

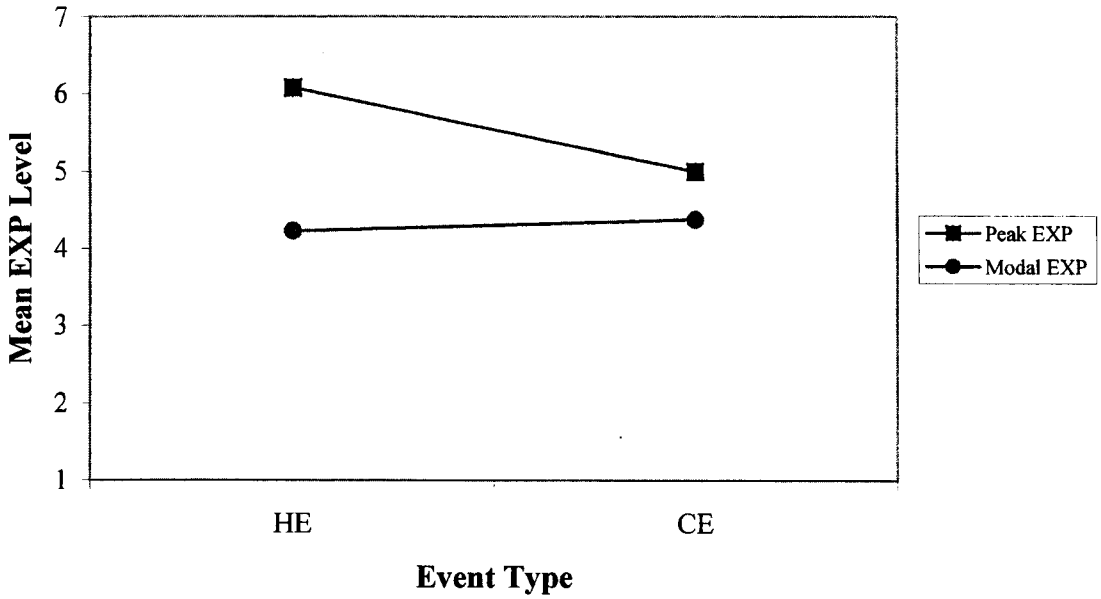

Figure 2. Mean modal and peak experiencing during Helpful and Control Events for 13 high experiencing clients.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER V

Discussion

Summary of Results

The objectives of the present study were to compare the content and client emotional processes within client-identified helpful events (HE) to those within researcher-identified control events (CE) in Emotion Focused Therapy for adult survivors of childhood abuse (EFT-AS; Paivio & Nieuwenhuis, 2001). Events identified by clients as helpful (HE) were found to be distinct in content and process from events within the remainder of the therapy (CE). The hypothesis regarding content was supported. HE were characterized by a greater focus on child abuse issues. The hypothesis regarding emotional arousal also was supported. Higher levels of emotional arousal were found in HE compared to CE, for both modal and peak measurements. Expectations regarding the therapeutic relationship similarly were supported. Equally high client-rated therapeutic alliance quality was present in sessions containing both HE and CE. Finally, while the hypothesis regarding depth of client experiencing was not supported, a post hoc analysis of 13 high experiencers revealed higher levels of peak experiencing in HE compared to CE.

Illustrative Cases of HE and CE

Before proceeding with the discussion of issues, the following case example will illustrate findings of this study through a description of the content and emotional processes in the HE and CE of one client.

Client #16 was sexually abused by her father and physically and emotionally abused by both parents. She entered therapy struggling with feelings of worthlessness

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

and difficulties with assertiveness. In her HE, she explored negative beliefs about herself and expressed her feelings about the abuse during an imaginal confrontation with her parents. After stating that she felt like a nobody in response to being dismissed by her husband, she quickly recalled being similarly discounted by her mother despite repeated attempts to please her and obtain her approval. These memories evoked feelings of deep hurt and anger, which were predominant emotions in this event. By expressing these feelings toward her mother and specifying the actions that were hurtful, she was able to counteract some of the worthlessness she felt and access what she needed. The following statements toward her mother illustrate the very high emotional arousal demonstrated throughout this event, which was assigned the highest possible emotional arousal ratings (Mode and Peak = 5),

> I did everything I could think of for you. It got to the point where I wished I was dead. Wanting just a hug Mom - instead I was pushed away. I'm still angry at you. It would've meant the world to me, that I was worth something, but it didn't matter. M. was the fair-haired boy and I was just the person you had to put up with. I was *your child*, Mom.

After telling her imagined mother that her father had abused her, she was directed by the therapist to express her intense anger at her father. She verbally expressed her intense hatred, then she took the opportunity presented by the therapist to physically express her anger at her father by pounding her fists on a large pillow. The following statements illustrate how this expression of anger, along with empathic responsiveness from the therapist, allowed her to challenge self-blame by placing the responsibility for the abuse back onto her father, and to access needs for value and respect. This experience produced a shift toward valuing herself and feeling entitled to better treatment,

> (pounding fists) I hate you for what you did to me and Mom and everybody. Get out of my life and stay out (sobbing, stopped hitting pillow). It wasn't my fault at

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

> all. You should've gone to jail and I hope you rot in hell for it.....Never could trust you or believe you. You used me, I was just something to be used and abused. I'm angry and hurt. I needed so much more. I needed you to love me and respect me. When I see how my sons treasure their little girls I think god did I miss a lot. You just abused me. Something to be used, never to be cherished. You weren't fit to be a father. You weren't fit to have children. I was too good to be your daughter. I deserved a lot more than you ever gave me.

The intense expression of emotion and description of internal experience demonstrated throughout this event is indicative of a moderate level of experiencing (Mode = 4, Peak = 4), in which awareness of internal experience is heightened but not yet used for self-examination.

In contrast to the above HE, this client's CE indirectly focused on abuse, whereby she explored the impact of the abuse on her self-esteem. Compared to her HE, a higher experiencing level was present throughout this event (Mode = 5, Peak = 5), in which she questioned an aspect of her experience and set out to understand it better by exploring it. Posing and exploring questions about self define level five experiencing. Specifically, she asked herself why it was so hard to be good to herself. She described being constantly blamed and taken for granted by members of her family of origin, and connected her negative beliefs about herself to messages she received from her mother. At the point of her highest emotional arousal (EAS peak = 4) she stated to the therapist, "The only time Mom said 'I love you' was before she died. I was the accident. When I showed hurt I got spanked. I didn't belong and felt I didn't deserve anything." She then connected this to experiences in her current life in which she did not feel deserving. For example, she felt unworthy when her children threw her and her husband a surprise anniversary party. She also felt powerless and, for fear of their anger, was not able to stand up to her children and tell them that she had not wanted a party. Feelings of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

sadness for herself, and predominant feelings of anger and hurt toward family members for not considering her feelings, were expressed at a moderate level of emotional arousal (EAS mode = 3).

It is interesting to note that when high emotional arousal was present, experiencing levels were lower, and that when experiencing levels were higher, arousal levels were lower. This is consistent with what has been theorized about the relationship between experiencing and emotion. It has been suggested that high emotional arousal functions to evoke maladaptive material in need of reprocessing, and that decreased arousal is necessary for deeper levels of experiencing to occur in which one explores, makes sense of, and creates new meaning from the material (Clarke, 1989).

Methodological Considerations

Several methodological strengths merit consideration. First, data from multiple perspectives, including client interviews, self-report questionnaires, and observer ratings, were used in the present study. Thus, results are not attributable to shared method variance.

Second, the HAT and PTI instruments elicited information that was sufficiently precise and detailed to permit location of most HE, making them available for observation and analysis. Despite the retrospective nature of the questions on these instruments, many clients were able to recall session locations of HE with good accuracy, such that they often matched information in therapist process notes, and were easily identified in videotaped sessions by the researcher. HAT and PTI questions asking for description and specifics of the event were particularly useful in determining event location where client estimates were less accurate.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Third, the identification and analysis of CE in addition to HE provided a more complete picture of this type of therapy than previously has been reported. EFT-AS is a semistructured model which offers maximum client control over the process of therapy, and to date there has been only limited information on aspects of this therapy that were not specifically trauma focused. For example, in previous studies (e.g., Paivio et al., 2001) there has been an exclusive focus on analyzing the imaginal confrontation (IC) procedure as a researcher-identified primary process, even though the IC occurred, on average, in only one quarter of sessions in the 20 session therapy. The present sample of HE identified by clients, together with CE, indicated a focus on the IC as well as work on child abuse material without using the IC, exploration of self-related disturbances with and without use of Gestalt-derived techniques, and exploration of current issues. It is notable that the IC and work on child abuse material stood out for clients amidst this variability.

Fourth, the use of CE as a comparison group also strengthens conclusions that can be drawn from findings. Observational analysis not only confirmed client reports of helpful processes but indicated that the processes during HE were distinct from the remainder of therapy. Conclusions that can be drawn from this strategy about change processes, therefore, seem as valid as those from process-outcome analyses which directly examine the potency of change processes (Wampold, 1997).

Fifth, the present study used standardized process measures (EXP, EAS) and rating procedures which yielded reliable (interrater) and valid (convergent, predictive) ratings of psychotherapy process comparable to estimates reported in other research

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(Klein et al., 1986; Rosner, 1996). The marginal interrater reliability of peak EAS ratings may reduce confidence in the conclusions to be drawn from EAS findings, however.

Sixth, results of the present study are not confounded by stage of therapy because HE and CE were matched in terms of stage. This is important because research has demonstrated that particular processes can be phase specific. For example, research on therapies similar to EFT-AS has demonstrated higher levels of experiencing (e.g., Goldman, 1998), and higher levels of emotional arousal (e.g., Pos et al., 2003), in later stages of therapy.

Seventh, the use of a naturalistic length for events in the present study lends ecological validity to findings. As well, length did not differ for HE and CE (most were between approximately 20 and 40 minutes). This indicates focused and cohesive sessions throughout therapy that largely centred on the exploration of a single theme, regardless of the content explored. It is interesting to note, however, that some impactful and memorable events were as short as 11 minutes.

Eighth, results have important implications in terms of data obtained through retrospective client reports. Although the sample was representative of the entire sample of therapy completers in terms of pretreatment characteristics, it was not representative in terms of therapy processes. Those clients who could not recall specific helpful episodes, and therefore were excluded from the sample, also were less engaged (measured on the LES) in core therapy process. Since high ratings on the LES required meaning exploration and emotional expression (Paivio et al., 2001), present results suggest that events that were more emotionally alive and meaningful also were more memorable. This is consistent with research indicating that recall is better for material that is

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

meaningful, related to the self, and imbued with emotion (Greenberg, Rice, & Elliott, 1993; Martin & Stelmaczonek, 1988; Omer, Winch, & Dar, 1998; Watson, 1996). Conversely, low emotional engagement was associated with vague memories and possibly limited the impact of therapy on learning and change.

Ninth, and most importantly, results support the reliability and validity of client perspectives about aspects of therapy that are critical to change. Most clients were able to identify several specific sessions where helpful processes occurred, and the locations of these were corroborated by the researcher. Although client opinions about helpful processes could be biased by compliance with therapist opinion (Martin, Paivio, & Labadie, 1990), and demand characteristics of research participation (Kazdin, 1994), observations of what processes occurred during HE corroborated client reports. Furthermore, HE were found to be distinct from the remainder of therapy (CE) in terms of predicted dimensions of content and quality, suggesting that clients in the present study could detect productive therapy process over less helpful process.

Results Support the Treatment Model

Results of the present study support key features of the treatment model. First, results support the importance of a direct focus on child abuse material, rather than on aspects indirectly related to abuse. This finding is consistent with the recommendations of child abuse experts (Briere, 2002; Courtois, 1997; Herman, 1992) and previous EFT-AS theory and research (Paivio et al., 2001; Paivio & Nieuwenhuis, 2001; Paivio & Shimp, 1998) that explicit reprocessing of memories and feelings about abusive others is helpful in recovery from the negative effects of abuse. This does not necessarily mean that child abuse therapies which focus on current relationships or stressors (Cloitre et al.,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

1997; Zlotnick et al., 1997) are less helpful. For survivors who are severely distressed and lack emotion management skills, treatments which focus on mastery of symptoms may be necessary before proceeding to therapies directly focused on child abuse material (Wolfsdorf & Zlotnick, 2001). The focus on child abuse material also likely was helpful because in EFT-AS it occurred within a theoretically-driven and cohesive therapy experience, with particular attention to regulation of emotional experience and establishment of a secure therapeutic bond (Paivio & Greenberg, 2000; Paivio & Nieuwenhuis, 2001). As well, the focus on abuse was consistent with collaborative agreement about goals and tasks of therapy, and therefore with client expectations.

Results also support a focus on accessing and expressing emotion and, furthermore, the distinguishing feature was emotional arousal, rather than emotional content. It is notable that expression and exploration of emotions consistently have been reported by clients as helpful across differing types of psychotherapies (Cooley, 1996; Feifel & Ells, 1963; Llewelyn et al., 1988; Martin & Stelmaczonek, 1988; Paulson et al., 1999; Paulson & Worth, 2002; Sloane et al., 1977; Wheeler et al., 1992). Higher emotional arousal in helpful events also is consistent with trauma theory (Herman, 1992; van der Kolk, McFarlane, & van der Hart, 1996), child abuse treatment theory (Briere, 2002; Courtois, 1997; Herman, 1992; Paivio & Shimp, 1998), and research (Foa et al., 1995; Jaycox et al., 1998; Paivio et al., 2001), all of which posit that emotional processing of trauma memories is necessary for recovery. Allowing emotions that are constricted or have been split off from awareness to be aroused is crucial because arousal is thought to activate elements of a survivor's pathological trauma memory structure (Foa & Kozak, 1986). Higher emotional arousal is believed to render more elements of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

structure available for exploration and change (Foa et al., 1995; Hembree & Foa, 2000; Paivio et al., 2001). Within experiential therapies such as EFT-AS, higher arousal also is believed to provide more complete access to crucial adaptive information contained within specific emotions, such as anger or sadness (Greenberg & Paivio, 1997). The emerging agreement across client, observer, and researcher perspectives strengthens confidence in child abuse treatment theory and in the EFT-AS model regarding the importance of emotional arousal. This has important implications for therapist training, since novice therapists frequently are reluctant to evoke and maintain a focus on intense (often painful and/or threatening) emotion. Facilitating intense emotional expression appears important, not only because it is theoretically sound, but because clients find it helpful.

Although the emotional content did not statistically differ between HE and CE, the emotions (e.g. anger, sadness, fear, shame, disgust) found in therapy events are consistent with expectations for a therapy focused on childhood abuse. Anger and sadness as predominant emotions expressed in events is consistent with the treatment model and focus on accessing adaptive emotion and associated orienting information (Greenberg & Paivio, 1997; Paivio & Greenberg, 2000; Paivio & Shimp, 1998). Sadness expression is thought to allow grieving and acceptance of the many losses associated with abuse, and accesses self-soothing resources which help one cope with distress (Paivio & Greenberg, 2000). Since children in abusive environments often shut down their emotions in order to survive, many abuse survivors have never had the chance to grieve their suffering and loss (Paivio & Laurent, 2001). The frequent focus on anger likely reflects the view that one of the most problematic features of emotional experience for

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

many abuse survivors is constricted or overcontrolled anger (Paivio & Laurent, 2001), and the importance EFT-AS therapists placed upon accessing it for its ability to promote feelings of empowerment and adaptive behavior such as assertiveness, and boundary definition between self and others (Greenberg & Paivio, 1997). When anger at violation is expressed assertively, the emerging sense of empowerment is thought to counteract abuse survivors' feelings of powerlessness and insecurity. Maladaptive internalization of blame in the form of guilt and shame also is transformed since anger expression facilitates the externalization of blame and responsibility (Paivio & Greenberg, 2000). It is noteworthy that anger was the predominant emotion in HE and CE (predominant in 50% of events and second most frequently expressed in others). This is one of the few studies (also Carriere, 2003) to directly support the value of anger expression in therapy. The predominant focus in the treatment literature has been from the cognitive-behavioral perspective and has exclusively concerned anger management (Deffenbacher, 1999; Mayne & Ambrose, 1999). Thus, present results contribute to a more complete understanding of anger in therapy.

Although there was not sufficient power to detect differences in experiencing level between the two event groups, the average level of EXP found throughout is consistent with experiential therapies and an emphasis on meaning exploration versus catharsis (McGuire, 1991). It has been argued that discharge of emotion will not produce therapeutic change unless one focuses on and articulates the broader context of meanings associated with the emotion (Clarke, 1989; Gendlin, 1991; McGuire, 1991; Safran & Greenberg, 1989). While the traditional behavioural conceptualization of emotional processing (e.g. Foa & Kozak, 1986) includes only the activation and tolerance of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

previously overwhelming emotional experience, it has been argued that emotional processing would be optimized by integrating it with cognition, whereby emotional experience would be explored, reflected on, and made sense of (Pos et al., 2003). Indeed, higher levels of meaning exploration have been found in qualitative analysis of clients' subjective experience of significant therapy episodes (Watson & Rennie, 1994). As well, higher levels of meaning exploration (measured by the EXP) following emotional reactions have been found to characterize sessions rated as showing a high degree of resolution of therapy issues as compared to sessions with no resolution (Watson, 1996). Average EXP level in the present study also was higher than that reported in other similar therapies (Goldman, 1998). This indicates that the emphasis in EFT-AS and its model of resolution is on constructing new meaning. Post hoc analyses also indicated that the quality of meaning exploration was higher in HE than in CE for clients with the capacity for higher experiencing. However, since this analysis involved a biased sample comprised exclusively of clients with the highest peak experiencing levels, results may be due to regression to the mean. Nonetheless, these findings draw attention to possibilities about experiencing in helpful events which require additional investigation, and they suggest that therapists should be trained to facilitate the highest levels of experiencing possible.

Results supported the benefits of the IC exposure-based procedure for exploring child abuse material. In addition to the benefits that IC may have afforded clients in terms of reprocessing child abuse material, the novelty and the multi-modal enactment involving thoughts, feelings, imagery, and behavior (Paivio & Shimp, 1998) likely contributed to its memorability. However, findings may not generalize to other exposure

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

procedures. Although all approaches are sensitive to issues of safety and emotion regulation (Foa, 2000; Foa et al., 1989), EFT-AS emphasizes empathic attunement and responsiveness along with client control over the frequency of IC participation (Paivio et al., 2001; Paivio & Laurent, 2001). Additionally, the IC procedure explicitly focuses on resolving attachment relationships, rather than exposure to trauma memories per se. Overall, the finding that clients in this sample found the procedure helpful, adds direct support to the research findings (Paivio et al., 2001) that higher dosage of the IC was associated with improved outcome. As well, this finding stands in contrast to concerns that exposure-based procedures may be too stressful for trauma survivors (Herman, 1992; Scott & Stradling, 1997; Wolfsdorf & Zlotnick, 2001; Zlotnick et al., 1997). Having come directly from clients' experiences, this information reduces concerns about reexperiencing abuse material, at least in an empathically responsive context and in samples screened for the capacity to manage intense emotion.

Results additionally support the benefits of a secondary focus on self-related disturbances, which is consistent with the secondary task specified in the treatment model (Paivio & Nieuwenhuis, 2001). Self-related disturbances such as avoidance of emotional experience, dissociation, feelings of hopelessness, and other negative beliefs about self must be addressed because they are maladaptive processes which interfere with reprocessing and integrating trauma material (Greenberg & Paivio, 1997; Paivio & Greenberg, 2000). For example, shame that has been internalized as a core sense of self as worthless, flawed, and unlovable, hinders the accessing of adaptive feelings and needs (Paivio & Greenberg, 2000). These maladaptive self-conflicts and disturbances were addressed in the context of various interventions, including the IC procedure, two-chair

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

dialogues, and empathic exploration. For example, client #24, who was sexually abused by her father for many years, explored her experience of carrying the guilt and shame for the abuse during an imaginal confrontation with her father. As she explored her shame, she recounted how she often had been sent by her mother and sisters to their stingy father to obtain money and other family needs and how she was coerced to perform sexual acts in return. She had believed that by taking these things it meant that she was somehow agreeing to the abuse, and thus partly to blame for it happening. As she explored this guilt and shame, with the help of the therapist's empathic responding and directives to tell her father about this experience and express her feelings toward him, her view of self shifted. She accessed adaptive angry feelings and was able to place the blame and guilt for the abuse back onto him. At the point of her highest emotional arousal she stated in a stronger voice, "I want him to have the burden of guilt. You should have the guilt". Resolving self-related difficulties was a predominant focus throughout therapy, however, and was not unique to HE.

As well, results support the treatment model that the therapeutic relationship is a critical contextual factor throughout therapy. The finding of equally strong therapeutic alliances across events is consistent with research that the therapeutic alliance is a common change factor across treatment models (Horvath & Luborsky, 1993; Horvath & Symonds, 1991), and especially important in child abuse therapies (Briere, 1996; Courtois, 1997; Herman, 1992). It provides the crucial context in which painful abuse material can be safely reprocessed, and in which attachment injuries can be corrected. Support for the therapeutic relationship as more contextual than event-related has been demonstrated by meta-analyses indicating that clients in particular tend to view the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

alliance as stable (Martin, Garske, & Davis, 2000). Support also was found in the preliminary study of client perceptions of helpful process in EFT-AS (Holowaty & Paivio, 2000). While the therapeutic alliance was identified by clients as an important core process, clients could not readily identify specific events in which the relationship had been particularly helpful. Only one client reported a helpful therapeutic relationship event with a specific location. When identifying the relationship as helpful, clients either reported no location or they indicated that the alliance had occurred 'throughout' the therapy. For example, client #3 reported the following as an event on the M-HAT:

> Simply talking with my therapist in an environment that I became comfortable with. And the belief that I could trust my therapist made it safe to get in touch with feelings.

The fact that helpful events were not characterized by a particular focus on the therapeutic relationship is consistent with the proposed contextual function of the therapeutic relationship in EFT-AS. It is not explicitly focused on except to collaborate on goals and tasks or when a relationship rupture occurs which interferes with other crucial therapy processes and tasks, such as reexperiencing abuse material, which are dependent upon a solid therapeutic bond (Gaston et al., 1995). Possibly one would find differential alliance quality among events in psychodynamic models where the therapeutic alliance and working through transference reactions are the explicit focus of therapy work (e.g., Binder, Strupp & Henry, 1995).

The relationship in therapies similar to EFT-AS also has been found to be stable except for alliance ruptures and repairs (Nieuwenhuis, 2002), and there was no reason to assume that CE in the present study were characterized by either ruptures or repairs. Thus, it appeared that further costly process analyses of the alliance would likely not be

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

productive. However, the WAI ratings were available for only half of sessions containing events, demonstrating one of the problems with using archival data. As well, WAI ratings referred to sessions rather than episodes within sessions. Since some events were as short as 11 minutes, they possibly were not representative of the entire session. Despite the finding that mean WAI ratings were not different for HE and CE, WAI ratings for individual clients across treatment were examined. No pattern emerged, but in two instances the client WAI for the HE was considerably higher than for the CE. This raises the possibility of more instances of this in sessions for which data was unavailable. Therefore, conclusions regarding the therapeutic relationship are only tentative. One would need to observe events to draw firm conclusions.

Limitations

Conclusions that can be drawn from present findings are limited by a number of factors. First, increased Type I error rate from multiple comparisons and small sample size means that some significant findings may have been due to chance. Second, there may have been insufficient power to detect differences between HE and CE in terms of client-rated therapeutic alliance quality, experiencing level, and emotion content. Third, although the average quality of emotional processes was consistent with expectations, the small number of ratings at high and low ends of the EXP scale likely limited the ability to detect subtle effects in terms of depth of experiencing. Greater variability in experiencing may have resulted in greater capacity to differentiate between HE and CE on this dimension. Fourth, since only half of all identified HE were part of the present sample, different findings may have resulted if all episodes had been examined. Fifth, since only one HE per client was identified, effects over time could not be examined. It

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

would have been interesting to know, for example, whether depth of experiencing remained stable, suggesting that capacity for experiencing was a temperamental factor, or improved, suggesting experiencing was a skill learned over the course of therapy. Sixth, regarding therapeutic relationship findings, again only limited data were available and only tentative conclusions could be drawn. Evidence from two clients suggests the possibility that HE also were characterized by higher quality therapeutic alliances compared to CE.

Finally, limitations concern generalizability of results. First, the present sample was not representative of all abuse survivors. Results therefore can be generalized only to those who meet similar inclusion and exclusion criteria and are suitable for short-term trauma focused therapy. Additionally, since the present sample only included clients who could identify HE with sufficient specificity that they could be located, findings obviously do not generalize to clients without episodic memories of therapy processes and events. By extrapolation, results further suggest that findings do not generalize to clients who were not engaged in core therapy processes. Research on attrition in trauma therapies, in general (Scott & Stradling, 2001), and engagement in EFT-AS, in particular (Paivio et al., 2001), indicates that this may represent a significant proportion of clients who participate in this type of therapy.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

CHAPTER VI

Conclusions

The fact that client perspectives were a reliable and valid source of information about change processes in the present study substantiates arguments about the value of information from the consumer perspective (Duncan & Miller, 2000; Macran et al., 1999; Seligman, 1995). Given the emerging view that clients are active contributors to the therapeutic process (Duncan & Miller, 2000), it makes sense that clients in the present study demonstrated the ability to detect productive therapy process over that which was less helpful, particularly in the context of a therapy designed to promote awareness of internal processes. Since client opinions represent a distinct perspective which provided results similar to those found in process-outcome studies, it follows that client opinions of therapy for child abuse issues routinely should be gathered and considered alongside those of researcher and therapist. The present investigation may be the only study to date to examine client views within a trauma focused therapy that employed an exposure-based procedure. Previous studies of attrition and compliance in trauma therapies have raised concerns about but provided no assessment of the usefulness of exposure-based procedures. Clients in the present study indicated that foci on child abuse issues, and emotional expression were memorable processes and perceived to be helpful. These results, together with the finding that clients perceived the IC procedure to be helpful, increase confidence in the usefulness of exposure-based procedures, at least when they are embedded in a safe, empathic, and collaborative relationship. Further process studies of client experiences can provide additional needed information on helpful and hindering aspects of these procedures. For instance, in the Holowaty & Paivio (2000) study of

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

EFT-AS, client reports included rich descriptions of what made the IC procedure helpful, and in at least two instances, hindering aspects were described. This is valuable information which could spark new routes for research and improvements in these procedures such that more clients could engage in and benefit from them.

The present information from the client perspective adds to growing evidence supporting the treatment model and has implications for training and practice with similar samples of abuse survivors. This includes the importance of helping clients sustain a focus on child abuse material and associated painful emotions, and engage in the IC procedure as frequently as is tolerable in order to facilitate effective emotional processing of abuse material. As well, results highlight the importance of facilitating intense emotional expression, particularly that of constricted anger.

Although results of the post hoc analysis concerning high level experiencers need to be interpreted with caution, these findings point to the need for further investigation of the hypothesis that experiencing may optimize emotional processing. This further study of the experiencing process in EFT-AS potentially could provide valuable information to guide training and practice with abuse survivors.

Examining client perspectives also contributed new information. This is the first study to provide a complete picture of this type of therapy. The contrast found between HE and CE content suggests that maximal time should be spent directly focused on child abuse material with and without IC, and that time spent exploring current issues could be reduced. Similarly, this is the first study to support exploring self-related disturbance with and without use of Gestalt interventions, as a crucial aspect of the treatment model.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

As well, the finding that clients who lacked episodic memories of therapy events also were less engaged in core therapy processes, highlights the contribution of emotional experience and meaning exploration to the integration of trauma work, learning, and change. For example, emerging evidence indicates that vivid description of events facilitates access to both emotional experience and meaning exploration, and that these in turn facilitate recollection (Watson, 1996). Further study is needed to understand client perceptions and characteristics that contributed to lack of compliance with or difficulty engaging in exposure procedures and processes. This information could contribute to the improvement of trauma therapies like EFT-AS such that their benefits could be made available to a larger number of abuse survivors.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

REFERENCES

Ainsworth, M. D. (1985). Patterns of attachment. *Clinical Psychologist, 38(2),* 27-29.

Alexander, P. C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Consulting and Clinical Psychology, 60,* 185-195.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Arnold, M. B. (1960). *Emotion and personality.* New York: Columbia University Press.

Barber, J. P., Connolly, M. B., Crits-Christophe, P., Gladis, L., & Siqueland, L. (2000). Alliance predicts patients' outcome beyond in-treatment change in symptoms. *Journal of Consulting and Clinical Psychology, 68(6),* 1027-1032.

Barlow, D. H. (1988). *Anxiety and its disorders.* New York: Guilford Press.

Beck, A. T. (1987). Cognitive therapy. In J. K. Zeig (Ed.), *The evolution of psychotherapy* (pp.149-163). New York: Brunner/Mazel.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect, 16,* 101-118.

Benjamin, L. S. (1988). *SASB Short Form user's manual.* Salt Lake City, UT: Intrex Interpersonal Institute.

Benjamin, L. S. (1996). A clinician-friendly version of the interpersonal circumplex: Structural analysis of social behavior (SASB). *Journal of Personality Assessment, 66(2),* 248-266.

Bernstein, D., Ahluvalia, T., Pogge, D., & Handelsman, L. (1997). Validity of the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Childhood Trauma Questionnaire in an adolescent psychiatric population. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 340-348.

Bernstein, D. P, & Fink, L. (1998). *Childhood Trauma Questionnaire Manual.* San Antonio, TX: The Psychological Corporation.

Bernstein, D., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K. et al. (1994). Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry, 151,*1132-1136.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guidelines for the systematic treatment of the depressed patient.* London: Oxford University Press.

Binder, J. L., Strupp, H. H., & Henry, W. P. (1995). Psychodynamic therapies in practice: Time-limited dynamic psychotherapy. In B. M. Bongar & L. E. Beutler (Eds.), *Comprehensive textbook of psychotherapy: Theory and practice. Oxford textbooks in clinical psychology Vol 1* (pp.48-63). London: Oxford University Press.

Bohart, A. C. (1993). Experiencing: The basis of psychotherapy. *Journal of Psychotherapy Integration, 3(1),* 51-67.

Bohart, A. C. (2000). The client is the most important common factor: Clients' self healing capacities and psychotherapy. *Journal of Psychotherapy Integration, 10(2),* 127-149.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice,16,* 252-260.

Boudewyns, P. A., & Hyer, L. (1990). Physiological response to combat memories and

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

preliminary treatment outcome in Vietnam veterans: PTSD patients treated with direct therapeutic exposure. *Behavior Therapy, 21,* 63-87.

Bowlby, J. (1988). *A secure base.* NewYork: Basic Books.

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association, 27,* 136-158.

Briere, J. N. (1989). *Therapy for adults molested as children: Beyond Survival.* New York: Springer.

Briere, J. N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects.* Newbury Park, CA: Sage.

Briere, J. N. (1996). *Therapy for adults molested as children.* New York: Springer.

Briere, J. N. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J. E. B. Myers, L. Berliner, J. N. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds), *The APSAC handbook on child maltreatment* (2nd ed., pp. 175-203). Thousand Oaks, CA: Sage.

Butler, S. F., & Strupp, H. H. (1991). The role of affect in time-limited dynamic psychotherapy. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 83-111). New York: The Guilford Press.

Carriere, M. (2003). *Anger expression as a predictor of outcome in emotion-focused therapy for adult survivors of childhood abuse.* Unpublished master's thesis, University of Windsor, Windsor, Ontario, Canada.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64(3),* 497-504.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Clarke, K. M. (1989). Creation of meaning: An emotional processing task in psychotherapy. *Psychotherapy, 26(2),* 139-148.

Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self-, and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress, 10,* 437-452.

Cohen, J. (1960). A coefficient of agreement for nominal scales. *Educational and Psychological Measurement, 20,* 37-46.

Cohen, J. (1969). *Statistical power analysis for the behavioural sciences.* New York: Academic Press.

Cole, P., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of Consulting and Clinical Psychology, 60,* 174-184.

Cooley, R. J. (1996). Borderline personality disorder client perceptions of helpful therapeutic events. *Dissertation Abstracts International, 56,* 4008B.

Cooper, N. A., & Clum, G. A. (1989). Imaginal flooding as a supplementary treatement for PTSD in combat veterans: A controlled study. *Behavior Therapy, 3,* 381-391.

Cornell, W. F., & Olio, K. A. (1991). Integrating affect in treatment with adult survivors of physical and sexual abuse. *American Journal of Orthopsychiatry, 61(1),* 59-69.

Courtois, C. A. (1996). *Healing the incest wound: Adult survivors in therapy.* New York: W.W. Norton.

Courtois, C. A. (1997). Healing the incest wound: A treatment update with attention to recovered-memory issues. *American Journal of Psychotherapy, 51(4),* 464-496.

Daldrup, R. J., Beutler, L. E., Engle, D., & Greenberg, L. S. (1988). *Focused expressive*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

psychotherapy: Freeing the overcontrolled patient. New York: Guilford Press.

Davis, J. L., Petretic-Jackson, P., & Ting, L. (2001). Intimacy dysfunction and trauma symptomatology: Long-term correlates of different types of child abuse. *Journal of Traumatic Stress, 14,* 63-80.

Deffenbacher, J. L. (1999). Cognitive-behavioral conceptualization and treatment of anger. *Journal of Clinical Psychology, 55(3),* 295-309.

Derogatis, L. R. (1983). *SCL-90-R administration, scoring, and procedures manual for the revised version,* Towson, MD: Clinical Psychiatric Research.

Draucker, C. B., & Petrovic, K. (1997). Therapy with male survivors of sexual abuse: The client perspective. *Issues in Mental Health Nursing, 18,* 139-155.

Duncan, B. L. & Miller, S. D. (2000). *The heroic client: Doing client-directed, outcome informed therapy.* San Francisco: Jossey-Bass.

Eaton, T. T., Abeles, N., & Gutfreund, M. J. (1988). Therapeutic alliance and outcome: impact of treatment length and pretreatment symptomatology. *Psychotherapy,25,* 536-542.

Ekman, P., & Friesen, W. V. (1975). *Unmasking the face.* Englewood Cliffs, NJ: Prentice Hall.

Elliott, D. M. (1994). Impaired object relations in professional women molested as children. *Psychotherapy, 31,* 79-86.

Elliott, R. (1983). That in your hands: A comprehensive process analysis of a significant event in psychotherapy. *Psychiatry, 46,* 113-129.

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology, 32(3),* 307-322.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Elliott, R. (1986). Interpersonal process recall (IPR) as a psychotherapy process research method. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp.503-528). New York: Guilford Press.

Elliott, R., & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review, 9,* 443-467.

Elliott, R., & Shapiro, D. A. (1992). Clients and therapists as analysts of significant events. In S. G. Toukmanian, & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 163-186). Newbury Park, CA: Sage.

Elliott, R., Shapiro, D., Firth-Cozens, J., Stiles, W. B., Hardy, G. E., Llewelyn, S. P., et al. (1994). Comprehensive process analysis of insight events in cognitive-behavioral and psychodynamic-interpersonal psychotherapies. *Journal of Counseling Psychology, 41(4),* 449-463.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer & D. L. Rennie (Eds.), *Qualitative psychotherapy research: Methods and methodology* (pp.69-111). Lengerich, Germany: Pabst Science.

Feifel, H., & Eells, J. (1963). Patients and therapists assess the same psychotherapy. *Journal of Counseling Psychology, 27(4),* 310-318.

Fleiss, J. L. (1981). *Statistical methods for rates and proportions* (2nd ed.). New York: Wiley.

Foa, E. B. (2000). Psychosocial treatment of posttraumatic stress disorder. *Journal of Clinical Psychiatry, 61(suppl. 5),* 43-51.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Foa, E. B., Dancu, C. V., & Hembree, E. (1999). The efficacy of exposure therapy, stress inoculation training and their combination in ameliorating PTSD for female victims of assault. *Journal of Consulting and Clinical Psychology, 67,* 194-200.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20-35.

Foa E. B., & Kozak, M. J. (1991). Emotional processing: Theory, research, and clinical implications for anxiety disorders. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 21-49). New York: Guilford Press.

Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology, 48,* 449-480.

Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress, 6,* 459-473.

Foa, E. B., Riggs, D. S., Massie, E. D., & Yarczower, M. (1995). The impact of fear activation and anger on the efficacy of exposure treatment for PTSD. *Behavior Therapy, 26,* 487-499.

Foa, E. B., Rothbaum, B. O., Riggs, D., & Murdock, T. (1991). Treatment of post traumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59,* 715-723.

Foa, E. B., Steketee, G., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualization of posttraumatic stress disorder. *Behavior Therapy, 20,* 155-176.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Frieswyk, S. H., Allen, J. G., Colson, D. B., Coyne, L., Gabbard, G. O., Horowitz, L., et al. (1986). Therapeutic alliance: Its place as process and outcome variable in dynamic psychotherapy research. *Journal of Consulting and Clinical Psychology, 1,* 32-39.

Frijda, N. H. (1986). *The emotions.* Cambridge, England: Cambridge University Press.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27,* 143-153.

Gaston, L., Goldfried, M. R., Greenberg, L. S., Horvath, A. O., Raue, P. J., & Watson, J. (1995). The therapeutic alliance in psychodynamic, cognitive-behavioral, and experiential therapies. *Journal of Psychotherapy Integration, 5,* 1-26.

Gaston, L., Piper, W. E., Debbane, E. G., Bienvenu, J. P., & Garrant, J. (1999). Alliance and technique for predicting outcome in short- and long-term analytic psychotherapy. *Psychotherapy Research, 4(2),* 121-135.

Gaston, L., Thompson, L., Gallagher, D., Cournoyer, L. G., & Gagnon, R. (1998). Alliance, technique, and their interactions in predicting outcome of behavioral, cognitive, and brief dynamic therapy. *Psychotherapy Research,8(2),* 190-209.

Gendlin, E. T. (1964). A theory of personality change. In P. Worchel, & D. Byrne (Eds.) *Personality change* (pp. 100-148). New York: Wiley.

Gendlin, E. T. (1974). Client-centred and experiential psychotherapy. In D. Wexler & L. N. Rice (Eds.), *Innovations in client-centred therapy* (pp. 211-246). New York: Wiley.

Gendlin, E. T. (1996). *Focusing-oriented psychotherapy: A manual of the experiential method.* New York: Guilford Press.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Gendlin, E. T. (1997). The use of focusing in therapy. In J. K. Zeig (Ed.), *The evolution of psychotherapy: The third conference* (pp.197-210). Philadelphia: Brunner/Mazel.

Gershefski, J. J., Arnkoff, D. B., Glass, C. R., & Elkin, I. (1996). Clients' perceptions of treatment for depression: I. Helpful aspects. *Psychotherapy Research, 6(4),* 233-247.

Glikauf-Hughes, C., Reviere, S. L., Clance, P. R., & Jones, R. A. (1996). An integration of object relations theory with gestalt techniques to promote structuralization of the self. *Journal of Psychotherapy Integration, 6,* 39-70.

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist, 35(11),* 991-999.

Goldman, R. N. (1998). Change in thematic depth of experiencing and outcome in experiential psychotherapy (Doctoral dissertation, York University, 1997). *Dissertation Abstracts International, 58,* 5643B.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology, 46(5),* 1023-1035.

Gottman, J. M. (1998). *Raising an emotionally intelligent child.* New York: Simon and Schuster.

Grafanaki, S., & McLeod, J. (1999). Narrative processes in the construction of helpful and hindering events in experiential psychotherapy. *Psychotherapy Research, 9(3),* 289-303.

Greenberg, L.S., Elliott, R. K., & Lietaer, G. (1994). Research on experiential

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

psychotherapies. In A. E. Bergin, & Garfield, S. L. (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 509-539). New York: Wiley.

Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology, 64(3),* 439-446.

Greenberg, L. S., & Malcolm, W. (2002). Resolving unfinished business relating process to outcome. *Journal of Consulting and Clinical Psychology, 70,(2),* 406-416.

Greenberg, L. S., & Paivio, S. C. (1997). *Working with emotions in psychotherapy.* New York: Guilford Press.

Greenberg, L. S., & Pinsof, W. M. (1986). *The psychotherapeutic process: A research handbook.* New York: Guilford Press.

Greenberg. L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change.* New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1987). *Emotion in psychotherapy: Affect, cognition, and the process of change.* New York: Guilford Press.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist,44(1),* 19-29.

Greenberg, L. S., & Van Balen, R. (1998). The theory of experience-centred therapies. In L. S. Greenberg, J. C. Watson, & G. Lietaer (Eds.), *Handbook of experiential therapy* (pp. 28-57). New York: Guilford Press.

Greenberg, L. S., & Webster, M. C. (1982). Resolving decisional conflict by gestalt two chair dialogue: Relating process to outcome. *Journal of Counseling Psychology, 29(5),* 468-477.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly, 34,* 155-181.

Guidano, V. F. (1991). Affective change events in a cognitive therapy system approach. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 50-79). New York: Guilford Press.

Hayes, A. M., & Strauss, J. L. (1998). Dynamic systems theory as a paradigm for the study of change in psychotherapy: An application to cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 66(6),* 939-947.

Hembree, E. A., & Foa, E. B. (2000). Posttraumatic stress disorder: Psychological factors and psychosocial interventions. *Journal of Clinical Psychiatry, 61(suppl. 7),* 33-39.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

Holowaty, K. A. M., & Paivio, S. C. (2000). *Client perceptions of helpful therapy process in emotion focused therapy for adult survivors of childhood abuse.* Unpublished manuscript, University of Windsor, Windsor, Ontario, Canada.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasneno, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical application. *Journal of Consulting and Clinical Psychology, 56,* 885-892.

Horowitz, M. J. (1986). *Stress response syndromes.* Northvale, NJ: Jason Aronson.

Horowitz, M. J., Marmar, C., Weiss, D. S., DeWitt, K. N., Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions. *Archives of General Psychiatry, 41,* 438-448.

Horvath, A. O. (1994). Research on the alliance. In A. O. Horvath & L. S. Greenberg

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(Eds.), *The working alliance: Theory, research, and practice* (pp. 259-286). New York: Wiley.

Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *JCLP/In Session: Psychotherapy in Practice, 56(2),* 163-173.

Horvath, A., Gaston, L., & Luborsky, L. (1993). The therapeutic alliance and its measures. In L. Luborsky, J. P. Barber, & J. P. Docherty (Eds.), *Psychodynamic treatment research: A handbook for clinical practice.* New York: Basic Books.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36(2),* 223-233.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61,* 561-573.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139-149.

Hy, L. X., & Loevinger, J. (1996). *Measuring ego development* (2nd ed.). New Jersey: Lawrence Erlbaum.

Izard, C. E. (1977). *Human emotions.* New York: Plenum Press.

Izard, C. E. (1991). Perspectives on emotions in psychotherapy. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp.280-289). New York: Guilford Press.

Janocko, K. M. (1995). Client perceptions of therapeutic factors in an inpatient sexual abuse survivors group. *Dissertation Abstracts International, 56,* 1110B.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Applications of the schema construct. *Social Cognition, 7(2),* 113-136.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: The Free Press.

Jaycox, L. H., Foa, E. B., & Morral, A. R. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of Consulting and Clinical Psychology, 66(1),* 185-192.

Kaschak, E. (1978). Therapist and client: Two views of the process and outcome of psychotherapy. *Professional Psychology, 9,* 271-277.

Kazdin, A. E. (1994). Methodology, design, and evaluation in psychotherapy research. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 19-71). Oxford: Wiley.

Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimmering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior Therapy, 20,* 245-260.

Kiesler, D. J., Mathieu, P. L., & Klein, M. H. (1964). Sampling from the recorded therapy interview: A comparative study of different segment lengths. *Journal of Consulting Psychology, 28,* 349-357.

Kiesler, D. J., Mathieu, P. L., & Klein, M. H. (1967). Patient experiencing level and interaction-chronograph variables in therapy interview segments. *Journal of Consulting and Clinical Psychology, 31,* 224.

Kilpatrick, D. G., Veronen, L. J., Resick, P. A. (1982). Psychological sequelae to rape:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Assessment and treatment strategies. In D. M. Dolays, & R. L. Meredith (Eds.), *Behavioral Medicine: Assessment and treatment strategies* (pp. 473-497). New York: Plenum Press.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. In L. S. Greenberg, & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 21-71). NewYork: Guilford Press.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., et al. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64(3),* 532-539.

Lambert, M. J., & Hill, C. E. (1994). Assessing psychotherapy outcomes and processes. In A. E. Bergin, & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 72-113). New York: Wiley.

Lazarus, R. S. (1982). Thoughts on the relations between emotion and cognition. *American Psychologist, 37,* 1019-1024.

Lazarus, R. S. (1991). Cognition and motivation in emotion. *American Psychologist, 46(4),* 352-376.

Leventhal, H. (1984). A perceptual-motor theory of emotion. In L. Berkowitz (Ed.), *Advances in experimental social psychology.* New York: Academic Press.

Lewis, M., & Saarni, C. (Eds.). (1985). *The socialization of emotions.* New York: Plenum Press.

Liem, J., O'Toole, J., & James, J. (1996). Themes of power and betrayal in sexual abuse

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

survivors' characterizations of interpersonal relationships. *Journal of Traumatic Stress, 9(4)*, 745-761.

Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology, 27,* 223-237.

Llewelyn, S. P., Elliott, R., Shapiro, D. A., Hardy, G., & Firth-Cozens, J. (1988). Client perceptions of significant events in prescriptive and exploratory periods of individual therapy. *British Journal of Clinical Psychology, 27,* 105-114.

Llewelyn, S. P., & Hume, W. I. (1979). The patient's view of therapy. *British Journal of Medical Psychology, 52,* 29-35.

Loevinger, J. (1987). *Ego development.* San Francisco: Jossey-Bass.

Luborsky, L. (1998). A guide to the CCRT method. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (2nd ed., pp. 15-42). Washington: American Psychological Association.

MacCormack, T., Simonian, J., Lim, J., Redmond, L., Roets, D., Dunn, S., & Butow et al. (2001). 'Someone who cares:' A qualitative investigation of cancer patients' experiences of psychotherapy. *Psycho-oncology, 10,* 52-65.

Machado, P. P., Beutler, L. E., & Greenberg, L. S. (1999). Emotion recognition in psychotherapy: Impact of therapist level of experience and emotional awareness. *Journal of Clinical Psychology, 55(1),* 39-57.

MacMillan, H. L., Fleming, J. E., Trocme, N., Boyle, M. H., Wong, M., Racine, Y. A. et al. (1997). Prevalence of child physical and sexual abuse in the community: Results from the Ontario Health Supplement. *Journal of the American Medical Association, 278,* 131-135.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health, 8,* 325-337.

Mahoney, M. J. (1991). *Human change processes: The scientific foundations of psychotherapy.* New York: Basic Books.

Malinosky-Rummel, R., & Hansen, D. J. (1993). Long-term consequences of childhood physical abuse. *Psychological Bulletin, 114,* 68-79.

Marmar, C. R., Gaston, L., Gallagher, D., & Thompson, L. W. (1989). Alliance and outcome in late-life depression. *The Journal of Nervous and Mental Disease, 177(8),* 464-472.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68(3),* 438-450.

Martin, J., Paivio, S., & Labadie, D. (1990). Memory-enhancing characteristics of client recalled important events in cognitive and experiential therapy: Integrating cognitive experimental and therapeutic psychology. *Counselling Psychology Quarterly, 3(3),* 239-256.

Martin, J. & Stelmaczonek, K. (1988). Participants' identification and recall of important events in counselling. *Journal of Counseling Psychology, 35(4),* 385-390.

Marziali, E. (1984). Three viewpoints on the therapeutic alliance: Similarities, differences, and associations with psychotherapy outcome. *Journal of Nervous and Mental Disease, 172,* 417-423.

Mayne, T. J., & Ambrose, T. K. (1999). Research review on anger in psychotherapy.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Journal of Clinical Psychology, 55(3), 353-363.

McCullough, L., Winston, A., Farber, B. A., Porter, F., Pollack, J., Vingiano, W., et al (1991). The relationship of patient-therapist interaction to outcome in brief psychotherapy. *Psychotherapy, 28(4),* 525-533.

McFarlane, A. C., & van der Kolk, B. A. (1996). Trauma and its challenge to society. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp. 24-46). New York: Guilford Press.

McGuire, K. N. (1991). Affect in focusing and experiential psychotherapy. In J. D. Safran & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 227-251). New York: Guilford Press.

Miller, S. D. & Duncan, B. L. (2000). Paradigm lost: From model-driven to client directed, outcome-informed clinical work. *Journal of Systemic Therapies, 19(1),* 20-34.

Morgan, T., & Cummings, A. L. (1999). Change experienced during group therapy by female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 67(1),* 28-36.

Muran, J. C., Gorman, B. S., Safran, J. D., Twining, L., Samstag, L., & Winston, A. (1995). Linking in-session change to overall outcome in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology, 63(4),* 51-657.

Murphy, P. M., Cramer, D., & Lillie, F. J.(1984). The relationship between curative factors perceived by patients in their psychotherapy and treatment outcome: An exploratory study. *British Journal of Medical Psychology, 57,* 187-192.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

Nichols, M. P. (1974). Outcome of brief cathartic psychotherapy. *Journal of Consulting and Clinical Psychology, 42(3),* 403-410.

Nichols, M. P., & Bierenbaum, H. (1978). Success of cathartic therapy as a function of patient variables. *Journal of Clinical Psychology, 34(3),* 726-728.

Nichols, M. P., & Zax, M. (1977). *Catharsis in Psychotherapy.* New York: Gardner Press.

Nieuwenhuis, J. A. (2002). Formations, ruptures, rebounds, and repairs: An intensive investigation of changes in the therapeutic relationship. (Doctoral dissertation, University of Saskatchewan, 2001). *Dissertation Abstracts International, 62,* 5385B.

Olio, K. A., & Cornell, W. F. (1993). The therapeutic relationship as the foundation for treatment with adult survivors of sexual abuse. *Psychotherapy, 30(3),* 512-522.

O'Malley, S. S., Suh, C. S., & Strupp, H. H. (1983). The Vanderbilt Psychotherapy Process Scale: A report on the scale development and a process-outcome study. *Journal of Consulting and Clinical Psychology, 51(4),* 581-586.

Omer, H., Winch, G., & Dar, R. (1998). Therapeutic impact in treatments for smoking and test-anxiety. *Psychotherapy Research, 8(4),* 439-454.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy – Noch Einmal. In A. E. Bergin, & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-376). New York: Wiley.

Paivio, S. C. (1995, June). *Analyzing the process of resolving "unfinished business"*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

related to child abuse. Paper presented at the meeting of the Society for Psychotherapy Research, Vancouver, BC.

Paivio, S. C. (1996). *Changing dysfunctional emotional processes stemming from childhood abuse.* Unpublished manuscript, University of Windsor, Windsor, ON.

Paivio, S. C., & Bahr, L. M. (1998). Interpersonal problems, working alliance, and outcome in short-term experiential therapy. *Psychotherapy Research, 8(4),* 392-407.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving 'unfinished business': Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology, 63(3),* 419-425.

Paivio, S. C., & Greenberg, L. S. (2000). Emotionally focused treatment of interpersonal trauma. *NC-PTSD Clinical Quarterly, 9,* 22-29.

Paivio, S. C., Hall, I. E., & Holowaty, K. A. M. (in press). The influence of therapist adherence and competence on client reprocessing of child abuse memories. *Psychotherapy.*

Paivio, S. C., Hall, I. E., Holowaty, K. A. M., Jellis, J. B., & Tran, N. (2001). Imaginal confrontation for resolving child abuse issues. *Psychotherapy Research, 11,* 433-453.

Paivio, S. C., & Laurent, C. (2001). Empathy and emotion regulation: Reprocessing memories of childhood abuse. *JCLP/In Session: Psychotherapy in Practice, 57(2),* 213-226.

Paivio, S. C., & Nieuwenhuis, J. A. (2001). Efficacy of emotion focused therapy for adult

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

survivors of child abuse: A preliminary study. *Journal of Traumatic Stress, 14,* 115-134.

Paivio, S. C., & Patterson, L. A. (1999). Alliance development in therapy for resolving child abuse issues. *Psychotherapy, 36(4),* 343-354.

Paivio, S. C., & Shimp, L. N. (1998). Affective change processes in therapy for PTSD stemming from childhood abuse. *Journal of Psychotherapy Integration, 8(4),* 211-229.

Paulson, B. L., Truscott, D., & Stuart, J. (1999). Clients' perceptions of helpful experiences in counseling. *Journal of Counseling Psychology, 46(3),* 317-324.

Paulson, B. L., & Worth, M. (2002). Counseling for suicide: Client perspectives. *Journal of Counseling and Development, 80(1),* 86-93.

Pennebaker, J. W., & Campbell, R. S. (2000). The effects of writing about traumatic experience. *NC-PTSD Clinical Quarterly, 9,* 18-21.

Pierce, R. A., Nichols, M. P., & DuBrin, J. R. (1983). *Emotional expression in psychotherapy.* New York: Gardner Press.

Pitman, R. K., Orr, S. P., Altman, B., Longpre, R. E., Poire, R. E., & Macklin, M. L. (1996). Emotional processing during eye movement desensitization and reprocessing therapy of Vietnam veterans with chronic posttraumatic stress disorder. *Comprehensive Psychiatry, 37(6),* 419-429.

Plutchik, R. (1980). *Emotion: A psychoevolutionary synthesis.* New York: Harper & Row.

Pos, A. E., Greenberg, L. S., Goldman, R. N., & Korman, L. M. (2003). Emotional

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 71(6),* 1007-1016.

Rennie, D. L., & Toukmanian, S. G. (1992). Explanation in psychotherapy process research. In S. G. Toukmanian, & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 234-251). Newbury Park, CA: Sage.

Resick, P. A., Jordan, C. G., Girelli, S. A., Hutter, C. K., & Marhoefer-Dvorak, S. (1988). A comparative victim study of behavioral group therapy for sexual assault victims. *Behavior Therapy, 19,* 385-401.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60,* 748-756.

Rice, L. N. (1974). The evocative function of the therapist. In D. A. Wexler, & L. N. Rice (Eds.), *Innovations in client-centred therapy* (pp. 289-311). New York: Wiley.

Rogers, C. R. (1951). *Client centred therapy: Its current practice, implications, and theory.* Oxford, England: Houghton Mifflin.

Rosner, R. (1996). *The relationship between emotional expression, treatment, and outcome in psychotherapy.* Frankfurt, Germany: Lang.

Rothbaum, B. O., & Foa, E. B. (1996). Cognitive-behavioral therapy for posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp.491-509). New York: Guilford Press.

Rounsaville, B. J., Chevron, E. S., Prusoff, B. A., Elkin, I., Imber, S., Sotsky, S., et al.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

(1987). The relation between specific and general dimensions of the psychotherapy process in interpersonal psychotherapy of depression. *Journal of Consulting and Clinical Psychology, 55(3),* 379-384.

Safran, J. D. (1998). *Widening the scope of cognitive therapy: The therapeutic relationship, emotion, and the process of change.* Northvale, NJ: Jason Aronson.

Safran, J. D., & Greenberg, L. S. (1991a). Affective change processes: A synthesis and critical analysis. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 339-362). New York: Guilford Press.

Safran, J. D., & Greenberg, L. S. (1991b). Emotion in human functioning: Theory and therapeutic implications. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 3-15). New York: Guilford Press.

Safran, J. D., & Wallner, L. K. (1991). The relative predictive validity of two therapeutic alliance measures in cognitive therapy. *Psychological Assessment, 3(2),* 188-195.

Saxe, B. J., & Johnson, S. M. (1999). An empirical investigation of group treatment for a clinical population of adult female incest survivors. *Journal of Child Sexual Abuse, 8(1),* 67-88.

Saxe, G. N., van der Kolk, B. A., Berkowitz, R., Chinman, G., Hall, K., Lieberg, G., & Schwartz, J. (1993). Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry, 150,* 1037-1042.

Scott, M. J., & Stradling, S. G. (1997). Client compliance with exposure treatments for posttraumatic stress disorder. *Journal of Traumatic Stress, 10(3),* 523-526.

Scott, M. J., & Stradling, S. G. (2001). Determining the ports of entry amongst the

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

post-traumatic states: Treatment implications. *Behavioural and Cognitive Psychotherapy, 29(2),* 245-250.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50(12),* 965-974.

Shapiro, F. (1989). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 20,* 211-217.

Silver, S. M., Brooks, A., & Obenchain, J. (1995). Treatment of Vietnam war veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training. *Journal of Traumatic Stress, 8,* 337-342.

Sloane, R. B., Staples, F. R., Whipple, K., & Cristol, A. H. (1977). Patients' attitudes toward behavior therapy and psychotherapy. *American Journal of Psychiatry, 134(2),* 134-137.

Solomon, D., Gerrity, E. T., Muff, A. M. (1992). Efficacy of treatments for posttraumatic stress disorder. *Journal of the American Medical Association, 268(5),* 633-638.

Spinelli, E. (2001). Listening to our clients: A dangerous proposal. *American Journal of Psychotherapy, 55(3)* 357-363.

Sroufe, L. A. (1995). *Emotional development: The organization of emotional life in the early years.* Cambridge, MA: Cambridge University Press.

Sterba, R. F. (1934). The fate of the ego in analytic therapy. *International Journal of Psycho-Analysis, 115,* 117-126.

Strauss, J. L. (2001). Patterns and impact of the alliance and affective arousal in

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

psychotherapy: An application to cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Dissertation Abstracts International, 62,* 2504B.

Strupp, H. H. (1996). The tripartite model and the Consumer Reports study. *American Psychologist, 51(10),* 1017-1024.

Taurke, E. A., Flegenheimer, W., McCullough, L., Winston, A., Pollack, J., & Trujillo, M. (1990). Change in patient affect/defense ratio from early to late sessions in brief psychotherapy. *Journal of Clinical Psychology, 46(5),* 657-668.

Teasdale, J. (1993). Emotion and two kinds of meaning: Cognitive therapy and applied cognitive science. *Behavior Research and Therapy, 31,* 339-354.

Turner, A., & Paivio, S. C. (2002). *Relations among childhood maltreatment, alexithymia, social avoidance, and social support.* Poster session presented at the annual convention of the American Psychological Association, Chicago, IL.

Vaillant, L. M. (1994). The next step in short-term dynamic psychotherapy: A clarification of objectives and techniques in an anxiety-regulating model. *Psychotherapy, 31,* 642-654.

van der Kolk, B. A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp. 182-213). New York: Guilford Press.

van der Kolk, B. A., & McFarlane, A. C. (1996). The black hole of trauma. In B. A. van

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp. 3-23). New York: Guilford Press.

van der Kolk, B. A., McFarlane, A. C., & van der Hart, O. (1996). A general approach to treatment of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body, and society* (pp. 417-440). New York: Guilford Press.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth L. (Eds.) (1996). *Traumatic Stress: The effects of overwhelming experience on mind, body, and society.* New York: Guilford Press.

Vaughan, K., Wiese, M., Gold, R., & Tarrier, N. (1994). Eye-movement desensitization: Symptom change in posttraumatic stress disorder. *British Journal of Psychiatry, 164,* 532-541.

Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research, 7,* 21-43.

Watson, J. C. (1996). The relationship between vivid description, emotional arousal, and in-session resolution of problematic reactions. *Journal of Consulting and Clinical Psychology, 64(3),* 459-464.

Watson, J. C., Greenberg, L. S., & Lietaer, G. (1991). The experiential paradigm unfolding: Relationship and experiencing in therapy. In J. D. Safran, & L. S. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 3-27). New York: Guilford Press.

Watson, J. C., & Rennie, D. L. (1994). Qualitative analysis of clients' subjective

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

experience of significant moments during the exploration of problematic reactions. *Journal of Counseling Psychology, 41(4),* 500-509.

Wheeler, I., O'Malley, K., Waldo, M., Murphey, J., Blank, C. (1992). Participants' perception of therapeutic factors in groups for incest survivors. *The Journal for Specialists in Group Work, 17(2),* 89-95.

Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology, 63,* 928-937.

Windholz, M. J., & Silberschatz, G. (1988). Vanderbilt Psychotherapy Process Scale: A replication with adult outpatients. *Journal of Consulting and Clinical Psychology, 56(1),* 56-60.

Wiser, S., & Arnow, B. (2001). Emotional experiencing: To facilitate or regulate? *JCLP/In session: Psychotherapy In Practice, 57(2),* 157-168.

Wolfsdorf, B. A., & Zlotnick, C. (2001). Affect management in group therapy for women with posttraumatic stress disorder and histories of childhood sexual abuse. *JCLP/In Session: Psychotherapy in Practice, 57(2),* 169-181.

Yalom, I. D. (1985). *The theory and practice of group psychotherapy* (3rd ed.). New York: Basic.

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37,* 369-376.

Zlotnick, C., Shea, T. M., Rosen, K., Simpson, E., Mulrenin, K., Begin, A., & Pearlstein,

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

T. (1997). An affect-management group for women with posttraumatic stress disorder and histories of childhood sexual abuse. *Journal of Traumatic Stress, 10(3),* 425-436.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX A

Helpful Aspects of Therapy Questionnaire (HAT; R. Elliott, 1985; Llewelyn, 1988)

1. Which event that occurred in therapy do you feel was most helpful to you personally?

2. Can you say why it was helpful? Please describe what made it helpful and/or what you got out of it.

3. How helpful was this particular event? Rate it on this scale: 1 to 9

   (1 = extremely hindering; 9 = extremely helpful)

4. About where in therapy (i.e. What session or sessions) did this event occur?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX B

Post-Treatment Interview (PTI; Paivio & Nieuwenhuis, 2001)

1. Were there specific things, incidents, or moments in therapy that you think contributed to any of the changes that you've described?

2. Do you remember one specific incident in therapy that you think may have contributed to the changes that you've described?

3. And how do you think that contributed to your change? (If client response was too vague, it was followed with: How else do you think that might have contributed to the change you discussed?)

4. Do you remember when that occurred approximately?

5. Were there any other specific incidents that contributed?

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#1 Explored Child Abuse Memories During IC: expressed anger at mother for not noticing abuse and not meeting need for affection What Helpful: "able to say what I felt without hurting her; expressed anger to her and not feeling so guilty about it; have a right to feel that way"	M-HAT P-HAT PTI	Early Session #4	14:55 mins B = 13:23 E = 28:18	M = 3 P = 4	M = 5 P = 5 anger hurt
#2 Explored Child Abuse Memories During IC: initial fear towards mother; then expressed anger at her for emotional abuse and treating her like a slave What Helpful: "big surprise to be so intimidated, then stopped being intimidated; very effective because very real and forced to face buried feelings about her; big help in sorting things out - physically get up and it's a different angle there"	M-HAT P-HAT PTI	Early Session #4	13:28 mins B = 35:20 E = 48:48	M = 4 P = 4	M = 3 P = 5 anger sadness

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#3 Explored Child Abuse Memories During IC: expressed anger at father for physical abuse and unmet need for respect; experienced feelings of sadness What Helpful: "very effective for getting me physically in touch with feelings instead of intellectually"	M-HAT P-HAT PTI	Early Session #4	19:33 mins B = 19:53 E = 39:26	M = 4 P = 4	M = 3 P = 4 sadness anger
#4 Explored Child Abuse Memories: sadness and anger about mother's neglect aroused while reading letters to and from mother What Helpful: "reading out loud was different - it struck me; telling her about everything and putting the blame where it belongs and sticking up for myself; it's relief from a bully or something, able to joke now and more clear"	P-HAT PTI	Early Session #7	35:02 mins B = 18:30 E = 53:32	M = 4 P = 4	M = 3 P = 4 sadness anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#5 Explored Child Abuse Memories During IC: expressed anger and disgust at grandfather for his sexual abuse and how it impacted her life What Helpful: "released some anger and put blame on him where it belongs; tell him how it affected my life"	M-HAT P-HAT PTI	Early Session #6	20:09 mins B = 23:57 E = 44:06	M = 4 P = 6	M = 5 P = 5 anger sadness disgust
#6 Explored Child Abuse Memories During IC: expressed fear, rage, and pain at mother for physical and emotional abuse and the impact on her life What Helpful: "I remembered the look on her face; seeing that look all of a sudden just everything hurt and that's when I could finally start to confront her; it made me realize that she was coldhearted, mean, and very sick woman and nothing I could have done would ever change that"	P-HAT PTI	Late Session #19	21:52 mins B = 19:47 E = 41:39	M = 4 P = 6	M = 5 P = 5 anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#7 Explored Child Abuse Memories During IC: expressed anger at mother for comparing client to deceased brother and for being emotionally unavailable to her due to brother's death What Helpful: "letting out feelings and allowing myself to feel the other side"	P-HAT	Early Session #4	17:43 mins B = 31:50 E = 49:33	M = 3 P = 4	M = 4 P = 5 anger hurt
#8 Explored Child Abuse Memories: work with abuse-related nightmare; initially experienced feelings of fear and lack of control; then created a new, empowering ending where stood up to father What Helpful: "gave me a way to deal with them and allowed me to sleep again; gave a feeling of control over my life again"	M-HAT P-HAT	Middle Session #8	47:07 mins B = 10:45 E = 57:52	M = 4 P = 4	M = 2 P = 3 fear sadness anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#9 Explored Child Abuse Memories: re-telling details of one sexual abuse incident and re-experiencing feelings of fear and shame; anger also expressed at abuser (friend of brother) What Helpful: "made it more real and moved me out of denial so didn't have to cover up for him anymore; felt empowered, able to cry and feel supportive of myself"	P-HAT PTI	Late Session #15	19:32 mins B = 38:58 E = 58:30	M = 4 P = 4	M = 3 P = 4 anger
#10 Explored Child Abuse Memories During IC: expressed anger at mother for her passivity and not leaving abusive father; also sadness at her not meeting need for affection What Helpful: "realized she was also responsible and not just my father"	P-HAT	Late Session #17	29:04 mins B = 25:48 E = 54:52	M = 4 P = 4	M = 3 P = 4 sadness anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#11 Explored Child Abuse Memories During IC: intense verbal and physical expression of anger at father using therapy bat What Helpful: "when I used the therapy bat to hit the cushion I felt in touch with my anger and was able to express that"	P-HAT	Late Session #17	11:04 mins B = 21:00 E = 32:04	M = 4 P = 6	M = 4 P = 5 anger sadness
#12 Explored Self-Conflict During 2-Chair: sorted out feelings of confusion and fear about entering into an intimate relationship with a male friend and lack of clarity about sexual orientation What Helpful: "realized my needs and desires separate from others; has allowed me to feel comfortable in my own self and comfortable with others"	P-HAT	Middle Session #11	53:03 mins B = 05:22 E = 58:25	M = 5 P = 7	M = 2 P = 3 fear hurt

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#13 Allowed Painful Emotion and Grieved For Self: realized that she feels sadness rather than anger with regard to being abused and has many wounds to grieve; crying throughout What Helpful: "therapist suggested anger may not be primary feeling but grief - this felt more real to me; helped me to say, yes it's ok to be sad and realized I have very limited grieving techniques"	M-HAT	Middle Session #11	42:51 mins B = 07:27 E = 50:18	M = 4 P = 6	M = 3 P = 5 sadness
#14 Explored Child Abuse Memories During IC: expressed anger at mother and father for their hurtful treatment and for creating a highly unpredictable and frightening atmosphere in the home What Helpful: "confronting them made me feel like an adult and not a scared little child; put blame where it belonged; like a big weight off my shoulders; I could deal with things more and not blame my past"	M-HAT P-HAT PTI	Early Session #4	40:08 mins B = 15:39 E = 55:47	M = 4 P = 6	M = 5 P = 5 anger disgust

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#15 Explored Child Abuse Memories During IC: expressed anger at stepmother for treating her like a slave and for not caring What Helpful: "tell(ing) her off; realized how hard it would be as raised with 'never talk back"	M-HAT P-HAT	Early Session #4	15:05 mins B = 25:48 E = 40:53	M = 3 P = 4	M = 1 P = 2 disgust anger
#16 Explored Child Abuse Memories During IC: physically expressed hurt and anger at father for sexually abusing her by pounding fists on pillow; also hurt and anger at mother for not giving affection or protecting her What Helpful: "was first time I was able to say 'I hate you'; being able to vocalize my anger, my hatred; it helped me to release the deep seated feelings I had toward my parents"	M-HAT P-HAT PTI	Early Session #4	25:37 mins B = 10:17 E = 35:54	M = 4 P = 4	M = 5 P = 5 hurt anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#17 Explored Child Abuse Memories During IC: physically expressed anger at stepfather by hitting pillow for sexually abusing her What Helpful: "when I got to beat up my stepfather with the little bat; I felt a whole lot better, didn't feel like I was out for revenge anymore"	P-HAT PTI	Middle Session #8	26:00 mins B = 18:56 E = 44:56	M = 4 P = 5	M = 3 P = 5 anger fear
#18 Explored Child Abuse Memories During IC: expressed anger at mother and father for using her as a slave, not meeting her needs and pushing their religion onto her What Helpful: "telling significant others to bug off and leave me alone; divorcing myself from old tape ideas, expectations, we're not glued anymore; ties into coming out of a cage - there's no more resistance, there's nothing to have to push at anymore"	P-HAT PTI	Middle Session #10	26:21 mins B = 30:42 E = 57:03	M = 4 P = 6	M = 4 M = 4 anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#19 Allowed Painful Emotion and Grieved for Self: admitted feelings of worthlessness and shame; anger at and ashamed of father for chaotic upbringing where needs not met and never felt safe What Helpful: "I exposed the shame and guilt and pain; it was a great relief and it caused me to grieve"	M-HAT	Early Session #5	48:33 mins B = 06:07 E = 54:40	M = 4 P = 6	M = 3 P = 4 sadness disgust
#20 Explored Self-Conflict During 2-Chair: enacted how interrupts emotion and shuts himself down in interactions with wife by feeling numbness and confusion; realized does this out of fear that marriage may end if shares true feelings What Helpful: "made me aware there's a connection between our problems and my relations to my dad, and that I can physically interfere with resolution of our problems"	P-HAT	Late Session #19	29:03 mins B = 28:22 E = 57:25	M = 4 P = 6	M = 2 P = 3 anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFUL	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#21 Explored Self-Conflict During 2-Chair: dialogued with critical part of self which sabotages attempts to succeed; discovered shame at alcoholic family and showing true self What Helpful: "helps me deal with my negative thinking and don't beat self up as much; getting to talk about the pain and humiliation finally"	P-HAT PTI	Middle Session #10	39:47 mins B = 11:13 E = 51:00	M = 5 P = 6	M = 2 P = 3 hurt anger
#22 Explored Child Abuse Memories: sorting out why she continues to be fearful of brother who sexually abused her What Helpful: "it validated my fear"	M-HAT	Early Session #5	12:41 mins B = 25:29 E = 38:10	M = 4 P = 4	M = 2 P = 3 fear sadness
#23 Explored Trauma Memories During IC: expressed anger at stepfather for his emotional abuse and unwillingness to take responsibility for his actions What Helpful: "able to let go of frustration at not being able to express these feelings to him"	M-HAT P-HAT	Early Session #4	23:31 mins B = 34:25 E = 57:56	M = 4 P = 6	M = 2 P = 3 anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#24 Explored Trauma Memories During IC: expressed guilt feelings about sexual abuse; placed burden of guilt for this back onto father What Helpful: "letting go of guilt; I was not to blame for what happened; made me feel better about myself and lifted a heavy weight off me"	M-HAT P-HAT	Middle Session #9	62:22 mins B = 09:38 E= 1:12:00	M = 4 P = 5	M = 3 P = 4 shame anger
#25 Allowed Painful Emotion and Grieved for Self: acknowledged how much she is guided by fear; explored fears of abandonment from childhood What Helpful: "it was a revelation. I allowed it to emerge; now I know it's there, I have to deal with it"	M-HAT	Middle Session #9	54:58 mins B = 00:58 E = 55:56	M = 5 P = 6	M = 2 P = 3 fear

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Event

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#26 Explored Child Abuse Memories During IC: expressed feelings of hurt at mother for her lack of attention and protection; switched to feelings of shame about brother sexually abusing her and placed the blame back onto him What Helpful: "she [mother] wasn't really responsible for that episode in my life so I couldn't keep blaming her. I had to put the blame where it belonged and that was on my brother; that was significant, that it was one person to blame, not a whole bunch"	PTI	Late Session #20	30:01 mins B = 27:09 E = 57:10	M = 4 P = 6	M = 3 P = 5 anger hurt
#27 Explored Self-Conflict During 2-Chair: sorting out feelings of anxiety during session and their meaning; discovered fear of becoming emotional in session What Helpful: "more able to recognize it [fear] when it occurs; seems to have diminished since it was discussed and I became more aware of it; now more relaxed and concentrate better"	M-HAT	Early Session #7	34:04 mins B = 14:10 E = 48:14	M = 4 P = 5	M = 3 P = 3 fear

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX C

Client-Identified Helpful Events

EVENT DESCRIPTION And HELPFULNESS	SOURCE	LOCATION	LENGTH	EXP Rating	EAS Rating
#28 Explored Child Abuse Memories During IC: expressed anger and hurt at father for not listening, visiting or caring What Helpful: "got to imagine how my father would or would not respond to me; tell him things I need to say to him"	M-HAT	Early Session #4	22:55 mins B = 13:29 E = 36:24	M = 3 P = 4	M = 3 P = 4 anger
#29 Explored Child Abuse Memories During IC: expressed shame and apologies to siblings for hurting them, for transferring the abuse she received from parents onto siblings What Helpful: "realizing it happened because I was exposed to sex at an early age; having therapist tell me I wasn't wrong"	M-HAT	Middle Session #9	37:13 mins B= 1:12:27 E= 1:49:40	M = 5 P = 5	M =3 P = 5 guilt hurt disgust

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

Researcher-Identified Control Events

EVENT DESCRIPTION	LOCATION	LENGTH	EXP Rating	EAS Rating
#1 Explored Impact of Abuse on Self-Esteem/Current Functioning: recounted memory of sexual abuse by family acquaintance and then impact of this on relationship with her husband	Early Session #3	20:18 mins B = 08:51 E = 29:09	M = 3 P = 4	M = 2 P = 3 anger
#2 Explored Feelings about a Current Relationship: in anticipation of tension with family at Xmas, expressed anger at sister for her dismissiveness and also fear of confronting sister and standing up for self	Early Session #7	21:33 mins B = 28:08 E = 49:36	M = 4 P = 4	M = 3 P = 4 anger sadness
#3 Explored Self-Conflict During Empathy: explored fears of expressing anger about father's physical and emotional abuse, and questioned how to release his anger in a positive way	Early Session #3	29:33 mins B = 19:40 E = 49:13	M = 5 P = 5	M = 2 P = 3 fear anger
#4 Explored Child Abuse Memories During IC: expressed hurt and anger at mother for her neglect; also feelings of sadness at being shut out and continued fear of abandonment	Early Session #6	41:39 B = 10:53 E = 52:32	M = 3 P = 4	M = 3 P = 4 anger
#5 Explored Impact of Abuse on Self-Esteem/Current Functioning: expressed fears of being disliked and abandoned if she were to speak her true feelings and needs to family and friends; deciding to work towards not being a "doormat" and asking for needs to be met	Early Session #5	30:58 mins B = 29:54 E= 1:00:52	M = 5 P = 6	M = 3 P = 4 sadness hurt anger
#6 Explored Child Abuse Memories: expressed sadness over the many losses (not allowed to have or show emotions, lost identity, no self-confidence) due to mother's physical and emotional abuse	Late Session #15	37:43 mins B = 15:30 E = 53:13	M = 4 P = 4	M = 3 P = 4 sadness anger

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

Researcher-Identified Control Events

EVENT DESCRIPTION	LOCATION	LENGTH	EXP Rating	EAS Rating
#7 Explored Feelings about a Current Relationship: expressed anger at spouse for prior physical abuse and for lack of responsibility; explored how she would like relationship to be different now	Early Session #5	36:33 mins B = 30:07 E= 1:06:40	M = 4 P = 4	M = 3 P = 3 anger
#8 Explored Non-Abuse Trauma Memory: recounted her recent confrontation with trauma memories/feelings (fear) in the shopping mall where she was lost at age 8; explored the changes to her self-concept (confidence, good feelings about self) and connected it to progress with abuse issues	Middle Session #9	25:35 mins B = 00:46 E = 26:21	M = 6 P = 6	M = 2 P = 3 content
#9 Explored Self-Conflict: expressed anger and disappointment at family's silence and not meeting his emotional needs; questioned/explored why can't let go of wanting them to meet needs	Late Session #19	46:26 mins B = 06:00 E = 52:26	M = 5 P = 6	M = 3 P = 4 fear anger
#10 Explored Feelings about a Current Relationship: expressed anger at father for current impaired driving and abusiveness toward mother	Late Session #16	19:43 mins B = 39:50 E = 59:33	M = 3 P = 4	M = 2 P = 3 anger
#11 Explored Self-Conflict: sorting out conflicting feelings about reestablishing relationship with spouse who sexually abused their daughter	Late Session #15	30:07 mins B = 14:03 E = 44:10	M = 5 P = 5	M = 2 P = 4 anger sadness
#12 Explored Self-Conflict: sorting out conflicting feelings about moral/ethical dilemma at work and connected to childhood abuse experiences - not wanting to compromise self-worth as has done in past	Middle Session #10	34:54 mins B = 08:09 E = 43:03	M = 5 P = 6	M = 2 P = 3 anger fear

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

Researcher-Identified Control Events

EVENT DESCRIPTION	LOCATION	LENGTH	EXP Rating	EAS Rating
#13 Explored Impact of Abuse on Self-Esteem/Current Functioning: explored how her fear and shame about expressing anger has come from father's angry and abusive behavior; resulting feelings of sadness	Middle Session #8	33:26 mins B = 15:26 E = 48:52	M = 4 P = 4	M = 3 P = 4 anger sadness
#14 Explored Impact of Abuse on Self-Esteem/Current Functioning: expressed sadness and anger at lost opportunities and negative impact on self-concept and ability to trust others due to parents' abuse and neglect of emotional needs	Early Session #5	22:22 mins B = 13:30 E = 35:52	M = 4 P = 5	M = 3 P = 4 anger sadness shame
#15 Explored Self-Conflict: explored her feeling that there are psychological factors creating her physical exhaustion	Early Session #3	15:05 mins B = 25:48 E = 40:53	M = 3 P = 4	M =2 P = 3 sadness
#16 Explored Impact of Abuse on Self-Esteem/Current Functioning: explored feelings of being undeserving, unworthy and powerless with her children and in family of origin; made connections to emotional abuse by parents	Early Session #3	34:34 mins B = 05:26 E = 40:00	M = 5 P = 5	M = 3 P = 4 anger hurt sadness
#17 Explored Child Abuse Memories During IC: expressed fear and sadness at mother for her suicidal threats, having to take care of mother instead of mother caring for her needs	Middle Session #12	19:07 mins B = 08:43 E = 27:50	M = 4 P = 4	M = 3 P = 4 fear sadness
#18 Explored Self-Conflict: explored how she has harshly judged herself and others similar to how she was judged by parents; discovery that it is ok to be imperfect, with accompanying feelings of sadness and loss	Middle Session #13	37:24 mins B = 22:06 E = 59:30	M = 5 P = 6	M = 3 P = 4 sadness

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

Researcher-Identified Control Events

EVENT DESCRIPTION	LOCATION	LENGTH	EXP Rating	EAS Rating
#19 Explored Child Abuse Memories: expressed shame about her childhood where she lived in constant fear; experienced fear of sharing feelings in session; expressed hurt about father's physical and emotional neglect	Early Session #3	34:37 mins B = 20:06 E = 54:43	M = 4 P = 5	M = 2 P = 3 fear sadness
#20 Explored Feelings about Problem at Work: expressed anger about difficulties with his disability pension and resulting interruption to his education; also feelings of defeat	Late Session #15	36:00 mins B = 00:38 E = 36:38	M = 3 P = 4	M = 2 P = 3 anger sadness
#21 Explored Child Abuse Memories: expressed anger and shame at alcoholic parents for their physical violence, neglect of his needs and robbing him of peacefulness and stability	Early Session #3	30:44 mins B = 15:37 E = 46:21	M = 4 P = 4	M = 2 P = 4 sadness disgust
#22 Explored Child Abuse Memories: expressed fear and anger at brother for sexually abusing and using her, and at parents for not protecting her	Early Session #3	20:18 mins B = 23:02 E = 53:20	M = 4 P = 4	M = 3 P = 4 sadness anger
#23 Explored Impact of Abuse on Self-Esteem/Current Functioning: explored how stepfather's emotional abuse and lack of attention by mother and stepfather has led to his distrust of others and difficulty viewing self as intelligent	Early Session #5	24:52 mins B = 08:48 E = 33:40	M = 4 P = 4	M =3 P = 3 anger sadness
#24 Explored Child Abuse Memories During IC: expressed wants and needs to mother; wanted her emotional support and closeness as child and still now; expressed hurt and helplessness about this lack of closeness	Middle Session #12	19:34 mins B = 19:31 E = 39:05	M = 4 P = 4	M = 2 P = 3 anger hurt

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX D

Researcher-Identified Control Events

EVENT DESCRIPTION	LOCATION	LENGTH	EXP Rating	EAS Rating
#25 Explored Self-Conflict During 2-Chair: explored why difficult to accept nurturing, let people in emotionally; part of self wants to take risk because tired of isolation, and discovered another part of self that fears being hurt and abandoned	Middle Session #14	45:17 mins B = 02:23 E = 47:40	M = 5 P = 6	M = 2 P = 3 sadness fear
#26 Explored Impact of Abuse on Self-Esteem/Current Functioning: explored how she punishes herself with compulsive eating and her feelings of confusion about this	Middle Session #13	17:15 mins B = 35:35 E = 52:50	M = 5 P = 6	M = 2 P = 3 sadness
#27 Explored Child Abuse Memories During IC: expressed anger at stepfather for his emotional abuse; connected this to current difficulties setting limits with people	Early Session #4	16:07 mins B = 33:44 E = 49:51	M = 4 P = 5	M = 2 P = 3 anger fear
#28 Explored Feelings about a Current Relationship: expressed hurt and anger about recent examples of mother's criticism and controlling behavior; expressed her right to assert boundaries with mother and say 'No'	Early Session #5	39:51 mins B = 02:52 E = 42:43	M = 3 P = 4	M = 2 P = 3 anger content
#29 Explored Self-Conflict: expressed guilt and fear about her drinking behavior and possible recent sexual encounter while impaired; questioning why she is "mean" to herself and wanting to regain control over herself	Middle Session #11	49:22 mins B = 02:46 E = 52:08	M = 5 P = 5	M = 2 P = 3 fear shame

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

APPENDIX E

Description of Event Content Categories

(1) Explored Child Abuse Memories During IC:

Contained the explicit reexperiencing of child abuse memories and feelings, and exploration of associated beliefs about self and the abusive other, in the context of the IC intervention.

(2) Explored Child Abuse Memories:

Contained reexperiencing and exploration of child abuse memories and feelings that was accomplished in the context of empathic exploration with the therapist.

(3) Allowed Painful Emotion and Grieved for Self:

Also contained exploration of child abuse material, but focused more specifically on accessing painful emotions such as sadness and shame.

(4) Explored Abuse Impact on Current Functioning:

Contained exploration of the impact of abuse on current functioning, such as interpersonal relating and beliefs about self.

(5) Explored Self-Conflict During 2-Chair:

Contained exploration of intrapsychic conflicts, particularly self-critical or self-interruptive processes stemming from abuse. (e.g. a client who was distrustful of others explored a part of herself that feared being emotionally wounded as she had been during her childhood).

(6) Explored Self-Conflict:

Contained exploration of intrapsychic conflicts that was accomplished in the context of empathic exploration with the therapist.

(7) Explored Current Relationship, (8) Explored Problem at Work, & (9) Explored Non-Abuse Trauma Memory:

Each of these categories contained little or no reference to child abuse-related issues, and generally focused on current life concerns.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

VITA AUCTORIS

NAME:	Karen Anne Marie Holowaty
PLACE OF BIRTH:	Brandon, Manitoba
YEAR OF BIRTH:	1971
EDUCATION:	Miles Macdonell Collegiate, Winnipeg 1986-1989
	University of Manitoba, Winnipeg, Manitoba 1989-1993, B.A.(Honours) Psychology
	University of Windsor, Windsor, Ontario 1993-1995, M.A. Clinical Psychology
	University of Windsor, Windsor, Ontario 1995-2004, Ph.D. Clinical Psychology

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.